STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AND MANGEMENT AUDIT OF

THE ILLINOIS DEPARTMENT OF PUBLIC AID'S KIDCARE PROGRAM

JULY 2002

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

This is our report of the Program and Management Audit of the Illinois Department of Public Aid's KidCare Program.

The audit was conducted pursuant to Senate Resolution 152, which was adopted May 24, 2001. 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
July 2002

REPORT DIGEST

PROGRAM AND MANAGEMENT AUDIT OF

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State of Illinois
Office of the Auditor General

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SYNOPSIS

The federal Balanced Budget Act of 1997 amended the Social Security Act to establish Title XXI – the State Children's Health Insurance Program (SCHIP). In response to the establishment of SCHIP at the federal level, Illinois Public Act 90-736 was signed into law on August 12, 1998 establishing the Children's Health Insurance Program Act (215 ILCS 106/1 *et seq.*) which is referred to as KidCare.

The Department of Public Aid has spent $162 million for KidCare medical expenditures since the program was created in January 1998 through Fiscal Year 2001. An additional $36.8 million has been spent on administrative expenditures of KidCare.

We identified 16 exceptions in the 92 KidCare case files that we reviewed, such as untimely redetermination of eligibility. We also identified enrollees in the Moms & Babies category who were neither mothers nor babies and enrollees who were adults in a category that should have included only children. Although some of these problems were minor, the Departments of Public Aid and Human Services should assure that KidCare income is properly determined and that redeterminations are done when required.

Although Public Aid had no formally written or approved plan for marketing KidCare, over time a three-stage strategy developed: Overarching Outreach on a Statewide Basis; Promotions at the Community Level; and KidCare Application Agents. Public Aid had 76 contracts and paid $9.5 million on outreach and advertising efforts for the KidCare program. They also paid $2.9 million to KidCare Application Agents who are paid $50 for each complete approved application.

Public Aid included measurable deliverables in most of the KidCare contracts and had established a good system for monitoring KidCare marketing and outreach contracts, however, some improvement was still needed. Seventy-one of 76 contracts included measurable deliverables and 63 of the 70 contract files we reviewed were well monitored.

As directed by Senate Resolution 152, we prepared demographic profiles of KidCare enrollees and compared the overall health of KidCare enrolled children with other children. We identified some characteristics of KidCare enrollees and reported statistics from Public Aid and other sources on children's health measures.

REPORT CONCLUSIONS

The federal Balanced Budget Act of 1997 amended the Social Security Act to establish Title XXI – the State Children's Health Insurance Program (SCHIP). In response to the establishment of SCHIP at the federal level, Illinois Public Act 90-736 was signed into law on August 12, 1998 establishing the Children's Health Insurance Program Act (215 ILCS 106/1 *et seq.*) which is referred to as KidCare.

Public Aid implemented KidCare in two phases. Phase I was approved effective January 1998 and was a Medicaid expansion for children under 19 years of age (Assist Expansion) and an expansion for pregnant women and their babies (Moms & Babies). Phase II was approved effective August 1998 and expanded eligibility further and established two new federal share categories (Share and Premium) and established a State-only program (Rebate).

Public Aid includes children in their KidCare enrollment figures who are enrolled in the regular Medicaid program. These children were eligible under the Medicaid income guidelines in place prior to implementation of SCHIP. Public Aid counts Medicaid children as KidCare because they were enrolled through outreach initiatives and were enrolled through the KidCare Central Bureau. In this report we refer to these Medicaid enrollees who came in through KidCare as Initiative. Fifty-six percent of KidCare enrollees reported as of December 1, 2001 were Initiative enrollees in the regular Medicaid program (97,036 of 174,778).

Public Aid has spent $162 million for KidCare medical expenditures since the program was created in January 1998 through Fiscal Year 2001. An additional $36.8 million has been spent on administrative expenditures of KidCare. Consistent with our discussion of enrollment, these expenditures do not include expenditures for children enrolled in Medicaid through KidCare outreach initiatives. Public Aid's medical expenditures for Initiative enrollees were $182 million for Fiscal Years 1999 through 2001.

To fund SCHIP, an annual federal allotment was made available to states each year from 1998 through 2007. For Fiscal Year 2002 expenditures Illinois, as well as many other states, was still drawing against its 1999 allotment and had not used any of the 2000 or 2001 allotments.

We found some problems in KidCare case files that we reviewed. Depending on the KidCare category, some case files are maintained by Public Aid and some are maintained by the Department of Human Services. There were eight total exceptions related to determining income for KidCare (8 of 92 cases tested), none of which affected eligibility. We also identified eight exceptions related to redetermination (8 of 61) including six which were not done on time and two cases where income was not determined properly. Although some of these problems were minor, Public Aid and Human Services should assure that KidCare income is properly determined and that redeterminations are done when required.

We identified enrollees in the Moms & Babies category who were neither mothers nor babies. The Moms & Babies category is intended to cover pregnant women and babies for the first year of their lives. Because this category is not eligible for enhanced federal match, it is to the State's advantage to have children moved into the appropriate children's category of KidCare as soon as possible.

Applicants failing to provide appropriate verifications with their applications (such as documentation of income) was the second most common reason that KidCare cases were denied. For the 20 month period from July 2000 to February 2002, 34 percent of denials were because applicants failed to provide verifications with their application or in follow-up requests.

Public Aid received federal approval in May 2000 to move from monthly paper eligibility cards to an electronically based system using permanent durable cards, but has not yet implemented a system. Enrollees in the KidCare program receive a new paper eligibility card in the mail each month. The State of Illinois currently mails out around 900,000 KidCare and other medical program cards each month, or about ten million cards each year. Public Aid estimated that the cards cost approximately 38 cents each to produce and mail or about $4 million annually. Public Aid should continue its planned conversion to permanent durable eligibility cards in order to realize cost savings to the State and improved program effectiveness.

