STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT
OF THE

COVERING ALL KIDS
HEALTH INSURANCE PROGRAM

OCTOBER 2012

WILLIAM G. HOLLAND

AUDITOR GENERAL

SPRINGFIELD OFFICE:
ILES PARK PLAZA
740 EAST ASH • 62703-3154
PHONE: 217/782-6046
FAX: 217/785-8222 • TTY: 888/261-2887
FRAUD HOTLINE: 1-855-217-1895

CHICAGO OFFICE:
MICHAEL A. BILANDIC BLDG. • SUITE S-900
160 NORTH LASALLE • 60601-3103
PHONE: 312/814-4000
FAX: 312/814-4006
FRAUD HOTLINE: 1-855-217-1895

OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

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

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

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

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

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
October 2012

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, 2011

Release Date: October 2012

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 third annual audit and covers FY11. 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 (e.g., those children whose family income was greater than 200 percent of the federal poverty level or who were undocumented immigrants).

This FY11 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. Our audit found:

- In FY11, 97,030 children were enrolled in the EXPANDED ALL KIDS program.
- Total claims paid in FY11 for the EXPANDED ALL KIDS enrollees were $96.6 million.
- HFS received approximately $10.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $85.7 million. The children added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.
- FY11 ALL KIDS claim data included 414 individuals who received 2,543 services totaling $126,092 after the month of their 19th birthday after their eligibility ended. Additionally, the data also included 315 individuals who appeared to be enrolled with more than one identification number.
- Our FY11 review indicated a continued problem with HFS incorrectly categorizing documented immigrants as undocumented in its data. As a result, HFS did not submit and receive federal matching funds for these misclassified documented immigrants.
- While HFS and DHS took action to address the 14 recommendations, many of these actions did not occur within this audit period (FY11). We determined that 3 recommendations were implemented, 1 was partially implemented, and 10 were repeated. For six of the recommendations that were repeated, the action taken by HFS or DHS did not occur until after the FY11 audit period.

Due to the limited time for HFS and DHS to implement prior audit recommendations before the next audit begins, the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

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

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." 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. (page 4)

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. The Public Act was effective June 1, 2009. The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. There were five new recommendations and three new areas added to previous recommendations. This is the third annual audit (FY11) and covers FY11 beginning on July 1, 2010.

This FY11 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. We did not undertake testing of eligibility files in this audit given that several of the eligibility requirements changed in FY12 as a result of Public Act 96-1501. Furthermore, many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY12, after our audit period. We will review these changes in future audits. (pages 2-3)

Matter for Consideration by the Illinois General Assembly

HFS and DHS accepted all recommendations from our past ALL KIDS audit and have been working to implement them.

The Covering ALL KIDS Health Insurance Act requires the Auditor General to conduct an annual audit of the EXPANDED ALL KIDS program. However, with an annual audit, HFS and DHS have had limited time to implement the recommendations before the next audit period began. The FY10 audit was released in April 2011. HFS and DHS were unable to address many of the recommendations prior to June 30, 2011. Consequently, these findings are repeated in this FY11 audit, which covers the period July 1, 2010, to June 30, 2011.

The General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

Due to the limited time for HFS and DHS to implement prior audit recommendations before the next audit begins, the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General. (pages 3-4)

ALL KIDS Program

In FY11, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $3.2 billion in claims. In FY11, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion (EXPANDED ALL KIDS) totaled 97,030. As seen in Digest Exhibit 1, on June 30, 2011, there were 74,975 enrollees as a result of the expansion of which 51,669 (69%) were classified as undocumented immigrants in the HFS data. (page 6)

Payments for ALL KIDS Services

According to claim data provided by HFS, in FY09, payments for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. Payments for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. The majority of the payments for services were for undocumented immigrants. Payments for children categorized by HFS as undocumented totaled $54.9 million in FY09, $59.2 million in FY10, and $58.8 million in FY11. Therefore, in FY10 and FY11, undocumented immigrants make up approximately 65 percent of the total payments for the EXPANDED ALL KIDS program over the last two fiscal years. Digest Exhibit 2 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was undocumented for both FY10 and FY11. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated. (pages 7-8)

Digest Exhibit 1

EXPANDED ALL KIDS ENROLLMENT BY PLAN [3, 4]

As of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY10	FY11	FY10	FY11
Assist <134% FPL/$29,725.50[2]	n/a	n/a	49,920	48,481
Share 134%-150% FPL/$33,525[2]	n/a	n/a	1,644	1,472
Premium Level 1 151%-200% FPL/$44,700[2]	n/a	n/a	1,538	1,253
Premium Level 2 201%-300% FPL/$67,050[2]	16,400	18,318	418	382
Premium Level 3[1] 301%-400% FPL/$89,400[2]	2,997	4,028	62	59
Premium Level 4[1] 401%-500% FPL/$111,750[2]	520	765	20	14
Premium Level 5[1] 501%-600% FPL/$134,100[2]	105	134	2	6
Premium Level 6[1] 601%-700% FPL/$156,450[2]	26	35	3	2
Premium Level 7[1] 701%-800% FPL/$178,800[2]	9	13	0	0
Premium Level 8[1] >800% FPL/No limit[2]	17	13	0	0
Total	**20,074**	**23,306**	**53,607**	**51,669**

Notes:

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

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY11.

[3] Enrollment is the total number of enrollees that were eligible on June 30 of 2010 and 2011. There were 94,628 enrollees eligible at some point during FY10 and 97,030 enrollees eligible at some point during FY11.

[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
PAYMENTS FOR EXPANDED ALL KIDS SERVICES BY ALL KIDS PLAN [1, 3]
Fiscal Years 2010 and 2011

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY10	FY11	FY10	FY11	FY10	FY11
Assist <134% FPL/$29,725.50[2]	n/a	n/a	$55,613,496	$55,291,285	$55,613,496	$55,291,285
Share 134%-150% FPL/$33,525[2]	n/a	n/a	$1,632,762	$1,514,515	$1,632,762	$1,514,515
Premium Level 1 151%-200% FPL/$44,700[2]	n/a	n/a	$1,383,299	$1,465,795	$1,383,299	$1,465,795
Premium Level 2 201%-300% FPL/$67,050[2]	$19,052,723	$26,632,165	$384,275	$328,189	$19,436,998	$26,960,354
Premium Level 3 301%-400% FPL/$89,400[2]	$4,204,290	$6,343,863	$41,496	$110,717	$4,245,785	$6,454,580
Premium Level 4 401%-500% FPL/$111,750[2]	$1,098,537	$2,722,244	$13,039	$12,001	$1,111,576	$2,734,246
Premium Level 5 501%-600% FPL/$134,100[2]	$384,142	$1,088,856	$108,452	$41,848	$492,595	$1,130,704
Premium Level 6 601%-700% FPL/$156,450[2]	$108,145	$776,095	$1,746	$1,439	$109,892	$777,535
Premium Level 7 701%-800% FPL/$178,800[2]	$26,467	$63,510	$0	$0	$26,467	$63,510
Premium Level 8 >800% FPL/No limit[2]	$146,631	$163,543	$8	$2	$146,639	$163,545
Totals	**$25,020,934**	**$37,790,277**	**$59,178,574**	**$58,765,792**	**$84,199,508**	**$96,556,069**

Notes:

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

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY11.

[3] Totals may not add due to rounding.

Source: ALL KIDS claim data provided by HFS.

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. In FY11, HFS received $10.8 million in premiums, making the net cost of the ALL KIDS expansion $85.7 million, an increase of $11.3 million from FY10. Digest Exhibit 3 shows the premiums paid for FY10 and FY11. (page 10)

Digest Exhibit 3
EXPANDED ALL KIDS PAYMENTS VS. PREMIUMS [1]
Fiscal Years 2010 and 2011

EXPANDED ALL KIDS Plan	FY10 Payments	FY11 Payments	FY10 Premiums Collected	FY11 Premiums Collected	FY10 Net Cost	FY11 Net Cost
Assist <134% FPL/$29,725.50[2]	$55,613,496	$55,291,285	n/a	n/a	**$55,613,496**	**$55,291,285**
Share 134%-150% FPL/$33,525[2]	$1,632,762	$1,514,515	n/a	$835	**$1,632,762**	**$1,513,680**
Premium Level 1 151%-200% FPL/$44,700[2]	$1,383,299	$1,465,795	$218,488	$206,970	**$1,164,810**	**$1,258,825**
Premium Level 2 201%-300% FPL/$67,050[2]	$19,436,998	$26,960,354	$6,610,052	$7,402,166	**$12,826,946**	**$19,558,188**
Premium Level 3 301%-400% FPL/$89,400[2]	$4,245,785	$6,454,580	$2,151,192	$2,175,092	**$2,094,593**	**$4,279,488**
Premium Level 4 401%-500% FPL/$111,750[2]	$1,111,576	$2,734,246	$534,494	$674,995	**$577,082**	**$2,059,251**
Premium Level 5 501%-600% FPL/$134,100[2]	$492,595	$1,130,704	$130,510	$245,505	**$362,085**	**$885,200**
Premium Level 6 601%-700% FPL/$156,450[2]	$109,892	$777,535	$58,905	$52,715	**$50,987**	**$724,820**
Premium Level 7 701%-800% FPL/$178,800[2]	$26,467	$63,510	$13,530	$16,210	**$12,937**	**$47,300**
Premium Level 8 >800% FPL/No limit[2]	$146,639	$163,545	$35,820	$30,755	**$110,819**	**$132,790**
Totals	**$84,199,508**	**$96,556,069**	**$9,752,991**	**$10,805,242**	**$74,446,517**	**$85,750,827**

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 during FY11.

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

Follow up on FY10 Recommendations

While HFS and DHS took some action to address the 14 recommendations, many of these actions did not occur within this audit period (FY11).

While HFS and DHS took some action to address the 14 recommendations, many of these actions did not occur within this audit period (FY11). We determined that 3 recommendations were implemented, 1 was partially implemented, and 10 were repeated. For six of the recommendations that were repeated, HFS or DHS took some action to address the recommendation; however, the action did not occur until after the FY11 audit period. (page 2)

Covering ALL KIDS Health Insurance Act Requirements

The Covering ALL KIDS Health Insurance Act [215 ILCS 170/20(a)(3)], which became effective on July 1, 2006, required 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. Our FY10 audit recommended HFS comply with the rulemaking requirement found in the Covering ALL KIDS Health

Insurance Act [215 ILCS 170]. HFS accepted this recommendation and provided the following updated response in May 2012: *"Implemented –Rule adoption was published January 27, 2012 with an effective date of January 14, 2012. See 36 Illinois Register 1062."*

We reviewed the new rule and verified that it was established and met the requirements in the Covering ALL KIDS Health Insurance Act. The status of this recommendation is **implemented**. (page 12)

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. 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.

The recommendation to organize policies into one section and ensure that policies are consistent with applicable laws and rules and are up to date was repeated in our FY10 audit.

During this FY11 audit, HFS demonstrated changes that had been made to the on-line policies and procedures. The changes included incorporating the policy memos into the manual and adding more links for subgroups under the main categories of the policy manual for the ALL KIDS section. We reviewed the changes to the policy manual and determined that HFS addressed this recommendation. Therefore, the status of this recommendation is **implemented**. (page 13)

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]. 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 indicated it reviewed the exceptions and "discovered an error in the programming that caused some claims to pay improperly," and noted that a programming change was implemented.

We reviewed FY11 EXPANDED ALL KIDS claim data and determined that no payments were made for non-emergency transportation for enrollees in Premium levels 2 through 8 after June 15, 2010. Therefore, the status of this recommendation is **implemented**. (pages 19-20)

Redetermination of Eligibility

In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. For ALL KIDS enrollees that fall in the Assist, Share, and Premium level 1 categories (e.g., at or below 200 percent of the federal poverty level), an annual "passive" redetermination was used by HFS. Prior to the end of the eligibility period, HFS sent each family an annual renewal notice. The renewal notice listed the eligibility information for the family and instructed the family to return the form **only if** any of the information had changed. If there were no changes, the family was instructed to do nothing. In contrast, to continue coverage, enrollees in Premium levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in our FY10 audit. HFS and DHS accepted this recommendation. HFS provided the following updated response in May 2012: "*In Progress –HFS is pursuing federal approval of a process for active electronic verification to replace passive redeterminations of eligibility at renewal. As part of the FY13 budget negotiation process, HFS is also seeking the staffing and contractual resources that will be required to implement this process. HFS is pursuing federal approval to allow the state to require additional information from families whose children's eligibility cannot be redetermined through electronic means."* We reviewed a letter from HFS to the federal Department of Human Services, which discussed Illinois' steps to create a new eligibility system to improve the accuracy of eligibility determinations and redeterminations.

The status of this recommendation is **repeated** and will be followed up on during the next audit cycle. (pages 13-14)

Income of Stepparent

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" (e.g., the child's stepparent). When determining family income when a stepparent is present, we found that HFS counted the income of the stepparent while DHS did not. The FY10 audit repeated the recommendation.

HFS and DHS provided the July 29, 2011, Manual Release to incorporate the new policy on counting stepparent income when determining eligibility for undocumented children covered under the EXPANDED ALL KIDS program into the Policy Manual.

During this FY11 audit, HFS and DHS provided the July 29, 2011, Manual Release to incorporate the new policy on counting stepparent income when determining eligibility for undocumented children covered under the EXPANDED ALL KIDS program into the Policy Manual. We reviewed this policy and determined that HFS and DHS did incorporate the necessary changes. However, since the policy changes did not occur during the FY11 audit period and would not be reflected in the FY11 claim and eligibility data, we could not determine whether the stepparent income was actually included as part of the income calculation for all EXPANDED ALL KIDS recipients at this time. Therefore, the status of this recommendation is **repeated**. (page 15)

Non-Payment of Premiums

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

In FY10, we recommended that HFS comply with Administrative Code requirements. HFS accepted the recommendation and provided the following updated response in May 2012: "*A reminder was sent in June 2011 to HFS and DHS staff regarding the proper coding needed to prevent re-enrollment of children with outstanding premium debt. HFS is also in discussion with DHS regarding system enhancements that could be made to AIS so the coding would be automatically applied to these cases*."

We reviewed this reminder sent to HFS and DHS staff. The notice was not sent until the last day of the audit period, June 30, 2011. Consequently, corrective action taken by HFS and DHS staff did not occur until FY12. Therefore, this recommendation is **repeated** and will be followed up on during the next audit cycle. (page 16)

ALL KIDS Data Reliability

Auditors identified five specific issues associated with 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.

In FY10, HFS accepted the recommendation and provided the following updated response in May 2012: "*Implemented –A system error that allowed coverage for the first day of the month following the child's 19th birthday has been identified and corrected as of September 2011."* This system change was implemented after the FY11 audit period. Therefore, when we reviewed the FY11 EXPANDED ALL KIDS claim data, we determined that eligibility data still contained individuals who were older than 18 years of age. More specifically, we indentified 414 individuals who received 2,543 services after the month of their 19th birthday. These services totaled $126,092. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle.

We determined that eligibility data still contained individuals who were older than 18 years of age. More specifically, we indentified 414 individuals who received 2,543 services after the month of their 19th birthday. These services totaled $126,092.

During our review of the FY11 EXPANDED ALL KIDS eligibility data, we also found that the eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY11 data, we identified 315 individuals who appeared to be enrolled with more than one identification number. Therefore, the status of this part of the recommendation is also **repeated** and will be followed up on during the next audit cycle. (pages 17-18)

We identified 315 individuals who appeared to be enrolled with more than one identification number.

Classification of Documented Immigrants

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

According to HFS, this recommendation was implemented prospectively. The system error was corrected to prevent incorrect coding from occurring on new approvals beginning October 29, 2010. The children that were previously coded incorrectly will require a manual review to determine the correct coding. The new active electronic review process that is being implemented to replace the existing annual passive renewal will provide the opportunity to code these children correctly. A vendor will be assisting the state in verifying a number of eligibility factors, one of which will be immigration status. The code will be updated when the redetermination is recorded in the system. HFS noted it was still working with the federal government to approve the State Plan and was preparing draft rules to permit qualified aliens to qualify for federal matching funds regardless of how long they have been in the country.

Our review of the FY11 data indicated a continued problem. We identified 11,130 ALL KIDS recipients who were coded as "undocumented" that had social security numbers in the database.

Our review of the FY11 data indicated a continued problem. We identified 11,130 ALL KIDS recipients who were coded as "undocumented" that had social security numbers in the database. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle. Additionally, as a result of the incorrect classification, HFS did not submit and receive federal matching funds for eligible enrollees. (pages 18-19)

Duplicate Claims

During the FY10 audit, 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. HFS reviewed each of the 20 potential duplicate pairs of claims and determined that 7 were duplicates.

We recommended HFS review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid in FY10. HFS accepted this recommendation and provided the following updated response in May 2012: "*In Progress - The Department has developed a query to monitor for duplicate claims. The Bureau of Claims Processing is working with the query but it is not ready to be implemented because there are still some modifications needed. HFS has been unable to complete this plan due to four vacancies*."

Since implementation of corrective action is still in progress, the status of this recommendation is **repeated**. (page 20)

Eligibility Documentation

Due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS did not obtain documentation to support eligibility in some instances. This included documentation for residency, birth, and income. As a result, during the FY09 and FY10 audits, auditors could not determine whether eligibility was determined correctly by HFS and DHS. Therefore, we recommended that HFS and DHS ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately.

In addition, we recommended HFS and DHS 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. We also recommended that HFS and DHS implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly. As a result of the passage of Public Act 96-1501 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 were effective on July 1, 2011. Additionally, the passage of Public Act 97-0689 (effective June 14, 2012) allows HFS to enter into a contract with a vendor to electronically verify eligibility criteria. These changes were not effective until after the FY11 audit period.