Although Public Aid had no formally written or approved plan for marketing KidCare, over time a three-stage strategy developed: Overarching Outreach on a Statewide Basis; Promotions at the Community Level; and KidCare Application Agents. Public Aid had 76 contracts and paid $9.5 million on outreach and advertising efforts for the KidCare program. They also paid $2.9 million to KidCare Application Agents (KCAAs) who are paid $50 for each complete approved application.

Public Aid had structured measurable deliverables into most of the KidCare contracts (71 of 76) but still had some contracts with weaknesses. Without measurable deliverables it is more difficult to monitor vendors and more difficult to determine if contracts were effective.

Public Aid had established a good system for monitoring KidCare marketing and outreach contracts but some improvement was still needed. Most contract monitoring documentation that we reviewed showed that contracts had been well monitored by Public Aid (63 of 70).

Only 45 of the 76 contracts for KidCare outreach services were procured through a competitive bid. However, the Children's Health Insurance Program Act exempted contracts for KidCare from normal competitive processes established under the Illinois Procurement Code.

As directed by Senate Resolution 152, we prepared demographic profiles of KidCare enrollees. The largest racial categories in KidCare were Caucasian (45%), Hispanic (27%) and African-American (23%). The proportion of Caucasians generally increased as the income thresholds for various KidCare categories increased while the proportion of African-Americans declined. Fifty percent of KidCare enrollees were from two-parent households and the proportion of two-parent households increased with the increasing income thresholds of KidCare categories.

Although it is difficult to compare the overall health of KidCare enrolled children with other children, there are some health measures that can be used to make an attempt. Public Aid identified and reported KidCare data on three conditions that are good measures of children's health status.

BACKGROUND

On May 24, 2001, the Illinois Senate adopted Senate Resolution 152. The Resolution requires the Auditor General to conduct a program and management audit of the Illinois Department of Public Aid's KidCare program. The Resolution asked us to evaluate:

1. The Department of Public Aid's compliance with federal and State laws, the State of Illinois' Children's Health Insurance Plan submitted to the Health Care Finance Administration, and rules, regulations and policies adopted by the Department of Public Aid;

2. The Department of Public Aid's adherence to eligibility requirements, including evaluating the eligibility of enrolled children, whether or not the Department enrolls children for benefits prior to verification of eligibility for benefits, the Department's practice of allowing for onetime encounter enrollments, and the Department's adherence to income verification procedures;

3. The effectiveness of the Department's marketing strategies, including the effectiveness of bid and no-bid outreach contracts, broadcast and print advertising and other outreach advertising mechanisms targeted to increase enrollment in the program and the correlation between each strategy and the number of children enrolled that are attributed to that specific contract or strategy;

4. The compliance and effectiveness of all KidCare outreach contracts issued by the Department of Public Aid since the creation of the KidCare program including the amounts of the contracts, the bid status of the contracts, the terms of the contracts, the responsibilities outlined in the contracts, the fulfillment of the contractors' responsibilities, and verification of required contract documentation;

5. The application and enrollment process to ensure that the families of enrolled children have properly completed applications, which include all proof of information and documentation required pursuant to the KidCare application;

6. Summarize and compare the socio-economic profile of applicants and enrolled children and their families based on information required on the application form;

7. Evaluate the efficiency of the process by which monthly paper eligibility cards are issued to enrollees;

8. Evaluate the effectiveness and efficiency of the eligibility redetermination process; and

9. Using recognized public health standards, compare the overall health of enrolled children with the overall health of (i) privately insured children of the same socio-economic status and (ii) uninsured children of the same socio-economic status.

A copy of the Senate Resolution is included as Appendix A of the Program and Management Audit.

THE KIDCARE PROGRAM

KidCare is a State program that offers health care coverage to children and pregnant women.

KidCare is a State program that offers health care coverage to children and pregnant women and helps in paying premiums of employer-sponsored or private insurance plans. KidCare is available to children through age 18 who are Illinois residents, who are U.S. citizens or qualified legal immigrants, and whose family meets the income requirements. Pregnant women who are Illinois residents and meet the income requirements are also eligible.

Income requirements vary by KidCare Plan and are based on family size. Payments made for childcare expenses or child support are subtracted from income. KidCare services are available at no cost or at low cost and how much a family pays depends on whether income qualifies a family for KidCare Assist, KidCare Share, or KidCare Premium.

KidCare covered services for kids include doctor and nursing care, immunizations and preventive care, hospital and clinic care, laboratory tests and x-rays, prescription drugs, medical equipment and supplies, medical transportation, dental care, eye care, psychiatric care, podiatry, chiropractic care, physical therapy, mental health and substance abuse services. Pregnant women receive prenatal care and other medical services.

History of the Program

The federal Balanced Budget Act of 1997 amended the Social Security Act to establish Title XXI – the State Children's Health Insurance Program (SCHIP). The purpose of SCHIP was to provide funds to the states to expand health insurance coverage to uninsured low-income children. Under SCHIP, states were given the option of expanding Medicaid, establishing a separate stand-alone program, or using a combination of the two approaches.

In response to the establishment of SCHIP at the federal level, Illinois Public Act 90-736 was signed into law on August 12, 1998 establishing the Children's Health Insurance Program Act (215 ILCS 106/1 *et seq.*). Public Aid implemented the federal/State Children's Health Insurance Program Act (SCHIP) in two phases. Phase I was a Medicaid expansion which consisted of an expansion for children under 19 years of age and an expansion for pregnant women and their babies. The initial plan, effective January 5, 1998, was approved April 1, 1998, by the federal Health Care Financing Administration or HCFA (now called the Centers for Medicare & Medicaid Services or CMS.) Illinois was one of the first eight states to have an approved plan in place.

The first phase of KidCare was approved by HCFA on April 1, 1998 with an effective date of January 5, 1998.

Phase II, which was effective August 1998, expanded Illinois' SCHIP program for children under 19 years of age with family incomes above 133% of the federal poverty level (FPL) up to 185% FPL. Phase II established, under Title XXI, KidCare Share and KidCare Premium. Although not part of Title XXI, Phase II also established the KidCare Rebate program which is supported by State funds only.

Categories of KidCare

KidCare is made up of five separate categories in which children and pregnant women can be enrolled. The following is a brief description of each of the categories:

Assist – covers children with family incomes at or below 133% of the FPL. Children receive services through the State's regular Medicaid program under Title XIX or through the Medicaid Phase I expansion under Title XXI. The original Medicaid program is referred to as KidCare Assist Base and the Phase I expansion is referred to as KidCare Assist Expansion. Children in Base are actually enrolled in the regular Medicaid program.

Share – is a Title XXI SCHIP program that allows kids in families with higher income levels (>133% - #150% of FPL) to be enrolled but requires them to make a co-payment for some services. The Share co-payment is $2 for medical visits or prescriptions.

Premium – is also a Title XXI SCHIP program that allows kids in families with higher income levels to be enrolled but requires them to pay a small premium and to make a co-payment for some services. The premium per month is $15 for one child up to $30 for 3 or more children with a co-payment of $5 for medical visits or brand-name prescriptions, $3 for generic prescriptions, and $25 for non-emergency use of the emergency room.

Rebate – is a State program that reimburses families for all or part of premiums for insurance coverage that they can obtain through their employer or through private policies. The federal government does not reimburse any of the costs of this program.

Moms & Babies – covers pregnant women and their babies with family incomes at or below 200% of the FPL. The mother receives coverage during the pregnancy and for 60 days after birth and the baby receives coverage for a year after birth. Moms & Babies is a federal Title XIX expansion, not a new Title XXI SCHIP program. The Moms & Babies category is similar to Assist in that enrollees below 133% of FPL are actually enrolled in the regular Medicaid program. (pages 4-7)

KIDCARE ENROLLMENT

Public Aid includes children in its KidCare enrollment figures that are within Medicaid income guidelines but not within the income guidelines of the new Children's Health Insurance Program. Fifty-six percent of enrollees as of

December 1, 2001 were actually enrolled in the regular Medicaid program (97,036 of 174,778).

These children were eligible under the Medicaid income guidelines in place prior to implementation of SCHIP. Public Aid counts these children as KidCare enrollees because they were enrolled through the KidCare Central Bureau. Although the federal government encouraged outreach initiatives to find both Medicaid and SCHIP children, the federal government does not include these Medicaid children in its numbers when reporting on SCHIP enrollment.

Public Aid includes children in their KidCare enrollment figures that are within Medicaid income guidelines but not within the income guidelines of the new Children's Health Insurance Program.

Digest Exhibit 1
KIDCARE ENROLLMENT
As of December 1, 2001

Assist Expansion	48,510
Moms & Babies	7,171
Share	7,420
Premium	8,887
Rebate	5,754
Total	77,742
Initiative	97,036
Total including Initiative	174,778

Source: Public Aid data summarized by OAG.

Public Aid started including these children who came in through the Central Bureau as KidCare in September 1999. We refer to this sixth category as Initiative. Digest Exhibit 1 shows the total KidCare enrollment broken down by category as of December 1, 2001. The Initiative category has children that are in Medicaid based on the old pre-expansion income standards. (pages 7-8)

ENROLLMENT PROCESS

The following narrative and the flow chart shown in Digest Exhibit 3 help to explain the KidCare enrollment process. Applications are received at the KidCare Central Bureau from KidCare Application Agents (KCAAs) or from families by mail. The application must include documentation on income, citizenship status (if applicable), deductible expenses, proof of pregnancy (if applicable), and social security number or proof of application for a social security number.

Next, applications are registered into the system. To register applications Public Aid employees enter information from the application into the client database and three different data checks for eligibility are done automatically by the computer system. The employees that register cases do not determine eligibility, rather they assess whether the application is complete and all required documentation is submitted.

When all the information has been submitted, applications are assigned to caseworkers. The caseworkers calculate the adjusted income to be compared to the standard and also consider all non-financial factors of eligibility determination. When an application is determined eligible, a notification of enrollment is generated by an automated system and mailed to the applicant. All cases that are part of Expansion (KidCare Assist or Moms & Babies) are sent to local Department of Human Services (DHS) offices for case maintenance.

Enrollment at the Department of Human Services

In addition to the eligibility determination process at Public Aid, DHS caseworkers can determine eligibility. The main difference at DHS is that applicants may come in to the local office and actually work with a caseworker from the beginning. Applicants may walk in or mail an application to any of the 130 local DHS offices. At the local offices caseworkers process applications and determine eligibility. If an application is mailed in to DHS, the process works in a similar way as at Public Aid. Missing information will be requested from the applicant and if information is not provided the application is denied and a notice is mailed out. (pages 15-17)

KIDCARE SPENDING

Public Aid has spent $162 million for KidCare medical expenditures since the program was created in January 1998.