HFS officials responded that their agency was planning to implement the new federal option under CHIPRA (Children's Health Insurance Program Reauthorization Act) and use social security records to verify citizenship and identity. HFS and DHS accepted the recommendation and HFS provided the following updated response in May 2012: "*SVES [State Verification Exchange System] data matching went into production on November 30, 2011. At application and renewal, anyone who claims to be a citizen and whose status has not been previously verified will have their information checked through SVES. Anyone claiming to be a citizen who cannot be verified through SVES must provide documentation of citizenship. A fully automated version of the SVES process is in development to eliminate certain manual entries by caseworkers required currently*." Although we reviewed the manual releases provided by HFS regarding SVES data matching, the manuals were not established until after the FY11 audit period. As a result, audit testing FY11 files would not determine whether HFS and DHS were verifying citizenship through data matching.

The status of this recommendation is **repeated**. Since the three parts of the recommendation could not be verified at this time, this recommendation will be followed up on during the next audit cycle. (page 21)

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 did not contain edits for pickup or drop off times or locations.

We recommended that HFS ensure controls over transportation are in place to prevent duplicate payments and to ensure providers submit accurate claim details. HFS accepted this recommendation and provided the following updated response in May 2012: "*In Progress - The system change to restrict one trip per day as authorized by the prior approval has not been implemented because testing revealed some issues. Further, testing is being conducted to ensure all transportation provider types are handled properly and*

changes to restrict origin and destination times are also working."

Since implementation of corrective action is still in progress, the status of this recommendation is **repeated**. (pages 22-23)

Optical Edits

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allowed 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 for 41 recipients. These 41 recipients had 180 frames ordered through ICI and had 186 fittings during FY10.

When auditors reviewed this matter with the HFS Office of the Inspector General (OIG) during the FY10 audit, the OIG noted it was aware of this provider's billing patterns and noted it was in the early stages of auditing the provider. When OAG auditors requested an update on the audit (investigation) as part of this audit, the OIG noted it could not find a case on this provider. The current Inspector General noted that former staff failed to act on the referral. Subsequent to this follow up, the OIG has generated the profiles and routines necessary to initiate a probe audit of this provider related to the multiple eyeglass issue. The OIG is currently in the process of finalizing the protocols for this probe audit and will initiate as resources allow.

Subsequent to this follow up, the OIG has generated the profiles and routines necessary to initiate a probe audit of this provider related to the multiple eyeglass issue. The OIG is currently in the process of finalizing the protocols for this probe audit and will initiate as resources allow.

Since the process did not begin until after the audit period ended on June 30, 2011, this recommendation is **repeated**. (pages 23-24)

Guidance Over Preventive Medicine Service Claims

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

HFS accepted this recommendation and provided the following updated response in May 2012: "*A provider notice*

was sent in May 2011 to remind providers of the proper use and frequency limits of preventative CPT codes. As of April 2011, the Bureau of Claims Processing has also initiated a manual review of applicable preventative CPT codes."

We reviewed the notice that HFS sent to providers. However since corrective action was not taken until the FY11 audit period was almost completed, resulting changes were not reflected in the FY11 data. As a result, the status of this recommendation is **repeated**. (page 25)

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.

In the FY10 audit, we recommended that HFS identify and recoup unallowable past dental payments made to providers. HFS accepted this part of the recommendation and provided the following response in April 2011: "*The Department has reduced DentaQuest's March 2011 administrative payment to recover the funds that were overpaid to dental providers in 2009 and 2010.*" We reviewed supporting documents provided by HFS in June 2012. These documents show that HFS did recoup $19,737 in payments for unallowable services. Therefore, this part of the recommendation has been **implemented**.

We reviewed supporting documents provided by HFS in June 2012. These documents show that HFS did recoup $19,737 in payments for unallowable services.

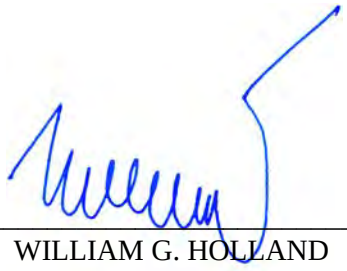
In the FY10 audit, we also recommended that HFS strengthen controls to ensure that dental providers are not paid for services beyond benefit limitation. In May of 2012, HFS provided an updated response which stated, "*A complete audit of the Windward system was completed in August 2011 to ensure all edits are working.*" Auditors reviewed a copy of the Windward System audit. The Windward System is the dental database used by DentaQuest. However, since the audit and any resulting changes were not completed until after the FY11 audit period, the status of this part of the recommendation is **repeated**.

Lastly, in the FY10 audit, we recommended that HFS ensure that dental policies or other information available to the public accurately states frequency of benefits. HFS provided the following updated response in May 2012: "*The Dental Policy Review manual was updated in August 2011*." HFS also provided the updated Dental Office Reference Manual. However, the ALL KIDS Dental services webpage still states

that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle. (page 26)

RECOMMENDATIONS

The audit report contains 11 recommendations. Eight recommendations were specifically for the Department of Healthcare and Family Services. Three recommendations were for both the Department of Healthcare and Family Services and the Department of Human Services. The Department of Healthcare and Family Services and the Department of Human Services agreed with all 11 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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COVERING ALL KIDS HEALTH INSURANCE PROGRAM

REPORT CONCLUSIONS

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. The Public Act was effective June 1, 2009. The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. There were five new recommendations and three new areas added to previous recommendations. This is the third annual audit and covers FY11 beginning on July 1, 2010.

This FY11 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. A significant portion of our FY09 and FY10 audits were spent testing eligibility files. We did not undertake such testing in this audit because several of the eligibility requirements changed in FY12 as a result of Public Act 96-1501. Furthermore, many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY12. This annual audit's time period is FY11. The changes from Public Act 96-1501 made by the agencies occurred in FY12, after our audit period. We will review these changes in future audits.

Matter for Consideration by the Illinois General Assembly

HFS and DHS accepted all recommendations from our past ALL KIDS audit and have been working to implement them. The Covering ALL KIDS Health Insurance Act requires the Auditor General to conduct an annual audit of the EXPANDED ALL KIDS program. However, with an annual audit, HFS and DHS have had limited time to implement the recommendations before the next audit period began. The FY10 audit was released in April 2011. HFS and DHS were unable to address many of the recommendations prior to June 30, 2011. Consequently, these findings are repeated in this FY11 audit, which covers the period July 1, 2010, to June 30, 2011.

Due to the limited time for HFS and DHS to implement prior audit recommendations before the next audit begins, the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

ALL KIDS Program

In FY11, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $3.2 billion in claims. In FY11, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion (EXPANDED ALL KIDS) totaled 97,030. On

June 30, 2011, there were 74,975 enrollees as a result of the expansion of which 51,669 (69%) were classified as undocumented immigrants in the HFS data.

According to claim data provided by HFS in FY09, payments for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. The payment for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. The majority of the payments for services were for undocumented immigrants. Payments for children categorized by HFS as undocumented totaled $54.9 million in FY09, $59.2 million in FY10, and $58.8 million in FY11. Therefore, in FY10 and FY11, undocumented immigrants made up approximately 65 percent of the total payments for the EXPANDED ALL KIDS program. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated.

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. In FY11, HFS received $10.8 million in premiums, making the net cost of the ALL KIDS expansion $85.7 million, an increase of $11.3 million from FY10.

Follow-up on FY10 Recommendations

While HFS and DHS took some action to address the 14 recommendations, many of these actions did not occur within this audit period (FY11). As a result, many recommendations are repeated in this audit because the annual audit cycle did not allow implementation of the steps necessary to address the recommendation before the end of the audit period. We determined that 3 recommendations were implemented, 1 was partially implemented, and 10 were repeated. For six of the recommendations that were repeated, HFS or DHS took some action to address the recommendation; however, the action did not occur until after the FY11 audit period.

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 (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. The FY10 audit had five new recommendations and three new areas added to previous recommendations. This is the third annual audit and covers FY11 beginning on July 1, 2010. 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.

Recent Changes to the Covering ALL KIDS Health Insurance Act

Following our initial audit of the EXPANDED ALL KIDS program that was released in May 2010, the Illinois Senate and House of Representatives held hearings on reforming the State's medical assistance program. The Auditor General testified before both committees on the results of our 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 and second audit (released in April 2011) of the EXPANDED ALL KIDS program. 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 for determining eligibility 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.

Impact on Fiscal Year 2011 Audit

This FY11 audit of the EXPANDED ALL KIDS program follows up on HFS and DHS actions to address prior audit findings. A significant portion of our FY09 and FY10 audits were spent testing eligibility files. We did not undertake such testing in this audit because several of the eligibility requirements changed in FY12 as a result of Public Act 96-1501. Furthermore, many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY12. This annual audit's time period is FY11. The changes from Public Act 96-1501 made by the agencies occurred in FY12, after our audit period. We will review these changes in future audits.

Matter for Consideration by the Illinois General Assembly

HFS and DHS accepted all recommendations from our past ALL KIDS audit and have been working to implement them. The Covering ALL KIDS Health Insurance Act requires the Auditor General to conduct an annual audit of the EXPANDED ALL KIDS program. However, with an annual audit, HFS and DHS have had limited time to implement the recommendations before the next audit period began. The FY10 audit was released in April 2011. HFS and DHS were unable to address many of the recommendations prior to June 30, 2011. Consequently, these findings are repeated in this FY11 audit, which covers the period July 1, 2010, to June 30, 2011.

Due to the limited time for HFS and DHS to implement prior audit recommendations before the next audit begins, the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

MATTER FOR CONSIDERATION BY THE GENERAL ASSEMBLY EXPANDED ALL KIDS Audit Frequency
The General Assembly may wish to consider reducing the frequency of the audit requirement found at 215 ILCS 170/63 from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General. This would provide the Department of Human Services and the Department of Healthcare and Family Services with additional time to take corrective action, which would then be reviewed by the Auditor General's subsequent audit.

HISTORY OF THE 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.

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

Throughout 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.**

Children who became eligible for ALL KIDS after the expansion include: (1) children whose family income exceeded 200 percent of the federal poverty level (e.g., exceed the income requirements of Medicaid and the Children's Health Insurance Program), and (2) 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 who were added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.**

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 who are not covered by the Illinois Public Aid Code or by the Children's Health Insurance Program Act. (Public Act 96-1501 amended the Covering ALL KIDS Health Insurance Act and made changes to the eligibility requirements which became effective in FY12.) The children who were added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.

The provisions in the Covering ALL KIDS Health Insurance Act during FY11 define a child as a person under the age of 19. In FY11, the Act had specific eligibility requirements for the program. In order to be eligible under this Act, a person under the age of 19:

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 Illinois Administrative Code [89 Ill. Adm. Code 123] implements the Covering ALL KIDS Health Insurance Act that authorizes HFS to administer an insurance program that offers access to health insurance to all uninsured children in Illinois. The rules reiterate some of the eligibility criteria set forth by the Act and expand on some of the eligibility exclusions and reasons for termination of coverage. The rules note that covered services are those that are covered by the Children's Health Insurance Program, minus service exclusions that include non-emergency medical transportation and over-the-counter drugs. The rules also have several important provisions that specifically relate to this audit. These include:

- eligibility shall be reviewed annually;

- premiums will not increase during the eligibility period, unless the family adds children to the coverage or there is a regulatory change in cost sharing;

- family is defined as the child applying for the program and the following individuals who live with the child: the child's parents, the spouse of the child's parent, children under 19 years of age of the parents or the parent's spouse, the spouse of the child, the children of the child, and if any of the previously mentioned are pregnant, the unborn children;

- the family at any time may request a downward modification of the premium for any reason including a change in income or change in family size; and

- there is a grace period through the end of the month of coverage to pay premiums, and failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

As noted earlier in this report, in 2011, Public Act 96-1501 added an income limit for determining eligibility 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.

ALL KIDS PROGRAM

In FY11, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $3.2 billion in claims. In FY11, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 97,030. On June 30, 2011, there were 74,975 enrollees as a result of the expansion of which 51,669 (69%) were classified as undocumented immigrants in the HFS data. Exhibit 1 breaks out enrollment by fiscal year, by plan, and by whether the child had documentation for citizenship/immigration status or whether the child was undocumented. Appendix B shows the ALL KIDS premium and co-pay requirements by plan.

ALL KIDS Enrollment

Families interested in enrolling their children in the ALL KIDS program must fill out an application. See Appendix C 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 D includes a list of Application Agents, the number of approved applications, and the amount each Application Agent was paid in FY11. 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.

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

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY10	FY11	FY10	FY11
Assist <134% FPL/$29,725.50[2]	n/a	n/a	49,920	48,481
Share 134%-150% FPL/$33,525[2]	n/a	n/a	1,644	1,472
Premium Level 1 151%-200% FPL/$44,700[2]	n/a	n/a	1,538	1,253
Premium Level 2 201%-300% FPL/$67,050[2]	16,400	18,318	418	382
Premium Level 3[1] 301%-400% FPL/$89,400[2]	2,997	4,028	62	59
Premium Level 4[1] 401%-500% FPL/$111,750[2]	520	765	20	14
Premium Level 5[1] 501%-600% FPL/$134,100[2]	105	134	2	6
Premium Level 6[1] 601%-700% FPL/$156,450[2]	26	35	3	2
Premium Level 7[1] 701%-800% FPL/$178,800[2]	9	13	0	0
Premium Level 8[1] >800% FPL/No limit[2]	17	13	0	0
Total	**20,074**	**23,306**	**53,607**	**51,669**

Notes:

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

[2] Denotes the applicable federal poverty level (FPL) income guidelines for the plan level and the maximum income for a family of four for that plan during FY11.

[3] Enrollment is the total number of enrollees that were eligible on June 30 of 2010 and 2011. There were 94,628 enrollees eligible at some point during FY10 and 97,030 enrollees eligible at some point during FY11.

[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.

PAYMENTS FOR ALL KIDS SERVICES

According to claim data provided by HFS, in FY09, payments for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. Payments for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. The majority of the payments for services were for undocumented immigrants. Payments for children categorized by HFS as undocumented totaled $54.9 million in FY09, $59.2 million in FY10, and $58.8 million in FY11. Therefore, in FY10 and FY11, undocumented immigrants make up approximately 65 percent of the total payments for the EXPANDED ALL KIDS program over the last two fiscal years. Exhibit 2 breaks out the payments for services by whether the child had documentation for

citizenship/immigration status or whether the child was undocumented for both FY10 and FY11. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated.

Exhibit 2
PAYMENTS FOR EXPANDED ALL KIDS SERVICES BY ALL KIDS PLAN [1, 3]
Fiscal Years 2010 and 2011

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY10	FY11	FY10	FY11	FY10	FY11
Assist <134% FPL/$29,725.50[2]	n/a	n/a	$55,613,496	$55,291,285	$55,613,496	$55,291,285
Share 134%-150% FPL/$33,525[2]	n/a	n/a	$1,632,762	$1,514,515	$1,632,762	$1,514,515
Premium Level 1 151%-200% FPL/$44,700[2]	n/a	n/a	$1,383,299	$1,465,795	$1,383,299	$1,465,795
Premium Level 2 201%-300% FPL/$67,050[2]	$19,052,723	$26,632,165	$384,275	$328,189	$19,436,998	$26,960,354
Premium Level 3 301%-400% FPL/$89,400[2]	$4,204,290	$6,343,863	$41,496	$110,717	$4,245,785	$6,454,580
Premium Level 4 401%-500% FPL/$111,750[2]	$1,098,537	$2,722,244	$13,039	$12,001	$1,111,576	$2,734,246
Premium Level 5 501%-600% FPL/$134,100[2]	$384,142	$1,088,856	$108,452	$41,848	$492,595	$1,130,704
Premium Level 6 601%-700% FPL/$156,450[2]	$108,145	$776,095	$1,746	$1,439	$109,892	$777,535
Premium Level 7 701%-800% FPL/$178,800[2]	$26,467	$63,510	$0	$0	$26,467	$63,510
Premium Level 8 >800% FPL/No limit[2]	$146,631	$163,543	$8	$2	$146,639	$163,545
Totals	**$25,020,934**	**$37,790,277**	**$59,178,574**	**$58,765,792**	**$84,199,508**	**$96,556,069**

Notes:

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

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY11.

[3] Totals may not add due to rounding.

Source: ALL KIDS claim data provided by HFS.

PAYMENTS BY CATEGORY OF SERVICE

According to data provided by HFS, 93 percent of the payments during FY11 for EXPANDED ALL KIDS services were paid for 14 categories of services. Exhibit 3 shows that $90.3 million of the $96.6 million in total EXPANDED ALL KIDS payments were for the following services: Pharmacy; Dental Services; Inpatient Hospital Services (General); Physician Services; General Clinic Services; Outpatient Services (General); Inpatient Hospital Services (Psychiatric); Healthy Kids Services; Capitation Services; Mental Health Rehab Option Services;

Home Health Services; Medical Supplies; Alcohol and Substance Abuse Rehab Services; and Medical Equipment/Prosthetic Devices.

The category with the highest percentage of payments was Pharmacy at 22 percent. **Pharmacy payments increased from $10.7 million in FY10 to $20.8 million in FY11.** Exhibit 4 shows the number and amount of pharmacy claims from FY09 through FY11. We asked HFS why there was such a large increase. HFS indicated the American Recovery and Reinvestment Act (ARRA) ended June 30, 2011, and there was an additional incentive to push vouchers through at fiscal year end. Additionally, HFS indicated that in March/April 2011, it received tobacco settlement funds and the funds were used to pay down outstanding pharmacy claims.

Exhibit 3
TOTAL PAYMENTS BY CATEGORY OF SERVICE FOR EXPANDED ALL KIDS PROGRAM
Totaling more than $1 million during FY11

Category of Service	Total FY11 Payments	Percent of Total FY11 Payments
Pharmacy	$20,793,748	22%
Dental Services	$13,282,696	14%
Inpatient Hospital Services (General)	$12,110,061	13%
Physician Services	$12,078,550	13%
General Clinic Services	$8,110,110	8%
Outpatient Services (General)	$6,162,981	6%
Inpatient Hospital Services (Psychiatric)	$3,619,832	4%
Healthy Kids Services	$3,551,188	4%
Capitation Services	$3,548,354	4%
Mental Health Rehab Option Services	$2,486,541	3%
Home Health Services	$1,331,560	1%
Medical Supplies	$1,113,741	1%
Alcohol and Substance Abuse Rehab Services	$1,045,415	1%
Medical Equipment/Prosthetic Devices	$1,037,983	1%
Total for categories with payments > than $1 million	**$90,272,760**	**93%**
Other categories totaling < than $1 million	$ 6,283,309	7%
Total Payments for All Service Categories	**$96,556,069**	**100%**

Note: Totals may not add due to rounding.