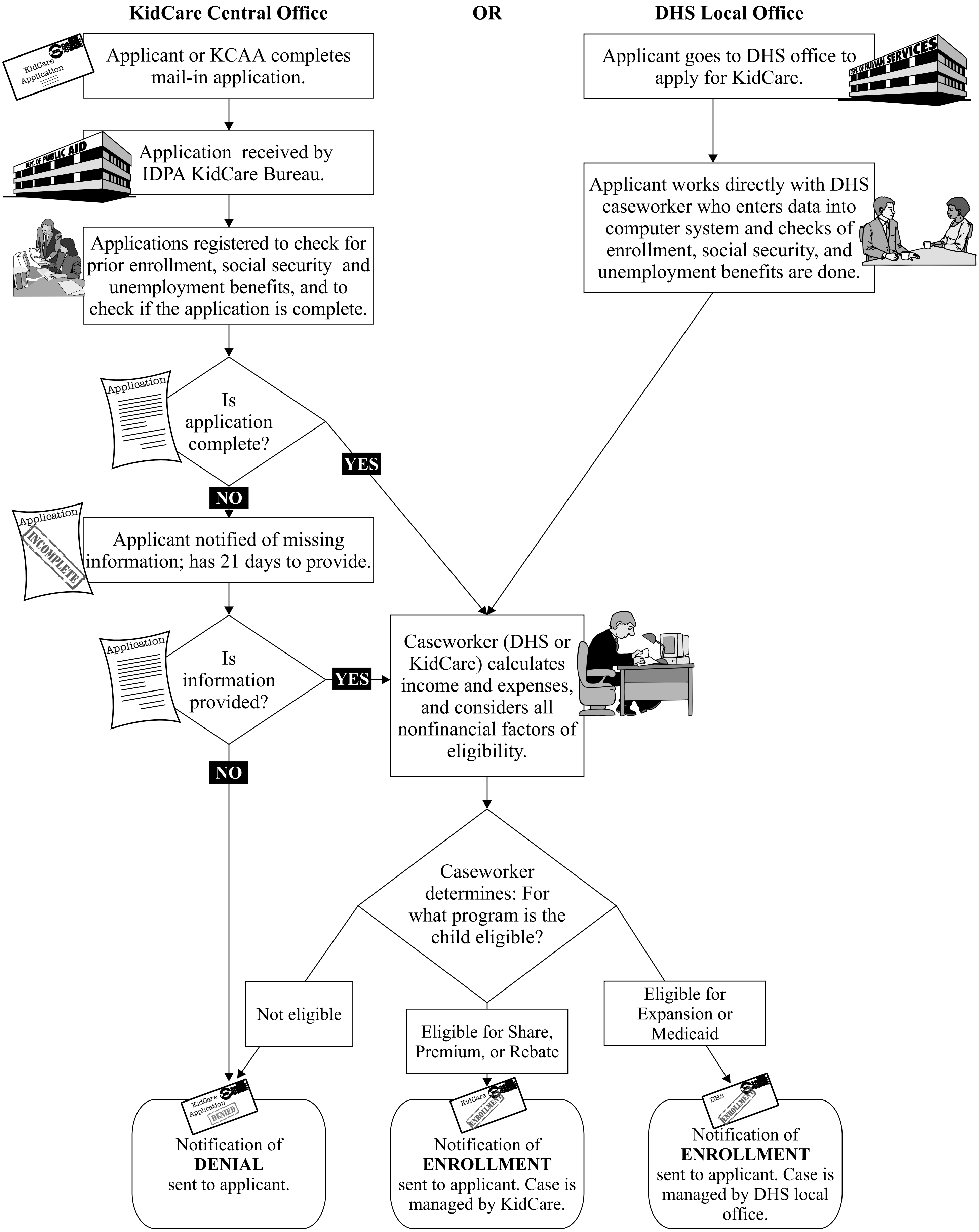
Public Aid has spent $162 million for KidCare medical expenditures since the program was created in January 1998 through Fiscal Year 2001. An additional $36.8 million has been spent on administrative expenditures of KidCare. Consistent with our discussion of enrollment, this does not include expenditures for children enrolled in Medicaid through KidCare outreach initiatives. Digest Exhibit 2 shows KidCare medical and administrative expenditures from Fiscal Years 1998 through 2001. (pages 8-10)

Digest Exhibit 2
KIDCARE EXPENDITURES
MEDICAL AND ADMINISTRATIVE
Fiscal Years 1998 to 2001 (in millions)

KidCare Medical Expenditures	
Assist Expansion Children	$84.0
Moms & Babies Pregnant Women	$30.4
Moms & Babies Infants	$27.1
Share	$7.9
Premium	$8.8
State-Only Rebate	$4.0
Total Medical Expenditures	$162.2
KidCare Administrative Expenditures	$36.8

Source: Public Aid data summarized by OAG.

Digest Exhibit 3
KIDCARE ENROLLMENT FLOWCHART



Source: Public Aid information summarized by OAG.

MONTHLY PAPER ELIGIBILITY CARDS

Public Aid should continue its planned conversion to permanent durable eligibility cards.

Public Aid received federal approval in May 2000 to move from monthly paper eligibility cards to an electronically based system using permanent durable cards but has not yet implemented the electronically based system. Enrollees in the KidCare program receive a new paper eligibility card in the mail each month. The State of Illinois currently mails out around 900,000 KidCare and other medical program cards each month, or about ten million cards each year. Public Aid estimated that the cards cost approximately 38 cents each to produce and mail or about $4 million annually. The current system raises concerns including:

- unnecessary operational costs,
- possible restrictions on access to medical care,
- non-durability of the card, and
- potential for fraud and abuse.