Source: FY11 ALL KIDS data provided by HFS.

We reviewed pharmacy claim data provided by HFS over the last several years and compared the amount of pharmacy services paid by fiscal year with the pharmacy services provided during the same fiscal year. Since it can take providers months to submit claims and can take HFS months to pay the claims, some claims from a given fiscal year are not paid until the following fiscal year. Exhibit 4 shows that pharmacy services provided for the EXPANDED

ALL KIDS program increased over each of the last three fiscal years. However, HFS did not pay more than $4 million for FY10 pharmacy claims until FY11, thus causing the appearance of a much larger increase in pharmacy claims in FY11.

Exhibit 4
PHARMACY SERVICES PROVIDED COMPARED TO PHARMACY SERVICES PAID [1]
By Fiscal Year

	Pharmacy Services Provided		Pharmacy Services Paid	
Fiscal Year	Number of Claims	Amount	Number of Claims	Amount
2009	225,490	$13,005,976	223,978	$12,963,253
2010	238,989	$14,762,136	185,638	$10,672,656
2011	245,644	$16,751,445	300,876	$20,793,748
Totals	**710,123**	**$44,519,557**	**710,492**	**$44,429,657**

Note:

[1] Pharmacy services provided in one fiscal year may not be paid in that fiscal year due to State funding limitations or delays in the submission of claims by providers.

Source: FY09-FY12 ALL KIDS data provided by HFS.

Dental services accounted for 14 percent of the overall total. Appendix E shows the total FY11 payments by category of service. Appendix F shows the FY11 EXPANDED ALL KIDS payments by plan and by category of service. Appendix G shows FY11 Providers that received more than $50,000 from EXPANDED ALL KIDS.

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. In FY11, HFS received $10.8 million in premiums and the cost of the ALL KIDS expansion increased to $85.7 million, an increase of $11.3 million from FY10. Exhibit 5 shows both FY10 and FY11 payments and premiums collected from the EXPANDED ALL KIDS program.

Exhibit 5
EXPANDED ALL KIDS PAYMENTS VS. PREMIUMS [1]
Fiscal Years 2010 and 2011

EXPANDED ALL KIDS Plan	FY10 Payments	FY11 Payments	FY10 Premiums Collected	FY11 Premiums Collected	FY10 Net Cost	FY11 Net Cost
Assist <134% FPL/$29,725.50[2]	$55,613,496	$55,291,285	n/a	n/a	**$55,613,496**	**$55,291,285**
Share 134%-150% FPL/$33,525[2]	$1,632,762	$1,514,515	n/a	$835	**$1,632,762**	**$1,513,680**
Premium Level 1 151%-200% FPL/$44,700[2]	$1,383,299	$1,465,795	$218,488	$206,970	**$1,164,810**	**$1,258,825**
Premium Level 2 201%-300% FPL/$67,050[2]	$19,436,998	$26,960,354	$6,610,052	$7,402,166	**$12,826,946**	**$19,558,188**
Premium Level 3 301%-400% FPL/$89,400[2]	$4,245,785	$6,454,580	$2,151,192	$2,175,092	**$2,094,593**	**$4,279,488**
Premium Level 4 401%-500% FPL/$111,750[2]	$1,111,576	$2,734,246	$534,494	$674,995	**$577,082**	**$2,059,251**
Premium Level 5 501%-600% FPL/$134,100[2]	$492,595	$1,130,704	$130,510	$245,505	**$362,085**	**$885,200**
Premium Level 6 601%-700% FPL/$156,450[2]	$109,892	$777,535	$58,905	$52,715	**$50,987**	**$724,820**
Premium Level 7 701%-800% FPL/$178,800[2]	$26,467	$63,510	$13,530	$16,210	**$12,937**	**$47,300**
Premium Level 8 >800% FPL/No limit[2]	$146,639	$163,545	$35,820	$30,755	**$110,819**	**$132,790**
Totals	**$84,199,508**	**$96,556,069**	**$9,752,991**	**$10,805,242**	**$74,446,517**	**$85,750,827**

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 during FY11.

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

FOLLOW-UP ON FY10 RECOMMENDATIONS

The following examines the status of the 14 recommendations from the FY10 audit, which includes updated agency responses from May 2012. Many of the recommendations were not addressed by HFS or DHS within this audit period (FY11). As a result, many recommendations were repeated because the steps taken by the agencies to address the recommendations occurred after the annual audit period, which ended June 30, 2011. We will follow up on the actions taken after our period during our FY12 annual audit. Exhibit 6 shows the status of the recommendations from the two previous audits (FY09 and FY10). Additionally, a complete listing of the FY10 recommendations with agency responses from the last audit is included in Appendix H.

Exhibit 6
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS
As of May, 2012

Recommendation Area	Status of FY10 Recommendations
Compliance with the Covering ALL KIDS Health Insurance Act	Implemented
ALL KIDS policies and procedures	Implemented
Redetermination of ALL KIDS eligibility	Repeated
Stepparent income	Repeated [1]
Non-payment of premiums	Repeated [1]
ALL KIDS data reliability	Repeated [1]
Classification of documented immigrants	Repeated [1]
Payment of non-emergency transportation	Implemented
Duplicate Claims	Repeated
Eligibility documentation	Repeated [1]
Transportation Claims	Repeated
Optical Edits	Repeated
Guidance Over Preventive Medicine Service Claims	Repeated [1]
Payments Beyond Dental Benefit Limitations	Partially Implemented

Note:
[1] According to HFS and DHS, the recommendation was implemented after June 30, 2011, the end of our audit period. Therefore, it was repeated. Corrective actions taken will be reviewed in our subsequent audit.

RECOMMENDATION NUMBER 1
Covering ALL KIDS Health Insurance Act Requirements

The Covering ALL KIDS Health Insurance Act [215 ILCS 170/20(a)(3)], which became effective on July 1, 2006, required 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 had not adopted rules governing the exchange of health insurance information as required by the Act.

As a result, our FY10 audit recommended HFS comply with the rulemaking requirement found in the Covering ALL KIDS Health Insurance Act [215 ILCS 170]. HFS accepted this recommendation and provided the following updated response in May 2012: *"Implemented – Rule adoption was published January 27, 2012 with an effective date of January 14, 2012. See 36 Illinois Register 1062."*

Although the corrective action was taken after the end of the audit period, we reviewed the new rule and verified that it was established and met the requirements in the Covering ALL KIDS Health Insurance Act. The status of this recommendation is **implemented**.

RECOMMENDATION NUMBER 2
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.

During the FY10 audit period, HFS and DHS noted that it was in the process of updating the medical sections of the policy manual by incorporating policy memos. HFS also noted that it was establishing a procedure regarding standard practice to release policy changes as updates to the manual and not in memorandum format.

The recommendation to organize policies into one section and ensure that policies are consistent with applicable laws and rules and are up to date was repeated in our FY10 audit. HFS and DHS accepted this recommendation. HFS provided the following response in the previous audit: *"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 that 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."*

We met with HFS and HFS demonstrated changes that had been made to the on-line policies and procedures. The changes to the manual included incorporating the policy memos into the manual and adding more links for subgroups under the main categories of the policy manual for the ALL KIDS section. We reviewed the changes to the policy manual and determined that HFS addressed this recommendation. Therefore, the status of this recommendation is **implemented**.

RECOMMENDATION NUMBER 3
Redetermination of Eligibility

In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. For ALL KIDS enrollees that fall in the Assist, Share, and Premium level 1 categories (e.g., at or below 200 percent of the FPL), an annual "passive" redetermination was used by HFS. Prior to the end of the eligibility period, HFS sent each family an annual renewal notice. The renewal notice listed the eligibility information for the family and instructed the family to return the form only if any of the information had changed. If there were no changes, the family was instructed to do nothing. Therefore, a "passive" redetermination only required families to return the annual renewal form

if there was a change in their information. In contrast, to continue coverage, enrollees in Premium levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in our FY10 audit. HFS and DHS accepted this recommendation. HFS provided the following updated response in May 2012: "*In Progress –HFS is pursuing federal approval of a process for active electronic verification to replace passive redeterminations of eligibility at renewal. As part of the FY13 budget negotiation process, HFS is also seeking the staffing and contractual resources that will be required to implement this process. HFS is pursuing federal approval to allow the state to require additional information from families whose children's eligibility cannot be redetermined through electronic means."* We reviewed a letter from HFS to the federal Department of Human Services, which discussed Illinois' steps to create a new eligibility system to improve the accuracy of eligibility determinations and redeterminations.

The status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012.

REDETERMINATION OF ELIGIBILITY	
RECOMMENDATION NUMBER **3**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***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 and is moving from a passive renewal process to an annual active electronic review of eligibility.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	Agree. As a result of the passage of Public Act 96-1501, the Department is moving from a passive renewal process to an annual active electronic review of eligibility. The electronic review of eligibility is being conducted by the Illinois Department of Healthcare and Family Services (HFS).

RECOMMENDATION NUMBER 4
Income of Stepparent

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" (e.g., the child's stepparent). Therefore, the income calculation for any child receiving services under the Covering ALL KIDS Health Insurance Act (e.g., those children whose services are totally State funded) should include the income of the stepparent. When determining family income when a stepparent is present, we found that HFS counted the income of the stepparent while DHS did not.

The FY10 audit repeated the recommendation that HFS and DHS 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. HFS and DHS accepted this recommendation. HFS provided the following updated response in May 2012: *"Implemented – Policy has been revised as of July 2011 to require the income of any stepparent in the home to be included in the income calculation of eligibility for undocumented noncitizen children."*

HFS and DHS provided the July 29, 2011 Manual Release to incorporate the new policy on counting stepparent income when determining eligibility for undocumented children covered under the EXPANDED ALL KIDS program into the Policy Manual. We reviewed this policy and determined that HFS and DHS did incorporate the necessary changes. However since the policy changes did not occur during the FY11 audit period and would not be reflected in the FY11 claim and eligibility data, we could not determine whether the stepparent income was actually included as part of the income calculation for all EXPANDED ALL KIDS recipients at this time. Therefore, the status of this recommendation is **repeated**. Detailed testing for this recommendation will be conducted on during the next audit cycle.

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 and has revised policy to require use of stepparent income when determining eligibility for this population.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	Agree. Policy has been revised as of July 2011 to require the income of any stepparent in the home to be included in the calculation of eligibility for undocumented noncitizen children.

RECOMMENDATION NUMBER 5
Non-Payment of Premiums

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

In FY10, we recommended that HFS terminate families that do not pay monthly premiums as required by the Administrative Code. We also recommended that HFS ensure premiums past due and premiums for the first month are paid prior to re-enrollement as required by the Administrative Code. HFS accepted the recommendation and provided the following updated response in May 2012: "*A reminder was sent in June 2011 to HFS and DHS staff regarding the proper coding needed to prevent re-enrollment of children with outstanding premium debt. HFS is also in discussion with DHS regarding system enhancements that could be made to AIS [Automated Intake System] so the coding would be automatically applied to these cases*."

We reviewed this reminder sent to HFS and DHS staff. The notice was not sent until the last day of the audit period, June 30, 2011. Consequently, corrective action taken by HFS and DHS staff did not occur until FY12. Therefore, this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012.

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)(4).***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation and has revised the rules. A request to program a new report has been submitted to DHS that will improve the Department's ability to identify and correct the cases coded incorrectly at approval.

RECOMMENDATION NUMBER 6
ALL KIDS Data Reliability

Auditors identified five specific issues associated with 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.

In FY10, HFS accepted the recommendation and provided the following updated response in May 2012 : "*Implemented –A system error that allowed coverage for the first day of the month following the child's 19th birthday has been identified and corrected as of September 2011."* This system change was implemented after the FY11 audit period. Therefore, when we reviewed the FY11 EXPANDED ALL KIDS claim data, we determined that eligibility data still contained individuals who were older than 18 years of age. More specifically, we indentified 414 individuals who received 2,543 services after the month of their 19th birthday. These services totaled $126,092. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle.

During our review of the FY11 EXPANDED ALL KIDS eligibility data, we also found that the eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY11 data, we identified 315 individuals who appeared to be enrolled with more than one identification number. Therefore, the status of this part of the recommendation is also **repeated**

and will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012.

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 programming error that allowed one day of eligibility the month following a child's 19th birthday has been corrected. A process to identify individuals assigned more than one identification number is in development.

RECOMMENDATION NUMBER 7
Classification of Documented Immigrants

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

During the FY10 audit, HFS officials stated they researched the cases from the FY09 audit and found that a system error was causing the misclassifications. HFS noted the recommendation was implemented going forward and the system problem was fixed on October 29, 2010, which prevented the incorrect coding from happening on new approvals. HFS also noted that it was working with DHS to provide training to staff to assure individuals are classified correctly. HFS noted it was still working with the federal government to approve the State Plan and was preparing draft rules to permit qualified aliens to qualify for federal matching funds regardless of how long they have been in the country.

According to HFS, this recommendation was implemented prospectively. The system error was corrected to prevent incorrect coding from occurring on new approvals beginning October 29, 2010. The children that were previously coded incorrectly will require a manual review to determine the correct coding. The new active electronic review process that is being implemented to replace the existing annual passive renewal will provide the opportunity to code these children correctly. A vendor will be assisting the state in verifying a number of eligibility factors, one of which will be immigration status. The code will be updated when the redetermination is recorded in the system.

Our review of the FY11 data indicated a continued problem. We identified 11,130 ALL KIDS recipients who were coded as "undocumented" that had social security numbers in the database. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012. Due to the incorrect classification of documented and undocumented immigrants, the enrollee and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants. Additionally, as a result of the incorrect classification, HFS did not submit and receive federal matching funds for eligible enrollees.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS	
RECOMMENDATION NUMBER **7**	***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. New coding to more accurately record immigration status has been implemented. Staff are in the process of manually reviewing individuals who appear to have been identified as undocumented in error.

RECOMMENDATION NUMBER 8
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 transportation 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.

In FY10, we repeated the recommendation that HFS should have controls in place to ensure that no payments are made for non-emergency transportation services that are excluded from coverage by the Administrative Code. HFS accepted this recommendation and indicated that it reviewed the exceptions and "discovered an error in the programming that caused some claims to pay improperly." In response to our FY10 audit from April 2011, HFS officials noted that a programming change was implemented and provided the following response: *"On June 15, 2010 a programming change was implemented to prevent payments for non-emergency transportation for children in premium levels 2-8."*

We reviewed FY11 EXPANDED ALL KIDS claim data and determined that no payments were made for non-emergency transportation for enrollees in Premium levels 2 through 8 after June 15, 2010. Therefore, the status of this recommendation is **implemented**.

RECOMMENDATION NUMBER 9
Duplicate Claims

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

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

As a result, we recommended HFS review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid in FY10. HFS accepted this recommendation and provided the following updated response in May 2012: "*In Progress - The Department has developed a query to monitor for duplicate claims. The Bureau of Claims Processing is working with the query but it is not ready to be implemented because there are still some modifications needed. HFS has been unable to complete this plan due to four vacancies*."

Since implementation of corrective action is still in progress, the status of this recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle.

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. The Bureau of Claims Processing has been working to implement a data warehouse query to identify duplicate claims.

RECOMMENDATION NUMBER 10
Eligibility Documentation

Due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS did not obtain documentation to support eligibility in some instances. This included documentation for residency, birth, and income. As a result, during the FY09 and FY10 audits, auditors could not determine whether eligibility was determined correctly by HFS and DHS. Therefore, we recommended that HFS and DHS ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately. However, due to changes in eligibility criteria that occurred after the audit period, file testing was not conducted for this FY11 audit.

In addition, we recommended HFS and DHS 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. We also recommended that HFS and DHS implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly. As a result of the passage of Public Act 96-1501 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 were effective on July 1, 2011. Additionally, the passage of Public Act 97-0689 (effective June 14, 2012) allows HFS to enter into a contract with a vendor to electronically verify eligibility criteria. These changes were not effective until after the FY11 audit period.

HFS officials responded that their agency was planning to implement the new federal option under CHIPRA (Children's Health Insurance Program Reauthorization Act) and use social security records to verify citizenship and identity. HFS and DHS accepted the recommendation and HFS provided the following updated response in May 2012: "*SVES [State Verification Exchange System] data matching went into production on November 30, 2011. At application and renewal, anyone who claims to be a citizen and whose status has not been previously verified will have their information checked through SVES. Anyone claiming to be a citizen who cannot be verified through SVES must provide documentation of citizenship. A fully automated version of the SVES process is in development to eliminate certain manual entries by caseworkers required currently*." Although we reviewed the manual releases provided by HFS regarding SVES data matching, the manuals were not established until after the FY11 audit period. As a result, audit testing FY11 files would not determine whether HFS and DHS were verifying citizenship through data matching.

The status of this recommendation is **repeated**. Since the three parts of the recommendation could not be verified at this time, this recommendation will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012.

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **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 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. Policy has been established requiring a Social Security Administration (SSA) citizenship and identity inquiry at application and at renewal if citizenship and identity have not been verified. The policy includes instructions on requesting other acceptable documentation if the SSA inquiry does not verify citizenship and identity. Electronic reviews of other eligibility factors are in process.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	Agree. As a result of the passage of Public Act 96-1501, effective July 1, 2011, verification of Illinois residency is now 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.

RECOMMENDATION NUMBER 11
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 did not contain edits for pickup or drop off times or locations.

As a result, we recommended that HFS ensure controls over transportation are in place to prevent duplicate payments and to ensure providers submit accurate claim details. HFS accepted this recommendation and provided the following updated response in May 2012: "*In Progress - The system change to restrict one trip per day as authorized by the prior approval has not been implemented because testing revealed some issues. Further, testing is being conducted to ensure*

all transportation provider types are handled properly and changes to restrict origin and destination times are also working."

Since implementation of corrective action is still in progress, the status of this recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle.