Public Aid officials have made plans to switch from monthly paper eligibility cards to permanent durable cards. In May 2000, Public Aid received approval for $8.8 million of federal financial participation to help offset the development costs of the project to the State. As of April 2002, Public Aid had put those plans on hold until its Internet eligibility verification website is completed. Public Aid's internal documents indicated that switching to a permanent durable card system could save the State $12.8 million in operational costs over five years. We recommended that the Department continue its planned conversion to permanent durable eligibility cards in order to realize significant cost savings to the State as well as improved program effectiveness. (pages 18-21)

OTHER ELIGIBILITY ISSUES

Senate Resolution 152 asked us to look at four other issues related to the KidCare enrollment process. These issues are discussed in the following sections.

Enrollment for Benefits Prior to Verification of Eligibility

There is a situation where individuals can receive benefits prior to verification of eligibility. It is referred to as Presumptive Eligibility and can only be used related to KidCare for pregnant women. The purpose of presumptive eligibility is to encourage early prenatal care to low income pregnant women who otherwise may postpone or do without such care.

One-Time Encounter Enrollment

Under a federal mandate the regular Medicaid and Expansion plans must allow for benefit payments up to 3 months prior to applying for coverage each time an eligible person applies. For the Share and Premium plans retroactive payments are not federally mandated and the Illinois Children's Health Insurance Program Act allows prior coverage only once. Public Aid limits the one time retroactive benefit payments to only 2 weeks prior to applying for coverage.

Completeness of Applications

Less than half of KidCare applications in the case files that we reviewed were complete as submitted (48% or 33 of 69 case files with applications). We considered an application complete if it was filled out properly with all required elements and all required verifications were provided. If additional information was requested, the application was not considered complete. However, in all of these cases the required information was eventually provided and eligible family members were enrolled.

Denied Cases

Failing to provide appropriate verifications with applications was also a problem with denied cases. It was the second most common reason that KidCare applicants were denied. For the 20 month period of data that we analyzed, from July 2000 to February 2002, 34 percent were denied because applicants failed to provide verifications with their application or in follow-up. Verifications can include items like documentation of income. (pages 21-25)

ENROLLMENT CASE FILE TESTING

There were some problems in KidCare case files that we reviewed. Nine percent of case files tested (8 of 92) had exceptions related to determining income for KidCare. However, none of the exceptions affected eligibility. We also identified eight exceptions related to eligibility redetermination (8 of 61). This included six instances where redetermination was not performed as required at 12 months, and two instances where redetermined income was not determined properly. Although some of these problems were minor, Public Aid and Human Services should assure that KidCare income is properly determined and that redeterminations are done when required.

We found a few problems in KidCare case files that we reviewed. Sixteen exceptions were identified in the 92 case files that we reviewed.

There were enrollees in the Moms & Babies category who were neither mothers nor babies. The Moms & Babies category is intended to cover pregnant women and babies for the first year of their lives. Because this category is not eligible for enhanced federal match it is to the State's advantage to have children moved into the appropriate children's category of KidCare as soon as possible. We recommended that children over age one are transferred out of Moms & Babies into the appropriate KidCare category.

The Assist Expansion category of KidCare included 365 adults when it should have included only children. These adults ranged in age from 19 to 22. The Departments of Public Aid and Human Services should assure that only children are enrolled in KidCare. We recommended when enrollees become too old to be enrolled that they are excluded from the KidCare program. (pages 22-24)

OUTREACH AND ADVERTISING

Although Public Aid had no formally written or approved plan for marketing KidCare, over time a three-stage strategy developed: Overarching Outreach on a Statewide basis; Promotions at the Community Level; and KidCare Application Agents. Public Aid had 76 contracts and paid $9.5 million on outreach and advertising efforts for the KidCare program. Public Aid also paid $2.9 million to KidCare Application Agents (KCAAs) who are paid $50 for each complete approved application.

Public Aid had established a good system for monitoring KidCare marketing and outreach contracts.

Public Aid had structured measurable deliverables into most of the KidCare contracts (71 of 76) and had established a good system for monitoring KidCare marketing and outreach contracts, but some improvement was still needed. Sixty-three of the 70 contracts for which we reviewed monitoring documentation had been well monitored by Public Aid.

Of the 65 KidCare contracts which had measurable deliverables for which we reviewed contract monitoring files, 37 contracts met or substantially met deliverables and 28 did not meet all contractual deliverables. Digest Exhibit 4 shows contracts by category including the number of contracts and expenditures for those contracts. The Exhibit also summarizes contracts with deliverables, whether those deliverables were documented, and whether Public Aid monitored the contracts well.

KidCare Application Agents

Because KidCare Application Agents (KCAA) are paid only for complete and approved applications, assuring a relationship between payment and results is simple. Some KCAAs submitted many applications. Fourteen KCAAs had been paid for over 1,000 KidCare applications. In order to become a KCAA an entity must be incorporated under the laws of Illinois, an Illinois subdivision of government, or an insurance company or insurance producer under the Illinois Insurance Code. (pages 27-38)

Digest Exhibit 4
OUTREACH AND MARKETING CONTRACTS

Overarching:	#	Total Paid	Included Deliverables	Met Deliverables	Well Monitored
Media	11	$3,382,464	9	8	8
Marketing	2	$121,000	0	0	0
Printing	8	$332,185	8	2*	2*
Community Level:					
Hard to Reach	29	$1,951,754	29	21	29
Targeted	14	$459,860	14	1	14
Other	12	$3,298,280	11	5	10
Totals	76	$9,545,543	71	37 of 70	63 of 70

* Two of the eight printing contracts were reviewed.

Source: Public Aid data summarized by OAG.