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 was prepared to program a system edit that will only allow one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail. A notice was sent to transportation providers on May 9, 2011 reminding them to submit accurate claim details or they may be subject to recoupment. Additionally, the Department's OIG continues to identify aberrant billing patterns for transportation providers and audit questionable transportation services. These audits result in the establishment of overpayments and termination of the transportation provider if appropriate.

RECOMMENDATION NUMBER 12
Optical Edits

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allowed 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 for 41 recipients. These 41 recipients had 180 frames ordered through ICI and had 186 fittings during FY10.

When auditors reviewed this matter with the HFS Office of the Inspector General (OIG) during the FY10 audit, the OIG noted it was aware of this provider's billing patterns and noted it

was in the early stages of auditing the provider. When OAG auditors requested an update on the audit (investigation) as part of this audit, the OIG noted it could not find a case on this provider and it was the first time most of them had heard of the provider. The current Inspector General noted that former staff failed to act on the referral. Subsequent to this follow-up, the OIG noted it generated the profiles and routines necessary to initiate a probe audit of this provider related to the multiple eyeglass issue, and is currently in the process of finalizing the protocols for this probe audit and will initiate as resources allow.

Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient. Unless "more frequent care is medically necessary" HFS only allows for one eye exam per year. In FY10, 376 recipients received more than one eye exam. These 376 recipients received 793 exams from 198 different providers.

We recommended HFS 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. HFS accepted this recommendation and stated it would review the exceptions and determine whether electronic billing edits should be implemented to prevent optical claims abuse. In an updated response in May 2012, HFS accepted this recommendation and noted the following: "*Implemented –The Department has reviewed the exceptions identified by the auditors and determined no new edits will be implemented. The Department will continue to monitor for potential abuse by providers."* The status of this recommendation is **repeated**. Therefore, this recommendation will be followed up on during the next audit cycle.

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. For children through age 20, eyeglasses are replaced as needed through the DOC laboratory, with no prior approval required. The SMART Act limits adults to one pair of glasses every two years. OIG is in the process of developing predictive modeling routines related to optical care. Upon the discovery or referral of optometric cases, the OIG is prepared to initiate audits and investigations to attempt to recoup inappropriately spent funds. OIG has specifically run data mining routines to determine the top 7 children with multiple eyeglass expenditures and they are limited to 3 practitioners tied to one alternate payee. OIG is requesting these charts to determine whether the provision of multiple eyeglasses to these children is medically necessary or evidence of fraud, waste or abuse for this alternate payee.

RECOMMENDATION NUMBER 13
Guidance Over Preventive Medicine Service Claims

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

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

We reviewed the notice that HFS sent to providers. However since corrective action was not taken until the FY11 audit period was almost completed, resulting changes were not reflected in the FY11 data. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012.

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 has issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes. The Department is working to institute systematic edits to limit the number of preventive service billings.

RECOMMENDATION NUMBER 14
Payments Beyond Dental Benefit Limitations

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.

In the FY10 audit, we recommended that HFS identify and recoup unallowable past dental payments made to providers. HFS accepted this part of the recommendation and provided the following response in April 2011: "*The Department has reduced DentaQuest's March 2011 administrative payment to recover the funds that were overpaid to dental providers in 2009 and 2010.*" We reviewed supporting documents provided by HFS in June 2012. These documents show that HFS did recoup $19,737 in payments for unallowable services. Therefore, this part of the recommendation has been **implemented**.

In the FY10 audit, we also recommended that HFS strengthen controls to ensure that dental providers are not paid for services beyond benefit limitation. In response to our FY10 audit from April 2011, HFS accepted this part of the recommendation and provided the following response: "*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*." In May of 2012, HFS provided an updated response which stated, "*A complete audit of the Windward system was completed in August 2011 to ensure all edits are working.*" Auditors reviewed a copy of the Windward System audit. The Windward System is the dental database used by DentaQuest. However, since the audit and any resulting changes were not completed until after the FY11 audit period, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2011, to June 30, 2012.

Lastly, in the FY10 audit, we recommended that HFS ensure that dental policies or other information available to the public accurately states frequency of benefits. HFS accepted this part of the recommendation and provided the following updated response in May 2012: "*The Dental Policy Review manual was updated in August 2011*." HFS also provided the updated Dental Office Reference Manual. However, as stated in the previous audit, the ALL KIDS Dental services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle.

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; and*** • ***ensure that dental policies or other information available to the public accurately states frequency of benefits.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Bureau of Maternal and Child Health Promotion (BMCHP) will continue to perform routine reconciliations to ensure that dental providers are not paid for services beyond benefit limitations. BMCHP is in the process of revising the Dental Office Reference manual and Administrative Rules to ensure that dental policies or other information available to the public accurately state frequency of benefits.

SCOPE AND METHODOLOGY

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

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

This FY11 audit of the EXPANDED ALL KIDS program followed up on HFS and DHS actions to address prior audit findings. A significant portion of our FY09 and FY10 audits were spent testing eligibility files. We did not undertake such testing in this audit because these eligibility requirements changed in FY12 as a result of Public Act 96-1501.

During this audit, we followed up on the two previous audits' recommendations. Since the FY10 audit was released in April 2011, more than nine months into the FY11 audit period, many of the steps that HFS and DHS took to address the recommendations were not implemented as of the end of FY11. Therefore, most of the follow-up on these recommendations will be conducted during the FY12 audit. Like in FY10, HFS officials reported that there were no contracts specific to the ALL KIDS Expansion for FY11.

Since this is the third annual ALL KIDS audit and changes to the Covering ALL KIDS Health Insurance Act did not occur until after this audit period, we did not re-review risk and internal controls related to the EXPANDED ALL KIDS program related to the audit objectives. Any weaknesses in internal controls that have not been addressed from the previous audits are included as findings in this report.

APPENDICES

APPENDIX A

Covering ALL KIDS Health Insurance Act [215 ILCS 170]

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

Appendix A

COVERING ALL KIDS HEALTH INSURANCE ACT [215 ILCS 170]

(215 ILCS 170/1)
(Section scheduled to be repealed on July 1, 2016)
Sec. 1. Short title. This Act may be cited as the Covering ALL KIDS Health Insurance Act.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/5)
(Section scheduled to be repealed on July 1, 2016)
Sec. 5. Legislative intent. The General Assembly finds that, for the economic and social benefit of all residents of the State, it is important to enable all children of this State to access affordable health insurance that offers comprehensive coverage and emphasizes preventive healthcare. Many children in working families, including many families whose family income ranges between $40,000 and $80,000, are uninsured. Numerous studies, including the Institute of Medicine's report, "Health Insurance Matters", demonstrate that lack of insurance negatively affects health status. The General Assembly further finds that access to healthcare is a key component for children's healthy development and successful education. The effects of lack of insurance also negatively impact those who are insured because the cost of paying for care to the uninsured is often shifted to those who have insurance in the form of higher health insurance premiums. A Families USA 2005 report indicates that family premiums in Illinois are increased by $1,059 due to cost-shifting from the uninsured. It is, therefore, the intent of this legislation to provide access to affordable health insurance to all uninsured children in Illinois.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/7)
(Section scheduled to be repealed on July 1, 2016)
Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:
(a) The Department of Healthcare and Family Services or its designees shall:
(1) By July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of

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

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

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/10)
(Section scheduled to be repealed on July 1, 2016)
Sec. 10. Definitions. In this Act:

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

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

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

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

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

"Resident" means an individual (i) who is in the State for other than a temporary or transitory purpose during the taxable year or (ii) who is domiciled in this State but is absent from the State for a temporary or transitory purpose during the taxable year.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/15)
(Section scheduled to be repealed on July 1, 2016)
Sec. 15. Operation of Program. The Covering ALL KIDS Health Insurance Program is created. The Program shall be administered by the Department of Healthcare and Family Services. The Department shall have the same powers and authority to administer the Program as are provided to the Department in connection with the Department's administration of the Illinois Public Aid Code, including, but not limited to, the provisions under Section 11-5.1 of the Code, and the Children's Health Insurance Program Act. The Department shall coordinate the Program with the existing children's health programs operated by the Department and other State agencies.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/20)
(Section scheduled to be repealed on July 1, 2016)
Sec. 20. Eligibility.
(a) To be eligible for the Program, a person must be a child:
(1) who is a resident of the State of Illinois;
(2) who is ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act;

(3) either (i) who has been without health insurance coverage for 12 months, (ii) whose parent has lost employment that made available affordable dependent health insurance coverage, until such time as affordable employer-sponsored dependent health insurance coverage is again available for the child as set forth by the Department in rules, (iii) who is a newborn whose responsible relative does not have available affordable private or employer-sponsored health insurance, or (iv) who, within one year of applying for coverage under this Act, lost medical benefits under the Illinois Public Aid Code or the Children's Health Insurance Program Act; and

(3.5) whose household income, as determined by the Department, is at or below 300% of the federal poverty level. This item (3.5) is effective July 1, 2011.

An entity that provides health insurance coverage (as defined in Section 2 of the Comprehensive Health Insurance Plan Act) to Illinois residents shall provide health insurance data match to the Department of Healthcare and Family Services as provided by and subject to Section 5.5 of the Illinois Insurance Code.
The Department of Healthcare and Family Services, in collaboration with the Department of Insurance, shall adopt rules governing the exchange of information under this Section. The rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records, including provisions under the Federal Health Insurance Portability and Accountability Act (HIPAA).
(b) The Department shall monitor the availability and retention of employer-sponsored dependent health insurance coverage and shall modify the period described in subdivision (a)(3) if necessary to promote retention of private or employer-sponsored health insurance and timely

access to healthcare services, but at no time shall the period described in subdivision (a)(3) be less than 6 months.

(c) The Department, at its discretion, may take into account the affordability of dependent health insurance when determining whether employer-sponsored dependent health insurance coverage is available upon reemployment of a child's parent as provided in subdivision (a)(3).

(d) A child who is determined to be eligible for the Program shall remain eligible for 12 months, provided that the child maintains his or her residence in this State, has not yet attained 19 years of age, and is not excluded under subsection (e).

(e) A child is not eligible for coverage under the Program if:

(1) the premium required under Section 40 has not been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid; re-enrollment shall be completed before the next covered medical visit, and the first month's required premium shall be paid in advance of the next covered medical visit; or

(2) the child is an inmate of a public institution or an institution for mental diseases.

(f) The Department may adopt rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program in conformance with Section 7 of this Act; rules providing for re-enrollment, grace periods, notice requirements, and hearing procedures under subdivision (e)(1) of this Section; and rules regarding what constitutes availability and affordability of private or employer-sponsored health insurance, with consideration of such factors as the percentage of income needed to purchase children or family health insurance, the availability of employer subsidies, and other relevant factors.

(g) Each child enrolled in the Program as of July 1, 2011 whose family income, as established by the Department, exceeds 300% of the federal poverty level may remain enrolled in the Program for 12 additional months commencing July 1, 2011. Continued enrollment pursuant to this subsection shall be available only if the child continues to meet all eligibility criteria established under the Program as of the effective date of this amendatory Act of the 96th General Assembly without a break in coverage. Nothing contained in this subsection shall prevent a child from qualifying for any other health benefits program operated by the Department.
(Source: P.A. 96-1272, eff. 1-1-11; 96-1501, eff. 1-25-11.)

(215 ILCS 170/21)

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

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

(215 ILCS 170/25)

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

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

(Source: P.A. 96-326, eff. 8-11-09.)

(215 ILCS 170/30)

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

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

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

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

(215 ILCS 170/35)

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

Sec. 35. Health care benefits for children.

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

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

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

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

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

(f) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Act or the Illinois

Public Aid Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e of the Illinois Public Aid Code.
(Source: P.A. 97-689, eff. 6-14-12.)

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

(215 ILCS 170/40)
(Section scheduled to be repealed on July 1, 2016)
Sec. 40. Cost-sharing.
(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:
(1) The Department, by rule, shall set forth requirements concerning co-payments and coinsurance for health care services and monthly premiums. This cost-sharing shall be on a sliding scale based on family income. The Department may periodically modify such cost-sharing.

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

(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.
(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in a certain geographic area.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/41)
(Section scheduled to be repealed on July 1, 2016)
Sec. 41. Health care provider participation in State Employees Deferred Compensation Plan. Notwithstanding any other provision of law, a health care provider who participates under the Program may elect, in lieu of receiving direct payment for services provided under the Program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of

the Illinois Pension Code. A health care provider who elects to participate in the plan does not have a cause of action against the State for any damages allegedly suffered by the provider as a result of any delay by the State in crediting the amount of any contribution to the provider's plan account.
(Source: P.A. 96-806, eff. 7-1-10.)

(215 ILCS 170/45)
(Section scheduled to be repealed on July 1, 2016)
Sec. 45. Study; contracts.
(a) The Department shall conduct a study that includes, but is not limited to, the following:
(1) Establishing estimates, broken down by regions of the State, of the number of children with and without health insurance coverage; the number of children who are eligible for Medicaid or the Children's Health Insurance Program, and, of that number, the number who are enrolled in Medicaid or the Children's Health Insurance Program; and the number of children with access to dependent coverage through an employer, and, of that number, the number who are enrolled in dependent coverage through an employer.

(2) Surveying those families whose children have access to employer-sponsored dependent coverage but who decline such coverage as to the reasons for declining coverage.

(3) Ascertaining, for the population of children accessing employer-sponsored dependent coverage or who have access to such coverage, the comprehensiveness of dependent coverage available, the amount of cost-sharing currently paid by the employees, and the cost-sharing associated with such coverage.

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

(b) The studies described in subsection (a) shall be conducted in a manner that compares a time period preceding or at the initiation of the program with a later period.
(c) The Department shall submit the preliminary results of the study to the Governor and the General Assembly no later than July 1, 2008 and shall submit the final results to the Governor and the General Assembly no later than July 1, 2010.
(d) The Department shall submit copies of all contracts awarded for the administration of the Program to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.
(Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

(215 ILCS 170/47)
(Section scheduled to be repealed on July 1, 2016)
Sec. 47. Program Information. The Department shall report to the General Assembly no later than September 1 of each year beginning in 2007, all of the following information:

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

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

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

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

(215 ILCS 170/50)

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

Sec. 50. Consultation with stakeholders. The Department shall present details regarding implementation of the Program to the Medicaid Advisory Committee, and the Committee shall serve as the forum for healthcare providers, advocates, consumers, and other interested parties to advise the Department with respect to the Program. The Department shall consult with stakeholders on the rules for healthcare professional participation in the Program pursuant to Sections 52 and 53 of this Act.

(Source: P.A. 94-693, eff. 7-1-06; 95-650, eff. 6-1-08.)

(215 ILCS 170/52)

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

Sec. 52. Adequate access to specialty care.

(a) The Department shall ensure adequate access to specialty physician care for Program participants by allowing referrals to be accomplished without undue delay.

(b) The Department shall allow a primary care provider to make appropriate referrals to specialist physicians or other healthcare providers for an enrollee who has a condition that requires care from a specialist physician or other healthcare provider. The Department may specify the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral. A referral shall be effective for the period necessary to provide the referred services or one year, whichever is less. A primary care provider may renew and re-renew a referral.

(c) The enrollee's primary care provider shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist physician or other healthcare provider. If a secondary referral is necessary, the specialist physician or other healthcare provider shall advise the primary care physician. The primary care physician or specialist physician shall be responsible for making the secondary referral. In addition, the Department shall require the specialist physician or other healthcare provider to provide regular updates to the enrollee's primary care provider.

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

(215 ILCS 170/53)

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

Sec. 53. Program standards.

(a) Any disease management program implemented by the Department must be or must have been developed in consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These programs must be based on evidence-based, scientifically sound principles that are accepted by the medical community. An enrollee must be excused from participation in a disease management program if the enrollee's physician licensed to practice medicine in all its branches, in his or her professional judgment, determines that participation is not beneficial to the enrollee.

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

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

(215 ILCS 170/54)

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

(215 ILCS 170/55)

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

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

(215 ILCS 170/56)

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

Sec. 56. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary

care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

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

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

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

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

(215 ILCS 170/60)

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

Sec. 60. Federal financial participation. The Department shall request any necessary state plan amendments or waivers of federal requirements in order to allow receipt of federal funds for implementing any or all of the provisions of the Program. The failure of the responsible federal agency to approve a waiver or other State plan amendment shall not prevent the implementation of any provision of this Act.

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

(215 ILCS 170/63)

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

Sec. 63. Audits by the Auditor General. The Auditor General shall annually cause an audit to be made of the Program, beginning June 30, 2008 and each June 30th thereafter. The audit shall include payments for health services covered by the Program and contracts entered into by the Department in relation to the Program.

(Source: P.A. 95-985, eff. 6-1-09.)

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

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

(215 ILCS 170/97)
(Section scheduled to be repealed on July 1, 2016)
Sec. 97. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.
(Source: P.A. 94-693, eff. 7-1-06.)

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

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

APPENDIX B

Covering ALL KIDS Health Insurance Act Plans

Appendix B
COVERING ALL KIDS HEALTH INSURANCE ACT PLANS

	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) [1] $25 (2) $30 (3) $35 (4) $40 (5+)	$40	$5	$25 [2]	$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

Notes:

[1] The number in parentheses denotes the number of family members.

[2] Co-pay for non-emergency visits only.

Source: ALL KIDS Final Report –July 2010.

APPENDIX C
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.

Person #1	Person #2	Person #3
☐ Yes City:_____ State:_____	☐ Yes City:_____ State:_____	☐ Yes City:_____ State:_____
☐ No	☐ No	☐ 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.