CONTRACTOR EFFECTIVENESS

Using KidCare Application Agents appears to be an efficient way of bringing enrollees into the program. To analyze efficiency of outreach efforts on a dollars per application basis we looked at outreach efforts that tracked applications submitted. Several of the contract types lend themselves better to reviewing contract costs and enrollment. All of the Hard to Reach and Targeted contracts and all of the KCAA agreements specifically tracked application data related to the contract cost. In addition, five of the individual Other contracts tracked applications in their reports. Digest Exhibit 5 below shows data on contracts, applications, and contacts along with dollars per contract and application. Although contracts were not structured specifically to produce applications and enrollments, it is an important goal of the outreach and is presented for information. (pages 38-41)

Digest Exhibit 5
STATISTICS BY CONTRACT TYPE

	Hard to Reach	Targeted	Other [3]	KCAAs
Contracts	29	14	5	662
$ per Contract	$67,302	$32,847	$177,463	$4,365
Total Contacts	429,760	24,907	37,546	Not tracked
Applications	9,667[2]	2,242[1]	7,555[2]	88,685[4]
$ per Application	$202	$205	$117	$33

Notes:
(1) Total applications (1,815 approved).
(2) Whether the applications were approved was generally not tracked.
(3) Includes contracts where applications were tracked. The associated applications and contacts for those contracts are shown.
(4) Includes all applications including those for which follow-up was required and the KCAA was not paid (57,806 paid,17,566 not paid, 13,313 denied).

Source: Public Aid data summarized by OAG.

BID STATUS OF CONTRACTS

Contracts for KidCare are exempt from normal competitive processes established under the Illinois Procurement Code. According to Public Aid information, 45 of the 76 contracts used to do outreach services for the KidCare program were bid. This includes Hard to Reach contracts (29) and Targeted contracts (14) which were done through an RFP process. It also includes one large contract which included many responsibilities relating to developing and carrying out outreach strategies and a contract for marketing KidCare and other Public Aid programs. (page 40)

SOCIO-ECONOMIC/DEMOGRAPHIC PROFILES

As directed by Senate Resolution 152, we prepared demographic profiles of KidCare enrollees. Some characteristics of KidCare enrollees can be seen when they are analyzed based on the demographic codes that Public Aid captures in the electronic data from applications. For example, the largest racial categories are, in rank order, Caucasian (45%), Hispanic (27%) and African-American (23%). The codes for these three categories make up almost 95 percent of KidCare enrollment. Also, the proportion of Caucasians generally increases as KidCare categories' income thresholds increase while the proportion of African-Americans declines. A third characteristic is that 50 percent of enrolled children are from two-parent households. Again, the proportion of two-parent households increases with the income thresholds of KidCare categories. (pages 43-48)

OVERALL HEALTH OF ENROLLED CHILDREN

Although it is difficult to compare the overall health of KidCare enrolled children with other children, there are some health measures that can be used to make an attempt. The Agency for Healthcare Research and Quality (AHRQ), the health services research arm of the U.S. Department of Health and Human Services, identified three conditions that they refer to as ambulatory care sensitive conditions or conditions for which hospitalization might be avoided through high quality primary care. Those three, pediatric asthma, pediatric gastroenteritis, and low birth weight for infants, are the three identified conditions related to the care of children. Public Aid reported KidCare statistics for asthma and gastroenteritis plus some non-KidCare specific data for very low birth weight. The audit report contains Public Aid's measures of health status plus data from other sources. (pages 49-54)

AUDIT RECOMMENDATIONS

The Audit contains seven recommendations. The Departments of Public Aid and Human Services generally agreed with the recommendations. Agency responses to recommendations have been incorporated into the report and the full comments are included in Appendix G.

WILLIAM G. HOLLAND
Auditor General

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TABLE OF CONTENTS

Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

The federal Balanced Budget Act of 1997 amended the Social Security Act to establish Title XXI – the State Children's Health Insurance Program (SCHIP). In response to the establishment of SCHIP at the federal level, Illinois Public Act 90-736 was signed into law on August 12, 1998 establishing the Children's Health Insurance Program Act (215 ILCS 106/1 *et seq.*) which is referred to as KidCare.

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Public Aid includes children in KidCare enrollment figures who are enrolled in the regular Medicaid program. These children were eligible under the Medicaid income guidelines in place prior to implementation of SCHIP. Public Aid counts Medicaid children as KidCare because they were enrolled through outreach initiatives and were enrolled through the KidCare Central Bureau. In this report we refer to these Medicaid enrollees who came in through KidCare as Initiative. Fifty-six percent of KidCare enrollees reported as of December 1, 2001 were Initiative enrollees in the regular Medicaid program (97,036 of 174,778).

Public Aid has spent $162 million for KidCare medical expenditures since the program was created in January 1998 through Fiscal Year 2001. An additional $36.8 million has been spent on administrative expenditures of KidCare. Consistent with our discussion of enrollment, these expenditures do not include expenditures for children enrolled in Medicaid through KidCare outreach initiatives. Public Aid's medical expenditures for Initiative enrollees were $182 million for Fiscal Years 1999 through 2001.

To fund SCHIP, an annual federal allotment was made available to states each year from 1998 through 2007. For Fiscal Year 2002 expenditures Illinois, as well as many other states, was still drawing against its 1999 allotment and had not used any of the 2000 or 2001 allotments.

We found some problems in KidCare case files that we reviewed. Depending on the KidCare category, some case files are maintained by Public Aid and some are maintained by the Department of Human Services. There were eight total exceptions related to determining income for KidCare (8 of 92 cases tested) none of which affected eligibility. We also identified eight exceptions related to redetermination (8 of 61) including six which were not done on time and two cases where income was not determined properly. Although some of these problems were minor, Public Aid and Human Services should assure that KidCare income is properly determined and that redeterminations are done when required.