State of Illinois
Printed in-house by authority of the State of Illinois KC 2378KCC (R-4-09) IL478-2437
20,000 copies 4-09

APPENDIX D
Total Payments to ALL KIDS Application Agents

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	1,465	$73,250.00
WCHD WIC PROGRAM	JOLIET	1,022	$51,100.00
VNA HEALTH CENTER	AURORA	955	$47,750.00
GREATER ELGIN FAMILY CARE CTR	ELGIN	895	$44,750.00
ALIVIO MEDICAL CENTER	CHICAGO	814	$40,700.00
UPTOWN NEIGHBORHOOD H CENTER	CHICAGO	699	$34,950.00
DUPAGE MENTAL HLTH NORTH PHC	ADDISON	693	$34,650.00
ERIE FAMILY HEALTH CENTER	CHICAGO	670	$33,500.00
CHAMPAIGN URBANA PUBLIC HLTH	CHAMPAIGN	540	$27,000.00
LAWNDALE CHRISTIAN HLTH	CHICAGO	530	$26,500.00
AUNT MARTHAS YOUTH SRVC CENTER	CHICAGO HEIGHTS	502	$25,100.00
DUPAGE CTY HEALTH DEPT	WHEATON	487	$24,350.00
BHS FANTUS HEALTH CENTER	CHICAGO	485	$24,250.00
MIDLAKES CLINIC	ROUND LK BEACH	475	$23,750.00
WINNEBAGO HLTH DEPT MILLENNIUM	ROCKFORD	444	$22,200.00
ROCK ISLAND COUNTY HLTH DEPT	ROCK ISLAND	428	$21,400.00
DUPAGE MENTAL HEALTH EAST PHC	LOMBARD	427	$21,350.00
MCHENRY COUNTY DEPT OF HEALTH	WOODSTOCK	406	$20,300.00
PREGNANCY TESTING CENTER	BERWYN	385	$19,250.00
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	364	$18,200.00
POLISH AMERICAN ASSN NRTH SIDE	CHICAGO	345	$17,250.00
MCLEAN COUNTY HEALTH DEPT	BLOOMINGTON	335	$16,750.00
THE GENESIS CENTER	DES PLAINES	320	$16,000.00
KANKAKEE COUNTY HEALTH DEPT	KANKAKEE	308	$15,400.00
AURORA PUBLIC HEALTH CENTER	AURORA	296	$14,800.00
ARAB AMERICAN FAMILY SERVICES	BRIDGEVIEW	286	$14,300.00
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	267	$13,350.00
DEKALB COUNTY HLTH DEPT	DEKALB	252	$12,600.00
PRIMECARE WEST TOWN	CHICAGO	246	$12,300.00
WHITESIDE COUNTY HEALTH DEPT	MORRISON	242	$12,100.00
HENRY BOOTH HOUSE	CHICAGO	240	$12,000.00
KOREAN AMERICAN COMM SERVICES	CHICAGO	228	$11,400.00
MELROSE PARK FAMILY HEALTH CTR	MELROSE PARK	226	$11,300.00
RESURRECTION MEDICAL CENTER	DES PLAINES	222	$11,100.00
ACCESS NORTHWEST FMLY HLTH CTR	ARLINGTON HTS	219	$10,950.00
WEST TOWN NEIGHBORHOOD H CTR	CHICAGO	219	$10,950.00
DUPAGE MNTL HLTH WESTMONT PHC	WESTMONT	216	$10,800.00
ASIAN HUMAN SERVICES FAMILY	CHICAGO	209	$10,450.00
SIHF MOTHER AND CHILD CTR	CENTREVILLE	207	$10,350.00
KNOX COUNTY HEALTH DEPT	GALESBURG	205	$10,250.00
ELGIN PUBLIC HEALTH CENTER	ELGIN	197	$9,850.00
JACKSON COUNTY HEALTH DEPT	MURPHYSBORO	196	$9,800.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
MILE SQUARE HEALTH CENTER	CHICAGO	195	$9,750.00
SERVICIOS MEDICOS LA VILLITA	CHICAGO	181	$9,050.00
ERIE HELPING HANDS HEALTH CTR	CHICAGO	179	$8,950.00
SUWADA MARIA	ELK GROVE VLG	179	$8,950.00
DUPAGE COUNTY HEALTH DEPT	WEST CHICAGO	171	$8,550.00
MACON COUNTY HEALTH DEPT	DECATUR	165	$8,250.00
NORWEGIAN AMERICAN HOSP	CHICAGO	163	$8,150.00
CHINESE AMERICAN SERV LEAGUE	CHICAGO	158	$7,900.00
VERMILION COUNTY HEALTH DEPT	DANVILLE	158	$7,900.00
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	152	$7,600.00
AUNT MARTHAS YOUTH SERVICE CTR	HAZEL CREST	148	$7,400.00
ENGLEWOOD NEIGHBORHOOD H CTR	CHICAGO	142	$7,100.00
ST JOSEPH HOSP LAKEVIEW CLINIC	CHICAGO	140	$7,000.00
DR JORGE PRIETO HEALTH CENTER	CHICAGO	132	$6,600.00
AUNT MARTHAS YOUTH SERVICE CTR	CHICAGO HEIGHTS	131	$6,550.00
COMMUNITY HEALTH CARE INC	DAVENPORT	127	$6,350.00
FAMILY HEALTH SOCIETY	CHICAGO HEIGHTS	122	$6,100.00
SWEDISH COVENANT HOSPITAL	CHICAGO	122	$6,100.00
CENTRO DE SALUD ESPERANZA	CHICAGO	120	$6,000.00
CICERO HEALTH CENTER	CICERO	119	$5,950.00
LOWER WEST SIDE HEALTH CENTER	CHICAGO	116	$5,800.00
POLISH AMERICN ASSN SOUTH SIDE	CHICAGO	116	$5,800.00
GRUDZINSKI ANNA	CHICAGO	110	$5,500.00
DES PLAINES VALLEY HEALTH CTR	SUMMIT	107	$5,350.00
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	106	$5,300.00
ST CLAIR COUNTY HEALTH DEPT	BELLEVILLE	104	$5,200.00
GILEAD OUTREACH AND REFERRAL C	CHICAGO	103	$5,150.00
KEDZIE FAMILY HEALTH CENTER	CHICAGO	102	$5,100.00
COORDINATED YOUTH WIC PROGRAM	WOOD RIVER	98	$4,900.00
HAWTHORNE FAMILY HEALTH CENTER	CICERO	98	$4,900.00
SIHF W BELLEVILLE HEALTH CTR	BELLEVILLE	98	$4,900.00
CIRCLE FAMILY HEALTHCARE NETWK	CHICAGO	96	$4,800.00
LINCOLN SQUARE	CHICAGO	95	$4,750.00
SALUD FAMILY HEALTH CENTER	CHICAGO	95	$4,750.00
FRANCES NELSON HEALTH CENTER	CHAMPAIGN	94	$4,700.00
CRUSADER CLINIC	ROCKFORD	93	$4,650.00
UNIVERSITY OF IL AT CHIC HOSP	CHICAGO	92	$4,600.00
FRIEND FAMILY HEALTH CENTER	CHICAGO	91	$4,550.00
WOMENS HEALTH SERVICES	OAK LAWN	91	$4,550.00
MACOUPIN COUNTY HEALTH DEPT	CARLINVILLE	88	$4,400.00
MERCY DIAGNOSTIC TREATMENT CTR	CHICAGO	83	$4,150.00
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	80	$4,000.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
HANUL FAMILY ALLIANCE SUBURBAN	MT PROSPECT	80	$4,000.00
FAYETTE COUNTY HLTH DEPT	VANDALIA	79	$3,950.00
COORDINATED YOUTH SERVICES	GRANITE CITY	78	$3,900.00
RUSH ADOLESCENT FAMILY CENTER	CHICAGO	78	$3,900.00
SO CHICAGO MCH HEALTH CLINIC	CHICAGO	77	$3,850.00
CHINESE MUTUAL AID ASSOCIATION	CHICAGO	76	$3,800.00
CHRISTIAN COUNTY HEALTH DEPT	TAYLORVILLE	76	$3,800.00
JERSEY COUNTY HEALTH DEPT	JERSEYVILLE	76	$3,800.00
ADVOCATE NORTHSIDE	CHICAGO	74	$3,700.00
ROGERS PARK HIHC	CHICAGO	74	$3,700.00
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	73	$3,650.00
SOUTH LAWNDALE MCH CENTER	CHICAGO	71	$3,550.00
SHELBY COUNTY HEALTH DEPT	SHELBYVILLE	70	$3,500.00
CLARIDAD LETICIA	CHICAGO	69	$3,450.00
LIVINGSTON CO PUBLIC HLTH DEPT	PONTIAC	69	$3,450.00
PROGRAMA CIELO	CHICAGO	69	$3,450.00
EDGAR COUNTY HEALTH DEPT	PARIS	67	$3,350.00
THE CLINIC IN ALTGELD INC	CHICAGO	67	$3,350.00
WILL CO HEALTH DEPT NORTHERN B	BOLINGBROOK	67	$3,350.00
COMMUNITY ALTERNATIVES UNLTD	CHICAGO	65	$3,250.00
DROZD BEATA	NILES	65	$3,250.00
KLING PROFESSIONAL CENTER	CHICAGO	65	$3,250.00
EVANSTON HEALTH DEPT	EVANSTON	64	$3,200.00
MUSLIM WOMEN RESOURCE CTR	CHICAGO	64	$3,200.00
GRUNDY COUNTY HEALTH DEPT	MORRIS	63	$3,150.00
LOGAN SQUARE HLTH CTR COOK CO	CHICAGO	61	$3,050.00
PANTIRU MIHAELA	CHICAGO	61	$3,050.00
CLAY COUNTY HEALTH DEPT	FLORA	59	$2,950.00
FRANKLIN WILLIAMSON HLTH DEPT	MARION	59	$2,950.00
OGLE COUNTY HEALTH DEPT	OREGON	57	$2,850.00
LEE COUNTY HEALTH DEPT	DIXON	55	$2,750.00
PCC COMMUNITY WELLNESS CENTER	OAK PARK	55	$2,750.00
PETERSON FAMILY HEALTH CENTER	CHICAGO	54	$2,700.00
FAMILY FOCUS AURORA	AURORA	51	$2,550.00
SOUTH SUBURBAN HOSPITAL	HAZEL CREST	51	$2,550.00
SIHF WASHINGTON PARK CTR	WASHINGTON PARK	50	$2,500.00
MANO A MANO FAMILY RESOURCE	ROUND LAKE BCH	49	$2,450.00
CENTRO DE INFORMACION	ELGIN	48	$2,400.00
ALIA SIDDIQI MD	CHICAGO	47	$2,350.00
BHS JOHN SENGSTACKE PROF BLDG	CHICAGO	47	$2,350.00
PRIMECARE FULLERTON	CHICAGO	47	$2,350.00
AUNT MARTHA YTH SERV HLTHY KID	AURORA	46	$2,300.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
PEORIA CITY COUNTY HLTH DEPT	PEORIA	46	$2,300.00
RIVEREDGE HOSPITAL	FOREST PARK	46	$2,300.00
RONALD MCDONALD CARE MOBILE	ROCKFORD	45	$2,250.00
DECATUR OB GYN ASSOCIATES	DECATUR	44	$2,200.00
HANCOCK COUNTY HEALTH DEPT	CARTHAGE	44	$2,200.00
EVANSTON ROGERS PARK FAM HLTH	CHICAGO	43	$2,150.00
CHRISTIAN COMMUNITY HLTH CTR	CHICAGO	41	$2,050.00
WAYNE COUNTY HEALTH DEPT	FAIRFIELD	41	$2,050.00
PCC AUSTIN FAMILY HEALTH CNT	CHICAGO	40	$2,000.00
PRIMECARE NORTHWEST	CHICAGO	40	$2,000.00
WESTLAKE HOSPITAL	MELROSE PARK	40	$2,000.00
SIHF ALTON WOMENS HEALTH CTR	ALTON	38	$1,900.00
AUNT MARTHA YTH SERV CTR INC	HARVEY	37	$1,850.00
CHILD AND FAMILY CONNECTIONS	LISLE	37	$1,850.00
CLINTON COUNTY HEALTH DEPT	CARLYLE	37	$1,850.00
HOLY CROSS HOSPITAL	CHICAGO	37	$1,850.00
SIHF FAIRMONT CITY HEALTH CTR	FAIRMONT CITY	37	$1,850.00
SAN RAFAEL	CHICAGO	36	$1,800.00
BIRUTE PAULAUSKAITE	MUNDELEIN	35	$1,750.00
BOND CO HEALTH DEPT	GREENVILLE	35	$1,750.00
COLES COUNTY PUBLIC HLTH DEPT	CHARLESTON	35	$1,750.00
SIHF KOCH HEALTH CTR	GRANITE CITY	35	$1,750.00
STREAMWOOD BEHAVIORAL HLTH CTR	STREAMWOOD	35	$1,750.00
TKACZ JOANNA	CHICAGO	34	$1,700.00
ZABIEROWSKI URSULA	HOFFMAN ESTATES	34	$1,700.00
CENTRAL COUNTIES HEALTH CTR	SPRINGFIELD	32	$1,600.00
SIHF BELLEVILLE FP HEALTH CTR	BELLEVILLE	32	$1,600.00
STICKNEY PUBLIC HEALTH DIST	BURBANK	32	$1,600.00
COMMUNITY NURSE HEALTH ASSN	LAGRANGE	31	$1,550.00
GREENE COUNTY HEALTH DEPT	CARROLLTON	31	$1,550.00
ONE THOUSAND ONE INS AND FINAN	CHICAGO	31	$1,550.00
WEST CHICAGO FAMILY HEALTH CTR	WEST CHICAGO	31	$1,550.00
CENTRO MEDICO	CHICAGO	30	$1,500.00
CHILD AND FAMILY CONNECTIONS	CRYSTAL LAKE	30	$1,500.00
NEAR NORTH HEALTH SERV KOMED	CHICAGO	30	$1,500.00
HENRY COUNTY HEALTH DEPT	KEWANEE	29	$1,450.00
PLAZA MEDICAL CENTER	CHICAGO	29	$1,450.00
INSTITUTO DEL PROGRESO LATINO	CHICAGO	28	$1,400.00
LAKE CO H D ZION CLINIC	ZION	27	$1,350.00
OMNI YOUTH SERVICES PROS HGHTS	PROSPECT HTS	27	$1,350.00
JO DAVIESS CO HEALTH DEPT	GALENA	26	$1,300.00
KOZIOL MARIUSZ	ELK GROVE VLG	26	$1,300.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
CARE CENTER OF SPRINGFIELD INC	SPRINGFIELD	25	$1,250.00
KASZOWSKA ELZBIETA	NAPERVILLE	25	$1,250.00
BOBROWSKA IZABELLA	CHICAGO	24	$1,200.00
ADVANCED MEDICAL GROUP	WHEELING	23	$1,150.00
HAMILTON COUNTY HEALTH DEPT	MCLEANSBORO	22	$1,100.00
LOGAN SQUARE NEIGHBORHOOD ASSN	CHICAGO	22	$1,100.00
MENARD CO HEALTH DEPT	PETERSBURG	22	$1,100.00
PIKE COUNTY HEALTH DEPT	PITTSFIELD	22	$1,100.00
CARROLL COUNTY HEALTH DEPT	MT CARROLL	21	$1,050.00
CHICAGO HLTH OUTREACH HOMELESS	CHICAGO	21	$1,050.00
EVANSTON SCHOOL BASED HLTH CTR	EVANSTON	21	$1,050.00
MADISON MEDICAL CENTER	CHICAGO	21	$1,050.00
SOUTH EAST ASIA CENTER	CHICAGO	21	$1,050.00
ASHLAND FAMILY HEALTH CENTER	CHICAGO	20	$1,000.00
CHICAGO CTR FOR TORAH AND CHES	CHICAGO	20	$1,000.00
HENDERSON CO HEALTH DEPT	MONMOUTH	20	$1,000.00
SIHF WINDSOR HEALTH CTR	EAST SAINTLOUIS	20	$1,000.00
BRANDON FAMILY HEALTH CENTER	CHICAGO	19	$950.00
HOWARD AREA COMMUNITY CENTER	CHICAGO	19	$950.00
KID CARE MEDICAL	ELGIN	19	$950.00
RANDOLPH COUNTY HEALTH DEPT	CHESTER	19	$950.00
ALMA MEDICAL CENTER	MAYWOOD	18	$900.00
CHILD AND FAMILY CONNECTION 1	LOVES PARK	18	$900.00
INFANT WELFARE CLINIC	OAK PARK	18	$900.00
SOUTHWEST FAMILY HEALTH CENTER	CHICAGO	17	$850.00
A G FAMILY CARE LTD	BUFFALO GROVE	16	$800.00
SOUTHERN SEVEN HEALTH DEPT	VIENNA	16	$800.00
WINFIELD MOODY HEALTH CENTER	CHICAGO	16	$800.00
ALEXIAN CENTER FOR MENTAL HLTH	ARLINGTON HGTS	15	$750.00
EGYPTIAN HEALTH DEPT	CARMI	15	$750.00
HR STUDIO INC	CHICAGO	15	$750.00
JASPER CO HEALTH DEPT	NEWTON	15	$750.00
KID CARE MEDICAL	MOUNT PROSPECT	15	$750.00
LAKE COUNTY KIDCARE APP	WAUKEGAN	15	$750.00
SIHF CAHOKIA HEALTH CTR	CAHOKIA	15	$750.00
TAZEWELL COUNTY HLTH DEPT	TREMONT	15	$750.00
UPLIFT SCHOOL HEALTH CENTER	CHICAGO	15	$750.00
EFFINGHAM COUNTY HEALTH DEPT	EFFINGHAM	14	$700.00
FORD IROQUOIS PUB HLTH DEPT	WATSEKA	14	$700.00
MACNEAL HEALTH NETWORK	BERWYN	14	$700.00
OAK PARK HEALTH DEPT	OAK PARK	14	$700.00
SPANISH CTR LYRP OUTREACH PROJ	JOLIET	14	$700.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
EASTER SEALS CHILD FAM CONN 12	TINLEY PARK	13	$650.00
HEARTLAND HEALTH OUTREACH	CHICAGO	13	$650.00
MASON COUNTY HEALTH DEPARTMENT	HAVANA	13	$650.00
ADOLESCENT HEALTH CENTER	CARBONDALE	12	$600.00
KULPA ANNA	LK IN THE HLS	12	$600.00
PADOWSKI BOGUMILA	DES PLAINES	12	$600.00
RESEARCH AND EDUCATION FOUND	BLUE ISLAND	12	$600.00
SINAI HEALTH SYSTEM	CHICAGO	12	$600.00
ADVENTIST BOLINGBROOK HOSPITAL	BOLINGBROOK	11	$550.00
CARDINAL GLENNON MED CTR	ST LOUIS	11	$550.00
SIHF STATE STREET CTR	EAST ST LOUIS	11	$550.00
VILLAGE OF HOFFMAN ESTATES	HOFFMAN ESTATES	11	$550.00
WCHD EASTERN BRANCH OFFICE	UNIVERSITY PARK	11	$550.00
ACCESS CABRINI HEALTH CENTER	CHICAGO	10	$500.00
DISTRICT 62 SPARK	DES PLAINES	10	$500.00
HANUL FAMILY ALLIANCE CHICAGO	CHICAGO	10	$500.00
KID CARE MEDICAL	HANOVER PARK	10	$500.00
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	10	$500.00
MERCER COUNTY HEALTH DEPT	ALEDO	10	$500.00
MURPHYSBORO HEALTH CENTER	MURPHYSBORO	10	$500.00
OZDROVSKA NADIA	CHICAGO	10	$500.00
PUI TAK CENTER	CHICAGO	10	$500.00
SAINTS MARY AND ELIZ MED CEN N	CHICAGO	10	$500.00
BEACON THERAPEUTIC DIAGNOSTIC	CHICAGO	9	$450.00
CHICAGO HISPANIC HEALTH COALI	CHICAGO	9	$450.00
KENDALL CO HLTH AND HUMAN SERV	YORKVILLE	9	$450.00
SANGAMON CO DEPT PUBLIC HEALTH	SPRINGFIELD	9	$450.00
WES HEALTH SYSTEM	NORTH RIVERSIDE	9	$450.00
HUMBOLT PARK FAM HLTH CENTER	CHICAGO	8	$400.00
JEWISH CHILD AND FAMILY SRVS	CHICAGO	8	$400.00
KARWINSKI MALGORZATA	CHICAGO	8	$400.00
KID CARE MEDICAL	ADDISON	8	$400.00
KID CARE MEDICAL	ARLINGTON HGHTS	8	$400.00
MADISON COUNTY HEALTH DEPT	WOOD RIVER	8	$400.00
PILSEN FAMILY HEALTH CENTER	CHICAGO	8	$400.00
SHAHBAZ AKHTAR	CHICAGO	8	$400.00
ST ANTHONY HOSPITAL COMMUNITY	CHICAGO	8	$400.00
PEORIA CNTY BRD CARE DEV DISBL	PEORIA	7	$350.00
SERVICE OF WILL GRUNDY KANKAKE	JOLIET	7	$350.00
STAR DENTAL CENTER	WHEELING	7	$350.00
ART OF INSURANCE	ARLINGTON HTS	6	$300.00
CHURCH OF THE HOLY SPIRIT	SCHAUMBURG	6	$300.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
COM HLTH PARTNERSHIP HOOPESTEN	HOOPESTON	6	$300.00
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	6	$300.00
MOULTRIE COUNTY HEALTH DEPT	SULLIVAN	6	$300.00
PEDIATRICS CLINIC	DES PLAINES	6	$300.00
ALBANY CHILD CARE CENTER	CHICAGO	5	$250.00
AUBURN GRESHAM FAMILY HLTH CTR	CHICAGO	5	$250.00
BELOVED COMM FMLY WELLNESS CTR	CHICAGO	5	$250.00
BETHANY CHRISTIAN SRVCS OF MO	COLUMBIA	5	$250.00
BRIDGEPORT CHILD DEVELOPMENT	CHICAGO	5	$250.00
CHICAGO DEPARTMENT OF HEALTH	CHICAGO	5	$250.00
CHILD AND FAMILY CONNECTIONS	FREEPORT	5	$250.00
CHRISTIAN COMMUNITY HLTH CTR	CALUMET CITY	5	$250.00
CUMBERLAND COUNTY HEALTH DEPT	TOLEDO	5	$250.00
ERIE TEEN HEALTH CENTER	CHICAGO	5	$250.00
HORB NADIA	CHICAGO	5	$250.00
MALISZEWSKI MARZENA	ALGONQUIN	5	$250.00
SOUTHERN IL CASE COORDINATION	CENTRALIA	5	$250.00
AUSTIN COOK COUNTY COMM HC	CHICAGO	4	$200.00
AVON TOWNSHIP	ROUND LAKE PARK	4	$200.00
BERWYN PUBLIC HEALTH DIST	BERWYN	4	$200.00
BLUE ISLAND MEDICAL CENTER	BLUE ISLAND	4	$200.00
BOCHENEK BEATA	CHICAGO	4	$200.00
BONDAROWICZ RENATA	SCHAUMBURG	4	$200.00
CARTERVILLE FAMILY PRACTICE	CARTERVILLE	4	$200.00
COM HLTH PARTNERSHIP AURORA	AURORA	4	$200.00
EDUARDO V BARRIUSO MD	CHICAGO	4	$200.00
ERIE WESTSIDE FAMILY HEALTH	CHICAGO	4	$200.00
FIRMANS MT CH HLTH PROG WORTH	WORTH	4	$200.00
HENDERSON CO HEALTH DEPT	GLADSTONE	4	$200.00
JEFFERSON COUNTY HEALTH DEPT	MT VERNON	4	$200.00
KID CARE MEDICAL	WEST CHICAGO	4	$200.00
MACOUPIN CO COMM CARE HEALTH	GILLESPIE	4	$200.00
MARION COUNTY HEALTH DEPT	SALEM	4	$200.00
MONTGOMERY CO HLTH DEPT	HILLSBORO	4	$200.00
NEMETZ RONNIE	LOMBARD	4	$200.00
OMNI YOUTH SERVICES WHEELING	WHEELING	4	$200.00
ROSELAND COMMUNITY HOSPITAL	CHICAGO	4	$200.00
ST SABINA EMERGENCY SRVCS CTR	CHICAGO	4	$200.00
YONG MIMI	PLAINFIELD	4	$200.00
YOUTH SVCS GLENVIEW NORTHBROOK	GLENVIEW	4	$200.00
ADVOCATE CHRIST MEDICAL CENTER	OAK LAWN	3	$150.00
CATHOLIC CHARITIES AURORA	AURORA	3	$150.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
FIRMANS MT CH HLTH PROG CICERO	CHICAGO	3	$150.00
JANET WATTLES CENTER	BELVIDERE	3	$150.00
KID CARE MEDICAL	ELK GROVE VLGE	3	$150.00
LAUPER ROBERT	OSWEGO	3	$150.00
LONG TIM	WOODRIDGE	3	$150.00
PERRY CO HLTH DEPT	PINCKNEYVILLE	3	$150.00
PINKNEY HARVEY	ALSIP	3	$150.00
SIHF ALTON HEALTH CTR	ALTON	3	$150.00
SOUTHERN SEVEN HEALTH DEPT	JONESBORO	3	$150.00
SUBURBAN ACCESS CFC 7	HOMEWOOD	3	$150.00
SUBURBAN ACCESS INC	HILLSIDE	3	$150.00
TRINITY SERVICES INC	JOLIET	3	$150.00
TRIPLE CARE	CHICAGO	3	$150.00
ARMITAGE FAMILY HEALTH CENTER	CHICAGO	2	$100.00
AUNT MARTHAS CEDA WIC PROGRAM	CHICAGO HEIGHTS	2	$100.00
BOGAN HEALTH CENTER	CHICAGO	2	$100.00
CASS CO HEALTH DEPT VIRGINIA	VIRGINIA	2	$100.00
CENTRAL ILL SERVICE ACCESS	LINCOLN	2	$100.00
CHILD AND FAMILY CONNECTIONS	CHICAGO	2	$100.00
CLEARBROOK CFC 6	ARLINGTON HTS	2	$100.00
COMM COUNS CTR CHGO BROADWAY	CHICAGO	2	$100.00
DD SERVICES OF METRO EAST	BELLEVILLE	2	$100.00
DUPAGE COUNTY HUMAN RESOURCES	WHEATON	2	$100.00
DUPAGE MNTL HLTH CRISIS UNIT	LOMBARD	2	$100.00
DUPAGE TRANS SERVICES CENTER	WHEATON	2	$100.00
ERIE HENSON HEALTH CENTER	CHICAGO	2	$100.00
KANKAKEE SCHOOL BASED HLTH CTR	KANKAKEE	2	$100.00
KID CARE MEDICAL	EAST DUNDEE	2	$100.00
MORGAN COUNTY HLTH DEPT	JACKSONVILLE	2	$100.00
NORRIDGE PARK DISTRICT	NORRIDGE	2	$100.00
RIVERA ENRIQUE	BOLINGBROOK	2	$100.00
SEIU LOCAL 4 HEALTH FUND	CHICAGO	2	$100.00
SOUTHERN SEVEN HD	ULLIN	2	$100.00
STEPHENSON CO HEALTH DEPT	FREEPORT	2	$100.00
SUSAN A PETERS	MACHESNEY PARK	2	$100.00
THE SUCCESS CENTER	LANSING	2	$100.00
VIETNAMESE ASSOC OF ILLINOIS	CHICAGO	2	$100.00
WASHINGTON SEADRA	RICHTON PARK	2	$100.00
ACCESS AT LINDBLOM	CHICAGO	1	$50.00
ACCESS SULLIVAN HIGH SCHOOL HC	CHICAGO	1	$50.00
ASSOCIATION HOUSE OF CHICAGO	CHICAGO	1	$50.00
BOKOTU	ARLINGTON HTS	1	$50.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
BOOKER FAMILY HEALTH CENTER	CHICAGO	1	$50.00
BUREAU COUNTY DEPT OF HEALTH	PRINCETON	1	$50.00
CATHOLIC SOCIAL SERVICE	BELLEVILLE	1	$50.00
CCDPH SOUTH DISTRICT OFFICE	MARKHAM	1	$50.00
CFC 19	DECATUR	1	$50.00
CHARLES HAYES CENTER	CHICAGO	1	$50.00
COMMUNITY HLTH EMERGENCY SERV	CAIRO	1	$50.00
DEWITT PIATT BI CO HLTH DEPT	CLINTON	1	$50.00
DOCTORS MEDICAL CENTER	CHICAGO	1	$50.00
DR WU WOMEN HEALTH CENTER	CHICAGO	1	$50.00
ELGIN DUNDEE	ELGIN	1	$50.00
ERIE COURT HEALTH CENTER	OAK PARK	1	$50.00
FAMILY MEDICINE SPECIALISTS	WAUCONDA	1	$50.00
FAMILY SVC CMHC OF MCHENRY CTY	MCHENRY	1	$50.00
FIRMAN MT CH HLTH PROG ROL MED	ROLLING MEADOWS	1	$50.00
GRADZIK BARBARA	FRANKLIN PARK	1	$50.00
HANOVER TOWNSHIP	HANOVER PARK	1	$50.00
HEARTLAND PEDIATRIC CENTER	CHICAGO	1	$50.00
HUDSON BERNARD	BELLEVILLE	1	$50.00
HYMAN JOY	MT PROSPECT	1	$50.00
IRENA PANTELEMONIUK	CHICAGO	1	$50.00
KCAS ENTERPRISES INC	MARENGO	1	$50.00
LONG YVETTE	CHICAGO	1	$50.00
MARTINEZ LILLIAN	BENSENVILLE	1	$50.00
MORRIS HOSPITAL	MORRIS	1	$50.00
OAK FOREST HOSPITAL	OAK FOREST	1	$50.00
OAK PARK OFFICE	OAK PARK	1	$50.00
PUCHALSKI ALINA	LAKE FOREST	1	$50.00
ROGERS PARK COMMUNITY COUNCIL	CHICAGO	1	$50.00
ROSELAND ALTGELD ADOL PARENT	CHICAGO	1	$50.00
SCHOOL HEALTH LINK INC	ROCK ISLAND	1	$50.00
SCHOOL HEALTH LINK INC	SILVIS	1	$50.00
SHERMAN HOSPITAL	ELGIN	1	$50.00
SIHF EFFINGHAM HEALTH CTR I	EFFINGHAM	1	$50.00
SIHF SOUTHERN HEALTH CTR	BELLEVILLE	1	$50.00
SOUTHEASTERN HLTH CTR COOK CNT	SOUTH HOLLAND	1	$50.00
ST ANTHONY HOSPITAL	CHICAGO	1	$50.00
ST BLASE	SUMMIT	1	$50.00
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	1	$50.00
ST MARY OF NAZARETH HOSPITAL	CHICAGO	1	$50.00
SULTAN SHEIKH	CHICAGO	1	$50.00
THE PAVILION FOUNDATION	CHAMPAIGN	1	$50.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2011

Name	City	Approved Applications	Total Amount Paid
TRICITY FAMILY SERVICES	GENEVA	1	$50.00
YWCA CHILD CARE RESOURCE REFRL	GLENDALE	1	$50.00
	Totals	**28,972**	**$1,448,600.00**

Source: Application Agent payment data provided by HFS.

APPENDIX E

FY11 Total Payments by Category of Service

Appendix E
TOTAL PAYMENTS BY CATEGORY OF SERVICE
During FY11

Category of Service	FY11 Payment Amount	Percent of Total Payments
Pharmacy Services	$20,793,748	22%
Dental Services	13,282,696	14%
Inpatient Hospital Services (General)	12,110,061	13%
Physician Services	12,078,550	13%
General Clinic Services	8,110,110	8%
Outpatient Services (General)	6,162,981	6%
Inpatient Hospital Services (Psychiatric)	3,619,832	4%
Healthy Kids Services	3,551,188	4%
Capitation Services	3,548,354	4%
Mental Health Rehab Option Services	2,486,541	3%
Home Health Services	1,331,560	1%
Medical Supplies	1,113,741	1%
Alcohol and Substance Abuse Rehab Services	1,045,415	1%
Medical Equipment/Prosthetic Devices	1,037,983	1%
Optical Supplies	823,266	1%
Clinical Laboratory Services	743,572	1%
Anesthesia Services	498,752	1%
Psychiatric Clinic Services (Type 'A')	463,576	<1%
Speech Therapy/Pathology Services	390,128	<1%
Inpatient Hospital Services (Physical Rehabilitation)	279,403	<1%
Outpatient Services (ESRD)	274,857	<1%
Physical Therapy Services	245,465	<1%
Targeted Case Management Service (Mental Health)	236,111	<1%
Targeted Case Management Service (Early Intervention)	230,354	<1%
Emergency Ambulance Transportation	219,260	<1%
Occupational Therapy Services	216,079	<1%
Optometric Services	204,797	<1%
Nurse Practitioners Services	200,346	<1%
Clinic Services (Physical Rehabilitation)	190,910	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	149,627	<1%
Podiatric Services	131,421	<1%
Service Car	126,489	<1%
Psychiatric Clinic Services (Type 'B')	120,630	<1%
Nursing Service	108,418	<1%
LTC--ICF/MR	102,972	<1%

Appendix E
TOTAL PAYMENTS BY CATEGORY OF SERVICE
During FY11

Category of Service	FY11 Payment Amount	Percent of Total Payments
All Kids Application Agent	85,850	<1%
Non-Emergency Ambulance Transportation	39,569	<1%
Audiology Services	35,573	<1%
Early Intervention Services	34,473	<1%
SOPF--MI Recipient under 22 Years of Age	24,128	<1%
Midwife Services	23,973	<1%
Social Work Service	21,334	<1%
Psychologist Service	12,749	<1%
LTC - MR Recipient between Ages 21-65	9,706	<1%
Chiropractic Services	9,373	<1%
Medicar Transportation	9,198	<1%
Home Care	7,975	<1%
Taxicab Services	5,076	<1%
LTC - Intermediate	3,993	<1%
Fluoride Varnish	3,775	<1%
Waiver Service (Depends on HCPCS Code)	105	<1%
Portable X-Ray Services	27	<1%
Total FY11 Payments	**$96,556,069**	**100%**

Note: Totals may not add due to rounding.

Source: Summary of FY11 ALL KIDS data provided by HFS.

APPENDIX F

FY11 EXPANDED ALL KIDS Payments

Appendix F

FY11 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	Capitation Services	Chiropractic Services	Clinic Services (Physical Rehabilitation)	Clinical Laboratory Services	Dental Services
Assist Undocumented	$462,945.68	$46,550.00	$305,924.70	$14,375.28	$3,380,414.35	$8,675.40	$122,792.00	$573,530.66	$9,622,718.41
Share Undocumented	25,406.76	2,950.00	5,479.95	400.20	55,737.95	170.72	1,170.00	14,304.89	314,460.33
Level 1 Undocumented	26,094.03	4,950.00	6,528.21	249.10	39,227.37	0	5,726.00	12,234.77	328,123.54
Level 2	397,119.82	23,550.00	137,751.04	15,519.89	66,236.34	522.60	41,326.43	112,319.77	2,419,058.85
Level 2 Undocumented	0	950.00	1,719.20	256.20	1,006.24	4.69	0	3,057.10	85,506.94
Level 3	74,057.34	4,900.00	32,307.85	3,771.07	4,964.93	0	6,370.00	21,000.08	412,406.12
Level 3 Undocumented	0	250.00	0	0	82.90	0	0	603.62	15,642.64
Level 4	55,206.90	1,150.00	5,740.90	756.62	683.98	0	3,516.00	4,780.10	61,863.54
Level 4 Undocumented	0	200.00	0	0	0	0	0	10.36	4,287.37
Level 5	158.40	400.00	2,164.35	244.34	0	0	2,600.00	722.94	12,990.82
Level 5 Undocumented	0	0	276.30	0	0	0	5,330.00	0	367.25
Level 6	4,425.92	0	307.00	0	0	0	2,080.00	982.82	2,923.39
Level 6 Undocumented	0	0	0	0	0	0	0	0	1,099.75
Level 7	0	0	353.05	0	0	0	0	17.60	1,152.40
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	199.55	0	0	0	0	7.50	95.00
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$1,045,414.85**	**$85,850.00**	**$498,752.10**	**$35,572.70**	**$3,548,354.06**	**$9,373.41**	**$190,910.43**	**$743,572.21**	**$13,282,696.35**

Source: Summary of FY11 ALL KIDS data provided by HFS.