We identified enrollees in the Moms & Babies category who were neither mothers nor babies. The Moms & Babies category is intended to cover pregnant women and babies for the first year of their lives. Because this category is not eligible for enhanced federal match, it is to the State's advantage to have children moved into the appropriate children's category of KidCare as soon as possible.

Applicants failing to provide appropriate verifications with their applications (such as documentation of income) was the second most common reason that KidCare cases were denied. For the 20 month period from July 2000 to February 2002, 34 percent of denials were because applicants failed to provide verifications with their application or in follow-up requests.

Public Aid received federal approval in May 2000 to move from monthly paper eligibility cards to an electronically based system using permanent durable cards, but has not yet implemented a system. Enrollees in the KidCare program receive a new paper eligibility card in the mail each month. The State of Illinois currently mails out around 900,000 KidCare and other medical program cards each month, or about 10 million cards each year. Public Aid estimated that the cards cost approximately 38 cents each to produce and mail or about $4 million annually. Public Aid should continue its planned conversion to permanent durable eligibility cards in order to realize cost savings to the State and improved program effectiveness.

Although Public Aid had no formally written or approved plan for marketing KidCare, over time a three-stage strategy developed: Overarching Outreach on a Statewide Basis; Promotions at the Community Level; and KidCare Application Agents. Public Aid had 76 contracts and paid $9.5 million on outreach and advertising efforts for the KidCare program. They also paid $2.9 million to KidCare Application Agents (KCAAs) who are paid $50 for each complete approved application.

Public Aid had structured measurable deliverables into most of the KidCare contracts (71 of 76) but still had some contracts with weaknesses. Without measurable deliverables it is more difficult to monitor vendors and more difficult to determine if contracts were effective.

Public Aid had established a good system for monitoring KidCare marketing and outreach contracts but some improvement was still needed. Most contract monitoring documentation that we reviewed showed that contracts had been well monitored by Public Aid (63 of 70).

Only 45 of the 76 contracts for KidCare outreach services were procured through a competitive bid. However, the Children's Health Insurance Program Act exempted contracts for KidCare from normal competitive processes established under the Illinois Procurement Code.

As directed by Senate Resolution 152, we prepared demographic profiles of KidCare enrollees. The largest racial categories in KidCare were Caucasian (45%), Hispanic (27%) and African-American (23%). The proportion of Caucasians generally increased as the income thresholds for various KidCare categories increased while the proportion of African-Americans declined. Fifty percent of KidCare enrollees were from two-parent households and the proportion of two-parent households increased with the increasing income thresholds of KidCare categories.

Although it is difficult to compare the overall health of KidCare enrolled children with other children, there are some health measures that can be used to make an attempt. Public Aid identified and reported KidCare data on three conditions that are good measures of children's health status.

BACKGROUND

On May 24, 2001, the Illinois Senate adopted Senate Resolution 152. The Resolution requires the Auditor General to conduct a program and management audit of the Illinois Department of Public Aid's KidCare program. The Resolution asked us to evaluate:

1. The Department of Public Aid's compliance with federal and State laws, the State of Illinois' Children's Health Insurance Plan submitted to the Health Care Finance Administration, and rules, regulations and policies adopted by the Department of Public Aid;

2. The Department of Public Aid's adherence to eligibility requirements, including evaluating the eligibility of enrolled children, whether or not the Department enrolls children for benefits prior to verification of eligibility for benefits, the Department's practice of allowing for onetime encounter enrollments, and the Department's adherence to income verification procedures;

3. The effectiveness of the Department's marketing strategies, including the effectiveness of bid and no-bid outreach contracts, broadcast and print advertising and other outreach advertising mechanisms targeted to increase enrollment in the program and the correlation between each strategy and the number of children enrolled that are attributed to that specific contract or strategy;

4. The compliance and effectiveness of all KidCare outreach contracts issued by the Department of Public Aid since the creation of the KidCare program including the amounts of the contracts, the bid status of the contracts, the terms of the contracts, the responsibilities outlined in the contracts, the fulfillment of the contractors' responsibilities, and verification of required contract documentation;

5. The application and enrollment process to ensure that the families of enrolled children have properly completed applications, which include all proof of information and documentation required pursuant to the KidCare application;

6. Summarize and compare the socio-economic profile of applicants and enrolled children and their families based on information required on the application form;

7. Evaluate the efficiency of the process by which monthly paper eligibility cards are issued to enrollees;

8. Evaluate the effectiveness and efficiency of the eligibility redetermination process;

9. Using recognized public health standards, compare the overall health of enrolled children with the overall health of (i) privately insured children of the same socio-economic status and (ii) uninsured children of the same socio-economic status;

A copy of the Senate Resolution is included as Appendix A of this report.

THE KIDCARE PROGRAM

KidCare is a State program that offers health care coverage to children and pregnant women and helps in paying premiums of employer-sponsored or private insurance plans. KidCare is available to children through age 18 who are Illinois residents, who are U.S. citizens or qualified legal immigrants, and whose family meets the income requirements. Pregnant women who are Illinois residents and meet the income requirements are also eligible.

Income requirements vary by KidCare Plan and are based on family size. Payments made for childcare expenses or child support are subtracted from income. KidCare services are available at no cost or at low cost and how much a family pays depends on whether income qualifies a family for KidCare Assist, KidCare Share, or KidCare Premium.

KidCare covered services for kids include doctor and nursing care, immunizations and preventive care, hospital and clinic care, laboratory tests and x-rays, prescription drugs, medical equipment and supplies, medical transportation, dental care, eye care, psychiatric care, podiatry, chiropractic care, physical therapy, mental health and substance abuse services. Pregnant women receive prenatal care and other medical services.