Appendix F

FY11 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	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	$16,420.54	$2,971.98	$133,325.94	$1,092.00	$6,510,458.92	$1,997,046.36	$7,974.87	$144,453.24
Share Undocumented	0	0	5,200.12	26.00	145,118.53	71,353.63	0	613.40
Level 1 Undocumented	0	0	1,700.24	26.00	110,642.68	89,470.67	0	306.70
Level 2	90,626.68	20,505.22	61,622.07	2,054.00	1,073,400.78	1,050,295.32	0	379,345.05
Level 2 Undocumented	83.46	0	886.66	0	28,703.26	27,796.51	0	0
Level 3	31,332.10	3,305.37	13,540.75	447.20	208,312.15	251,921.43	0	206,149.10
Level 3 Undocumented	0	0	315.43	0	1,461.59	4,891.69	0	0
Level 4	3,308.50	1,249.36	1,873.92	78.00	28,420.18	44,233.56	0	221,326.88
Level 4 Undocumented	0	0	0	0	470.85	1,236.67	0	0
Level 5	4,405.63	5,306.48	371.31	26.00	2,634.71	8,403.90	0	16,898.82
Level 5 Undocumented	0	0	0	0	226.68	370.50	0	0
Level 6	2,532.05	400.40	0	0	107.84	2,101.80	0	215,472.00
Level 6 Undocumented	0	0	0	0	8.00	270.04	0	0
Level 7	918.06	734.00	423.19	26.00	4.00	1,064.70	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	139.60	731.47	0	146,994.56
Level 8 Undocumented	0	0	0	0	0	0	0	0
Totals by Category	**$149,627.02**	**$34,472.81**	**$219,259.63**	**$3,775.20**	**$8,110,109.77**	**$3,551,188.25**	**$7,974.87**	**$1,331,559.75**

Source: Summary of FY11 ALL KIDS data provided by HFS.

Appendix F

FY11 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 - Intermediate	LTC - MR Recipient between ages 21-65	LTC--ICF/MR	Medical Equipment/Prosthetic Devices	Medical Supplies	Medicar Transportation
Assist Undocumented	$5,986,220.22	$179,146.24	$2,193,795.13	$0	$7,447.21	$85,447.08	$522,644.63	$537,325.46	$9,197.66
Share Undocumented	78,338.61	0	85,615.00	0	74.12	0	37,728.30	3,652.31	0
Level 1 Undocumented	93,039.79	0	19,402.81	0	49.60	0	19,798.60	14,647.04	0
Level 2	3,764,022.72	80,079.06	1,019,095.38	3,992.67	1,276.86	0	362,503.28	411,419.27	0
Level 2 Undocumented	22,084.52	0	2,831.04	0	0	0	2,937.84	387.76	0
Level 3	1,391,148.24	20,177.56	179,412.29	0	858.06	0	49,788.76	111,063.89	0
Level 3 Undocumented	0	0	17,367.28	0	0	0	2,056.87	992.68	0
Level 4	71,476.29	0	60,417.11	0	0	0	30,734.77	19,604.44	0
Level 4 Undocumented	0	0	0	0	0	0	0	0	0
Level 5	687,398.75	0	15,634.45	0	0	0	8,165.90	3,082.10	0
Level 5 Undocumented	0	0	0	0	0	0	1,017.84	0	0
Level 6	16,331.49	0	0	0	0	0	289.50	9,537.62	0
Level 6 Undocumented	0	0	0	0	0	0	0	0	0
Level 7	0	0	26,261.95	0	0	17,524.52	0	970.89	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	0	0	317.20	1,057.42	0
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$12,110,060.63**	**$279,402.86**	**$3,619,832.44**	**$3,992.67**	**$9,705.85**	**$102,971.60**	**$1,037,983.49**	**$1,113,740.88**	**$9,197.66**

Source: Summary of FY11 ALL KIDS data provided by HFS.

Appendix F

FY11 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Mental Health Rehab Option Services	Midwife Services	Non-Emergency Ambulance Transportation	Nurse Practitioners Services	Nursing Service	Occupational Therapy Services	Optical Supplies	Optometric Services	Outpatient Services (ESRD)
Assist Undocumented	$1,319,856.16	$22,111.27	$36,127.06	$92,076.84	$108,418.08	$57,909.96	$617,934.04	$137,387.95	$274,856.91
Share Undocumented	38,948.24	0	1,168.83	5,147.93	0	3,284.10	17,940.32	4,729.85	0
Level 1 Undocumented	44,634.08	44.10	428.00	2,351.95	0	1,121.40	17,449.55	5,064.22	0
Level 2	855,458.38	1,694.35	1,845.09	81,491.16	0	102,669.42	138,807.77	45,925.38	0
Level 2 Undocumented	2,586.27	0	0	916.13	0	373.80	4,714.14	1,559.19	0
Level 3	167,403.45	123.38	0	14,389.09	0	32,406.25	21,280.66	8,057.77	0
Level 3 Undocumented	1,065.24	0	0	191.59	0	0	870.87	202.95	0
Level 4	34,399.82	0	0	3,395.57	0	3,733.06	3,395.34	1,491.22	0
Level 4 Undocumented	955.06	0	0	45.56	0	907.80	98.49	30.09	0
Level 5	17,678.21	0	0	266.83	0	7,312.37	659.25	256.95	0
Level 5 Undocumented	0	0	0	0	0	1,815.60	51.51	18.45	0
Level 6	773.26	0	0	72.91	0	2,768.70	0	36.45	0
Level 6 Undocumented	0	0	0	0	0	0	0	0	0
Level 7	2,190.13	0	0	0	0	1,342.36	0	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	593.01	0	0	0	0	434.42	64.20	36.90	0
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$2,486,541.31**	**$23,973.10**	**$39,568.98**	**$200,345.56**	**$108,418.08**	**$216,079.24**	**$823,266.14**	**$204,797.37**	**$274,856.91**

Source: Summary of FY11 ALL KIDS data provided by HFS.

Appendix F

FY11 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Outpatient Services (General)	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
Assist Undocumented	$3,864,989.63	$7,789,737.24	$55,886.92	$7,270,930.44	$93,036.57	$14.85	$254,927.00	$75,750.00	$10,175.62
Share Undocumented	108,668.12	233,785.67	2,610.32	226,340.94	4,118.10	0	14,076.00	0	99.20
Level 1 Undocumented	94,354.27	259,687.95	2,670.00	241,474.56	3,952.60	0	15,096.00	1,212.00	248.00
Level 2	1,584,628.54	8,147,864.77	125,210.08	3,339,579.47	23,725.08	12.60	145,541.80	30,025.00	1,750.52
Level 2 Undocumented	14,614.50	59,859.93	1,479.10	60,150.34	792.40	0	888.00	303.00	0
Level 3	382,069.79	1,709,668.09	37,578.16	769,321.79	5,208.97	0	23,351.00	10,411.00	446.12
Level 3 Undocumented	1,628.00	50,799.48	0	11,858.53	227.30	0	136.00	0	0
Level 4	51,814.77	1,821,139.41	8,480.78	111,961.20	355.28	0	7,582.00	2,929.00	29.80
Level 4 Undocumented	474.00	858.38	0	1,518.06	4.25	0	0	0	0
Level 5	30,736.97	209,163.93	5,734.48	32,026.82	0	0	1,978.00	0	0
Level 5 Undocumented	20,293.71	9,795.82	0	1,163.07	0	0	0	0	0
Level 6	6,677.45	491,354.05	2,730.15	7,031.91	0	0	0	0	0
Level 6 Undocumented	0	0	0	61.60	0	0	0	0	0
Level 7	913.00	1,527.70	2,547.36	3,337.79	0	0	0	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	1,118.00	8,505.42	538.08	1,791.29	0	0	0	0	0
Level 8 Undocumented	0	0	0	2.00	0	0	0	0	0
Totals by Category	**$6,162,980.75**	**$20,793,747.84**	**$245,465.43**	**$12,078,549.81**	**$131,420.55**	**$27.45**	**$463,575.80**	**$120,630.00**	**$12,749.26**

Source: Summary of FY11 ALL KIDS data provided by HFS.

Appendix F

FY11 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Service Car	Social Work Service	SOPF—MI Recipient Under 22 Years of Age	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	$124,706.86	15,862.64	$0	$42,473.83	$21,378.87	$126,789.01	$4,948.30	$105.28	**$55,291,285.29**
Share Undocumented	1,781.88	60.51	0	26.70	1,187.28	2,613.04	127.38	0	**1,514,515.23**
Level 1 Undocumented	0	49.03	0	1,361.70	217.25	2,161.12	0	0	**1,465,794.93**
Level 2	0	4,864.86	0	234,666.99	149,463.42	83,296.74	0	0	**26,632,164.52**
Level 2 Undocumented	0	0	0	787.65	715.68	237.73	0	0	**328,189.28**
Level 3	0	496.64	0	78,051.28	41,496.28	14,869.45	0	0	**6,343,863.46**
Level 3 Undocumented	0	0	0	0	0	71.92	0	0	**110,716.58**
Level 4	0	0	24,128.00	18,982.15	8,370.46	3,635.34	0	0	**2,722,244.25**
Level 4 Undocumented	0	0	0	854.40	0	49.95	0	0	**12,001.29**
Level 5	0	0	0	5,805.97	3,723.62	1,904.01	0	0	**1,088,856.31**
Level 5 Undocumented	0	0	0	1,121.40	0	0	0	0	**41,848.13**
Level 6	0	0	0	4,253.39	2,855.20	49.95	0	0	**776,095.25**
Level 6 Undocumented	0	0	0	0	0	0	0	0	**1,439.39**
Level 7	0	0	0	1,418.62	716.19	66.60	0	0	**63,510.11**
Level 7 Undocumented	0	0	0	0	0	0	0	0	**0**
Level 8	0	0	0	323.54	229.53	366.30	0	0	**163,542.99**
Level 8 Undocumented	0	0	0	0	0	0	0	0	**2.00**
Totals by Category	**$126,488.74**	**21,333.68**	**$24,128.00**	**$390,127.62**	**$230,353.78**	**$236,111.16**	**$5,075.68**	**$105.28**	**$96,556,069.01**

Source: Summary of FY11 ALL KIDS data provided by HFS.

APPENDIX G

Providers that Received more than $50,000 from the ALL KIDS Expansion During FY11

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: FY11 paid claim data provided by HFS.

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
CHILDRENS MEMORIAL HOSPITAL	CHICAGO	IL	$3,879,926.87
ACCREDO HEALTH GROUP	WARRENDALE	PA	$1,796,259.02
COMER CHILDRENS HOSPITAL	DARIEN	IL	$1,156,833.35
CHILDRENS HOSP OF WISCONSIN	MILWAUKEE	WI	$1,115,731.55
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	$995,686.56
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	$894,499.54
RUSH CHILDRENS SERVICES	CHICAGO	IL	$818,892.65
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	$748,781.21
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	$722,709.83
HARTGROVE HOSPITAL	CHICAGO	IL	$652,331.80
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	$561,152.04
CAREMARK INC	MT PROSPECT	IL	$530,550.83
LUTHERAN GENERAL CHILDRENS HOS	PARK RIDGE	IL	$527,407.04
CARLE HOME INFUSION	CHAMPAIGN	IL	$504,519.89
FANTUS HEALTH CENTER	CHICAGO	IL	$478,207.96
BOND DRUG COMPANY OF ILLINOIS	CHICAGO	IL	$468,767.76
ST MARY OF NAZARETH HOSPITAL	CHICAGO	IL	$448,841.38
BLOODCENTER OF WISCONSIN INC	MILWAUKEE	WI	$439,255.68
ST ALEXIUS MEDICAL CENTER	HOFFMAN ESTATES	IL	$416,972.69
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	$416,463.67
RIVEREDGE HOSPITAL	FOREST PARK	IL	$405,305.61
VISITING NURSE ASSN FOX VALLEY	AURORA	IL	$391,093.55
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	$385,816.39
BIOPARTNERS IN CARE	LENEXA	KS	$384,566.42
ST ANTHONY HOSPITAL	CHICAGO	IL	$365,560.80
GREATER ELGIN FAMILY CARE CTR	ELGIN	IL	$363,958.95
HOPE CHILDRENS HOSPITAL	OAK LAWN	IL	$362,816.82
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	$362,574.71
SERVICIOS MEDICOS LA VILLITA	CHICAGO	IL	$358,223.26
LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	$334,465.31
AMERICAN HOMECARE FEDERATION	ENFIELD	CT	$330,565.62
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	$329,985.23
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	IL	$325,226.70
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HGTS	IL	$293,413.49
MAXIM HEALTHCARE SERVICES INC	OAK PARK	IL	$288,245.75
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	$273,891.07

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
MT SINAI HOSP MED CTR CHICAGO	CHICAGO	IL	$271,259.19
ALIVIO MEDICAL CENTER	CHICAGO	IL	$271,015.83
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	$267,144.10
AQEL FADI	CHICAGO	IL	$267,009.04
COMPREHENSIVE BLEEDING	PEORIA	IL	$259,211.42
MARYVILLE SCOTT NOLAN CENTER	DES PLAINES	IL	$257,821.34
LAKE VILLA GATEWAY FOUNDATION	LAKE VILLA	IL	$254,864.44
CARDINAL GLENNON CHILDRENS HSP	SAINT LOUIS	MO	$246,734.83
ADVOCATE NORTHSIDE	CHICAGO	IL	$246,132.07
PRIVATE HOME CARE UNLIMITED	CHICAGO	IL	$242,557.00
OPTION CARE ENTERPRISES INC	WOOD DALE	IL	$241,344.30
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	$240,364.89
CHILDRENS HOS MED CTR CH	CINCINNATI	OH	$234,674.02
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	$230,297.05
THE GENESIS CENTER	DES PLAINES	IL	$224,779.32
PERFECT MANAGED CARE	CHICAGO	IL	$221,308.91
AMBER PHARMACY	CHICAGO	IL	$214,054.07
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	$204,700.64
COMM COUNSEL CTRS C4 NORTH	CHICAGO	IL	$204,068.53
IPA OF KANE COUNTY	MOKENA	IL	$201,808.77
RANKEN JORDAN A PED REHAB CTR	MARYLAND HTS	MO	$194,819.30
COPLEY MEMORIAL HOSPITAL	AURORA	IL	$194,501.96
AUNT MARTHAS YOUTH SERVICE CTR	HANOVER PARK	IL	$193,880.32
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	$192,966.34
MACNEAL HOSPITAL	BERWYN	IL	$190,188.92
UPTOWN INTERNATIONAL CENTER	CHICAGO	IL	$188,543.52
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	$186,069.18
C AND M PHARMACY LLC	GLENVIEW	IL	$185,880.83
ALEXIAN BROTHERS MED CTR	ELK GROVE VLGE	IL	$179,715.60
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	$179,338.65
LA RABIDA CHILDRENS HOSP	CHICAGO	IL	$179,171.22
CENTRO DE SALUD ESPERANZA	CHICAGO	IL	$177,487.67
AURORA CHICAGO LAKESHORE HOSP	CHICAGO	IL	$176,072.52
REHABTECH INC	LOMBARD	IL	$175,027.04
REHABILITATION INSTITUTE	CHICAGO	IL	$174,611.75
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	IL	$173,167.12

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
SHERMAN HOSPITAL	ELGIN	IL	$172,496.19
ADVANTAGE NURSING SVCS INC	OAK FOREST	IL	$170,558.00
ACCESS ARLINGTON HGHTS FAMILY	ARLINGTON HTS	IL	$169,709.51
NASREEN TAIBA	ADDISON	IL	$169,489.10
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	$166,397.61
OSTOMY CENTER	CHICAGO	IL	$163,655.49
PROVENA MERCY CENTER	AURORA	IL	$163,379.02
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	$159,935.36
THE KENNETH W YOUNG CENTERS	ELK GROVE VLGE	IL	$157,706.63
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	$153,751.66
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	$151,952.57
CRUSADER CLINIC BROADWAY	ROCKFORD	IL	$147,368.42
ROSECRANCE CENTER	ROCKFORD	IL	$146,158.05
BIOSCRIP PHARMACY SERVICES	COLUMBUS	OH	$145,003.10
PCC COMM WELLNESS CENTER	OAK PARK	IL	$141,403.02
HINSDALE HOSPITAL	HINSDALE	IL	$139,712.68
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	$137,993.60
AUNT MARTHAS HEALTH CENTER	AURORA	IL	$133,346.49
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	$130,340.44
MEDSTAR LABORATORY INC	HILLSIDE	IL	$129,228.48
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	$129,167.31
FAMILY HEALTH SOCIETY	CHICAGO HEIGHTS	IL	$128,303.10
ADVENTIST BOLINGBROOK HOSPITAL	BOLINGBROOK	IL	$128,145.12
NORWEGIAN AMERICAN HOSP GROUP	CHICAGO	IL	$127,740.51
EVANSTON HOSPITAL	EVANSTON	IL	$127,514.24
CENTURY PHO INC	CHICAGO	IL	$126,223.42
SOUTH LAWNDALE MCH CENTER	CHICAGO	IL	$125,877.16
VISTA MEDICAL CENTER WEST	WAUKEGAN	IL	$125,392.22
CHESTNUT HEALTH SYSTEMS WOMEN	BLOOMINGTON	IL	$124,877.97
HAWTHORNE FAMILY HEALTH CENTER	CHICAGO	IL	$124,079.77
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	IL	$121,530.07
WEST CHICAGO FAMILY HEALTH CTR	WEST CHICAGO	IL	$117,994.02
WALGREEN CO 0089	BRIDGEVIEW	IL	$117,899.37
HAWTHORNE FAMILY HEALTH CENTER	CICERO	IL	$117,636.92
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	$115,982.79
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	$113,840.56

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
FORTY SEVENTH STREET PHARMACY	CHICAGO	IL	$112,381.05
PARUCHURI AJITHA	WEST CHICAGO	IL	$109,586.92
BOND DRUG COMPANY OF IL 04940	ROUND LAKE BCH	IL	$109,545.73
NORWEGIAN AMERICAN HOSP	CHICAGO	IL	$109,534.43
PLAZA MEDICAL CENTER	CHICAGO	IL	$109,335.16
LIPPITZ STEFEN	BUFFALO GROVE	IL	$109,267.75
ACCESS ELK GROVE VLG FMLY HLT	ELK GROVE VLG	IL	$107,925.11
PROVENA ST JOSEPH HOSP	ELGIN	IL	$107,754.59
DSCC	SPRINGFIELD	IL	$106,630.00
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	$106,100.52
VISTA CLINIC OF COOK COUNTY	PALATINE	IL	$105,802.58
BOND DRUG COMPANY OF IL 4069	WEST CHICAGO	IL	$104,878.58
TSALIAGOS CHRISTOS	CHICAGO	IL	$104,636.93
PROVENA ST JOSEPH MED CNT	JOLIET	IL	$104,460.65
ERIE HELPING HANDS HEALTH CTR	CHICAGO	IL	$104,407.35
NDO	CHICAGO	IL	$104,278.89
BOND DRUG COMPANY OF IL 05103	CICERO	IL	$103,788.70
MIDWEST HEALTHCARE ASSOCIATES	AURORA	IL	$102,949.00
MIDLAKES CLINIC	ROUND LK BEACH	IL	$102,745.89
BOND DRUG COMPANY OF IL 03729	HANOVER PARK	IL	$102,234.65
SIDDIQUI ZAKI	CHICAGO	IL	$101,559.40
APOGEE HEALTH PARTNERS INC	CHICAGO	IL	$100,493.37
CLARK DAVID	CHICAGO	IL	$100,287.69
LEYDEN FAMILY SERVICE AND MHC	FRANKLIN PARK	IL	$99,652.34
LABORATORY CORPORATION AMERICA	DUBLIN	OH	$99,358.95
ERIE DENTAL HEALTH CENTER	CHICAGO	IL	$99,093.66
MERCY HOSPITAL MEDICAL CENTER	CHICAGO	IL	$97,362.93
SAN RAFAEL	CHICAGO	IL	$96,461.38
NAPERVILLE PSYCH VENTURES	NAPERVILLE	IL	$96,329.08
SHIELD DENVER HLT CARE CTR INC	ELMHURST	IL	$94,491.90
DUPAGE MENTAL HEALTH WEST PHC	WHEATON	IL	$94,039.13
GREATER CHICAGO MEDICAL ASSOC	CHICAGO	IL	$93,029.78
EDWARD HOSPITAL	NAPERVILLE	IL	$92,864.07
LAMBERGHINI FLAVIA	CHICAGO	IL	$92,334.87
MS LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	$92,264.67
INGALLS HOME CARE	HARVEY	IL	$91,464.10

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
WALGREENS SPECIALTY INFUSION	LOMBARD	IL	$90,984.95
CARLE FOUNDATION HOSPITAL	URBANA	IL	$90,763.04
NORTHWESTERN MEMORIAL HOSP	CHICAGO	IL	$90,692.73
SAINTS MARY AND ELIZABETH HP	CHICAGO	IL	$90,198.90
ADA S MCKINLEY COMMUNITY SVCS	CHICAGO	IL	$90,150.38
SCHWAB REHAB HOSP	CHICAGO	IL	$89,882.04
SHALTOONI ABDELKARIM	HOFFMAN ESTATES	IL	$89,848.23
ST FRANCIS HOSPITAL	EVANSTON	IL	$89,811.92
LAKE CO MNTL HLTH WAUKEGAN	WAUKEGAN	IL	$89,491.73
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	IL	$89,365.03
VHS WESTLAKE HOSPITAL INC	MELROSE PARK	IL	$88,338.06
LSSI MENTAL HEALTH SERVICE	CHICAGO	IL	$87,267.79
WALGREEN CO 12125	AURORA	IL	$85,539.64
ALDEN VILLAGE HEALTH FACILITY	BLOOMINGDALE	IL	$85,447.08
ALDALLAL NADA	CHICAGO	IL	$84,872.77
SILVER CROSS HOSPITAL	JOLIET	IL	$84,654.32
CICERO HEALTH CENTER	CICERO	IL	$84,463.97
WILL COUNTY HEALTH DEPT	JOLIET	IL	$84,412.92
BOND DRUG COMPANY OF IL 03078	WAUKEGAN	IL	$83,975.87
CENTRO MEDICO	CHICAGO	IL	$83,497.15
PHARMACY SOLUTIONS	ABBOTT PARK	IL	$83,067.79
WALGREEN CO 7100	ELGIN	IL	$82,596.00
CAREPLUS CVS PHARMACY 02831	CHICAGO	IL	$82,279.82
INDEPENDENCE PLUS INC	OAK BROOK	IL	$81,218.00
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	$80,701.51
PRIMECARE FULLERTON	CHICAGO	IL	$80,352.87
CHESTNUT HEALTH SYSTEMS INC	MARYVILLE	IL	$80,304.63
EDWARDS TWANA	CHICAGO	IL	$80,189.00
EKTERA ALI	CHICAGO	IL	$80,097.58
WALGREEN CO STORE 215	CHICAGO	IL	$79,884.22
RESURRECTION MEDICAL CENTER	CHICAGO	IL	$79,291.57
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	IL	$78,175.08
WALGREEN CO	CICERO	IL	$77,742.82
OUR LADY RES MED CTR	CHICAGO	IL	$77,700.15
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	$77,443.06
TRC CHILDRENS DIALYSIS CENTER	CHICAGO	IL	$77,437.19

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	IL	$77,088.15
MELROSE PARK FAMILY HEALTH CTR	MELROSE PARK	IL	$76,684.50
FAMILY MEDICAL NETWORK	CHICAGO	IL	$74,862.78
BOND DRUG COMPANY OF IL 03995	NORTHLAKE	IL	$74,338.44
CORNELL INTERVENTIONS CONTACT	WAUCONDA	IL	$74,220.20
RIVERSIDE MED CTR	KANKAKEE	IL	$73,905.95
ST JAMES HOSP AND HLTH CTRS	OLYMPIA FIELDS	IL	$73,579.06
WALGREENS SPECIALTY 10997	CARNEGIE	PA	$72,994.06
WALGREEN CO	CHICAGO	IL	$72,342.73
PILLARS COMMUNITY SERVICES	WESTERN SPRINGS	IL	$72,323.35
SARAH BUSH LINCOLN H C	MATTOON	IL	$72,294.46
MARIANJOY REHABILITATION HOSP	WHEATON	IL	$72,157.32
MEMORIAL MEDICAL CENTER	WOODSTOCK	IL	$71,880.01
BOND DRUG COMPANY OF ILLINOIS	JOLIET	IL	$71,796.88
WILL CO COMM HEALTH CTR	JOLIET	IL	$71,730.37
CRUSADER CLINIC BELVIDERE	BELVIDERE	IL	$71,661.42
HALSTED AND 79TH ST PHARMACY 1	MELROSE PARK	IL	$70,780.26
CORNELL INTERVENTION WOODRIDGE	WOODRIDGE	IL	$70,515.99
ACCESS ARMY TRAIL RD FMLY HLTH	ADDISON	IL	$69,354.41
LAWNDALE CHRISTIAN HEALTH CTR	CHICAGO	IL	$69,255.32
NRI LABORATORIES INC	CHICAGO	IL	$69,170.14
ACCESS GATEWAY CENTRE FMLY HLT	WEST CHICAGO	IL	$68,934.09
EVANSTON ROGERS PARK FAM HLT	CHICAGO	IL	$68,325.40
ACCESS NORTHWEST FMLY HLTH CTR	ARLINGTON HTS	IL	$67,787.35
ACCURATE HOME CARE	MOLINE	IL	$67,259.91
NGUYEN KHANH	CHICAGO	IL	$67,053.81
ANUMULA SAILA	JOLIET	IL	$66,815.51
CHANG RANDOLPH	CHICAGO	IL	$66,535.42
EDGEWATER UPTOWN COMM MHC	CHICAGO	IL	$65,784.13
KIM PU	CHICAGO	IL	$65,361.17
LOWER WEST SIDE HEALTH CENTER	CHICAGO	IL	$64,545.47
MINIMED DISTRIBUTION CORP	NORTHRIDGE	CA	$64,368.28
UNIFIED PHYSICIANS NETWORK	SKOKIE	IL	$64,255.69
ACCESS MOUNT PROSPECT FMLY HLT	MOUNT PROSPECT	IL	$64,145.20
BOND DRUG COMPANY OF IL 4233	CHICAGO	IL	$63,976.18
MARTINEZ CHARLES	MT PROSPECT	IL	$63,863.98

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
FAMILY SVC CMHC OF MCHENRY CTY	MCHENRY	IL	$62,635.95
WALGREEN CO	NORRIDGE	IL	$62,509.66
A MED HEALTH CARE	HUNTINGTN BCH	CA	$62,484.32
QUEST DIAGNOSTICS LLC IL	SCHAUMBURG	IL	$62,320.80
PILSEN FAMILY HEALTH CENTER	CHICAGO	IL	$62,221.29
SMITH FREDERICK	CHICAGO	IL	$62,081.53
FOSTER G MCGAW HOSPITAL	MAYWOOD	IL	$61,432.33
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	IL	$61,421.87
CHHIKARA SONIA	WAUKEGAN	IL	$61,369.10
AUNT MARTHAS YOUTH SERVICE CTR	CHICAGO HEIGHTS	IL	$61,318.26
METHODIST MEDICAL CNTR	PEORIA	IL	$60,911.76
CRUSADER CLINIC	ROCKFORD	IL	$60,847.72
FAMILY SERVICE ASSOCIATION	ELGIN	IL	$60,535.13
GOTTLIEB MEMORIAL HOSPITAL	MELROSE PARK	IL	$60,001.43
CONTINUUM PEDIATRIC NURSING	SCHAUMBURG	IL	$59,818.00
PARK JAMIE	NILES	IL	$59,566.21
JANET WATTLES CENTER	ROCKFORD	IL	$59,526.21
FAMILY CHRISTIAN HEALTH CENTER	HARVEY	IL	$58,902.65
PATEL RINA	ARLINGTON HTS	IL	$58,642.49
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	$58,557.24
CORNELL INTERVENTIONS DUPAGE	HINSDALE	IL	$58,444.67
TROPICAL OPTICAL	CHICAGO	IL	$58,320.00
GLENOAKS HOSPITAL	GLENDALE HGTS	IL	$57,563.21
BOND DRUG COMPANY OF IL 3940	PALATINE	IL	$57,518.00
UIC MILE SQUARE HEALTH CENTER	CHICAGO	IL	$56,610.99
KIM KYUNG	CHICAGO	IL	$56,570.73
KRASYUK ZHANA	BUFFALO GROVE	IL	$56,283.18
METRO REHAB SERVICE INC	ALSIP	IL	$56,163.58
PINTO JUAN	JOLIET	IL	$56,045.72
PHARMACY ONE PLUS	CHICAGO	IL	$56,008.20
CVS PHARMACY 5829	ELGIN	IL	$55,973.65
SKYWALK PHARMACY	WAUWATOSA	WI	$55,869.73
PILLARS COMMUNITY SERVICES	OAK PARK	IL	$55,312.03
ANCHOR HOME HEALTH CARE	GLEN CARBON	IL	$55,180.53
ANIOL HALINA	CHICAGO	IL	$54,986.10
BLUE ISLAND MEDICAL CENTER	BLUE ISLAND	IL	$54,347.69

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2011

Provider Name	City	State	Total Amount Paid
ACCESS AT ST FRANCIS HLTH CTR	CHICAGO	IL	$54,344.99
PEDIATRIC SERVICES OF AMERICA	TINLEY PARK	IL	$54,198.00
VISITING NURSE ASSN FOX VALLEY	ELGIN	IL	$53,893.12
WHITESMAN LOUIS	CHICAGO	IL	$53,850.20
SALUD FAMILY HEALTH CENTER	CHICAGO	IL	$53,713.87
WALGREEN CO 11154	BERWYN	IL	$53,693.52
WALGREEN CO STORE 4941	WHEELING	IL	$53,670.66
CHICAGO FAM HLTH CTR S CHICAGO	CHICAGO	IL	$53,278.80
BRUNELLE JORGE	AURORA	IL	$53,265.32
PILLARS COMMUNITY SERVICES	BERWYN	IL	$53,021.85
A PLUS HOME HEALTHCARE SERVICE	MOLINE	IL	$53,002.30
NATIONAL SEATING AND MOBILITY	LOMBARD	IL	$52,698.50
SPENCER DENA	WEST CHICAGO	IL	$52,536.24
GOOD SAMARITAN HOSPITAL	DOWNERS GROVE	IL	$52,477.27
CENTER FOR CHILDRENS SERVICES	DANVILLE	IL	$52,368.03
WEST TOWN NEIGHBORHOOD H CTR	CHICAGO	IL	$52,196.41
SAINT JOSEPH HOSPITAL	CHICAGO	IL	$52,171.51
DEWAARD DAVID D	CHICAGO	IL	$52,167.32
BOND DRUG COMPANY OF IL 4502	CARPENTERSVILLE	IL	$52,010.07
NORTHERN ILLINOIS MEDICAL CTR	MCHENRY	IL	$51,923.95
PANOS ERNEST	CHICAGO	IL	$51,524.60
PRIMECARE NORTHWEST	CHICAGO	IL	$51,347.17
ASWAD GHASSAN	CHICAGO	IL	$50,615.16
VHS GENESIS LABORATORY	BERWYN	IL	$50,537.93
ASIAN HUMAN SERVICES FAMILY	CHICAGO	IL	$50,513.19
COUNSELING CENTER LAKE VIEW	CHICAGO	IL	$50,308.07
OAK WEST PRIMARY PHYS ASSOC	MELROSE PARK	IL	$50,197.14
ABTAHI MOHAMMAD	DES PLAINES	IL	$50,115.87
IBT TRANSPORTATION	CHICAGO	IL	$50,035.57

Source: FY11 paid claim data provided by HFS.

APPENDIX H
FY10 Recommendations and Responses

Appendix H

FY10 Recommendations and Responses

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 **(April 2011)**	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.

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 **(April 2011)**	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 (April 2011)	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.

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 (April 2011)	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 (April 2011)	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 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 (April 2011)	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 (April 2011)	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.

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 (April 2011)	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.

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 (April 2011)	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	
RECOMMENDATION NUMBER **7**	***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 (April 2011)	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.

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 (April 2011)	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.

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 (April 2011)	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.

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **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 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 (April 2011)	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 (April 2011)	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.

TRANSPORTATION CLAIMS	
RECOMMENDATION NUMBER **11**	***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 (April 2011)	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.

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 (April 2011)	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 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 (April 2011)	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.

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 (April 2011)	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.

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

September 6, 2012

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) 558-2495 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 3: Redetermination of Eligibility
The Department of Healthcare and Family Services and the Department of Human Services should:

- 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 and is moving from a passive renewal process to an annual active electronic review of eligibility.

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 and has revised policy to require use of stepparent income when determining eligibility for this population.

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)(4).

Response:
The Department accepts the recommendation and has revised the rules. A request to program a new report has been submitted to DHS that will improve the Department's ability to identify and correct the cases coded incorrectly at approval.

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 programming error that allowed one day of eligibility the month following a child's 19th birthday has been corrected. A process to identify individuals assigned more than one identification number is in development.

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. New coding to more accurately record immigration status has been implemented. Staff are in the process of manually reviewing individuals who appear to have been identified as undocumented in error.

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. The Bureau of Claims Processing has been working to implement a data warehouse query to identify duplicate claims.

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. Policy has been established requiring a Social Security Administration (SSA) citizenship and identity inquiry at application and at renewal if citizenship and identity have not been verified. The policy includes instructions on requesting other acceptable documentation if the SSA inquiry does not verify citizenship and identity. Electronic reviews of other eligibility factors are in process.

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 was prepared to program a system edit that will only allow one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail. A notice was sent to transportation providers on May 9, 2011 reminding them to submit accurate claim details or they may be subject to recoupment. Additionally, the Department's OIG continues to identify aberrant billing patterns for transportation providers and audit questionable transportation services. These audits result 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. For children through age 20, eyeglasses are replaced as needed through the DOC laboratory, with no prior approval required. The SMART Act limits adults to one pair of glasses every two years. OIG is in the process of developing predictive modeling routines related to optical care. Upon the discovery or referral of optometric cases, the OIG is prepared to initiate audits and investigations to attempt to recoup inappropriately spent funds. OIG has specifically run data mining routines to determine the top 7 children with multiple eyeglass expenditures and they are limited to 3 practitioners tied to one alternate payee. OIG is requesting these charts to determine whether the provision of multiple eyeglasses to these children is medically necessary or evidence of fraud, waste or abuse for this alternate payee.

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 has issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes. The Department is working to institute systematic edits to limit the number of preventive service billings.

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; and
- ensure that dental policies or other information available to the public accurately states frequency of benefits;

Response:
The Department accepts the recommendation. The Bureau of Maternal and Child Health Promotion (BMCHP) will continue to perform routine reconciliations to ensure that dental providers are not paid for services beyond benefit limitations. BMCHP is in the process of revising the Dental Office Reference manual and Administrative Rules to ensure that dental policies or other information available to the public accurately state frequency of benefits.

15 YEARS
PARTNERING WITH COMMUNITIES

Pat Quinn, *Governor*

Illinois Department of Human Services

Michelle R.B. Saddler, *Secretary*

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

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 SFY2011, Office of the Auditor General audit of the All Kids Health Insurance program:

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

- 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: Agree. As a result of the passage of Public Act 96-1501, the Department is moving from a passive renewal process to an annual active electronic review of eligibility. The electronic review of eligibility is being conducted by the Illinois Department of Healthcare and Family Services (HFS).

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: Agree. Policy has been revised as of July 2011 to require the income of any stepparent in the home to be included in the calculation of eligibility for undocumented noncitizen children.

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: Agree. As a result of the passage of Public Act 96-1501, effective July 1, 2011, verification of Illinois residency is now 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.

If you have any questions, please feel free to contact Albert Okwuegbunam, Bureau Chief, Audit Liaisons at 217/785-7797.

Sincerely,

Michelle R.B. Saddler
Secretary

cc: Linda Saterfield, Director, Family and Community Services
Carol Kraus, Chief Financial Officer
Michael Layden, Director, Office of Fiscal Services
Jennifer Wagner, Associate Director, Family and Community Services
Sharon Dyer-Nelson, Manger, Family and Community Services
Albert Okwuegbunam, Bureau Chief, Audit Liaisons