History of the Program

The federal Balanced Budget Act of 1997 amended the Social Security Act to establish Title XXI – the State Children's Health Insurance Program (SCHIP). The purpose of SCHIP was to provide funds to the states to expand health insurance coverage to uninsured low-income children. Under SCHIP, states were given the option of expanding Medicaid, establishing a separate stand-alone program, or using a combination of the two approaches. As Exhibit 1-1 shows, states are evenly divided as to the type of plan they use. The federal law established SCHIP allotments to states for 1998 through 2007 and provided that states would get enhanced federal match for expenditures for this program.

In response to the establishment of SCHIP at the federal level, Illinois Public Act 90-736 was signed into law on August 12, 1998 establishing the Children's Health Insurance Program Act (215 ILCS 106/1 *et seq.*). Public Aid implemented the federal/State Children's Health Insurance Program Act (SCHIP) in two phases. Phase I was a Medicaid expansion which consisted of an expansion for children under 19 years of age and an expansion for pregnant women and their babies. The initial plan, effective January 5, 1998, was approved April 1, 1998, by the federal Health Care Financing Administration or HCFA (now called the Centers for Medicare & Medicaid Services or CMS.) Illinois was one of the first eight states to have an approved plan in place.

Exhibit 1-1
TYPE OF PLANS IN EFFECT
As of September 30, 2001

Medicaid Expansion	Stand-alone	Combination
Alaska	Arizona	Alabama
Arkansas	Colorado	California
District of Columbia	Delaware	Connecticut
Hawaii	Georgia	Florida
Idaho	Kansas	**Illinois**
Louisiana	Montana	Indiana
Minnesota	Nevada	Iowa
Missouri	North Carolina	Kentucky
Nebraska	Oregon	Maine
New Mexico	Pennsylvania	Maryland
Ohio	Utah	Massachusetts
Oklahoma	Vermont	Michigan
Rhode Island	Virginia	Mississippi
South Carolina	Washington	New Hampshire
Tennessee	West Virginia	New Jersey
Wisconsin	Wyoming	New York
		North Dakota
		South Dakota
		Texas

Source: Federal Centers for Medicare and Medicaid Services (formerly HCFA).

Illinois established a single income eligibility standard of 133% of the federal poverty level (FPL) for children from birth to age 18. Prior to the Medicaid expansion, Illinois had a graduated income eligibility standard depending on the age of the child (see Exhibit 1-2). Illinois also increased the income standard for pregnant women and their babies from 133% to 200% FPL.

Exhibit 1-2
INCOME LEVELS PRIOR TO EXPANSION

Age	Income (% of FPL)
0-5	up to 133%
6-16	up to 100%
17-18	up to 50%

Source: Public Aid.

In November 1998, Illinois submitted Phase II of their plan to establish a combination program. The federal CMS approved it on March 30, 2000, with an effective date of August 12, 1998. Phase II expanded Illinois' SCHIP program for children under 19 years of age with family incomes above 133% FPL up to 185% FPL. Phase II established, under Title XXI, KidCare Share and KidCare Premium. Although not part of Title XXI, Phase II also established the KidCare Rebate program which is supported by State funds only.

Categories of KidCare

KidCare is made up of five separate categories in which children and pregnant women can be enrolled. The categories and income eligibility guidelines are shown in Exhibit 1-3 below. Following is a brief description of each of the categories:

Assist – covers children with family incomes at or below 133% of the FPL. Children receive services through the State's regular Medicaid program under Title XIX or through the Medicaid Phase I expansion under Title XXI. The original Medicaid program is referred to as KidCare Assist Base and the Phase I expansion is referred to as KidCare Assist Expansion. Children in Base are actually enrolled in the regular Medicaid program.

Share – is a Title XXI SCHIP program that allows kids in families with higher income levels to be enrolled but requires them to make a co-payment for some services. The Share co-payment is $2 for medical visits or prescriptions.

Premium - is also a Title XXI SCHIP program that allows kids in families with higher income levels to be enrolled but requires them to pay a small premium and to make a co-payment for some services. The premium per month is $15 for one child up to $30 for 3 or more children with a co-payment of $5 for medical visits or brand-name prescriptions, $3 for generic prescriptions, and $25 for non-emergency use of the emergency room.

Exhibit 1-3

KIDCARE MONTHLY INCOME QUALIFICATION REQUIREMENTS

And Percent of Federal Poverty Level Criteria

Family Size	Assist any kid #133%	Share uninsured kids >133% - #150%	Premium uninsured kids >150% - #185%	Rebate insured kids >133% - #185%	Moms & Babies pregnant women #200%
1	$ 982 or less	$ 983 – 1108	$ 1109 – 1366	$ 983 – 1366	------
2	1323 or less	1324 – 1493	1494 – 1841	1324 – 1841	1990 or less
3	1665 or less	1666 – 1878	1879 – 2316	1666 – 2316	2503 or less
4	2006 or less	2007 – 2263	2264 – 2790	2007 – 2790	3017 or less
5	2347 or less	2348 – 2648	2649 - 3265	2348 – 3265	3530 or less

Source: KidCare home page on April 24, 2002.

Rebate – is a State program that reimburses families for all or part of premiums for insurance coverage that they can obtain through their employer or through private policies. The federal government does not reimburse any of the costs of this program.

Moms & Babies – covers pregnant women and their babies with family incomes at or below 200% of the FPL. The mother receives coverage during the pregnancy and for 60 days after birth and the baby receives coverage for a year after birth. Moms & Babies is a federal Title XIX expansion, not a new Title XXI SCHIP program. Moms & Babies is similar to Assist in that enrollees below 133% of FPL are actually enrolled in the regular Medicaid program.

Revenue from Premiums

As noted above, the Premium category of KidCare requires families to pay a premium to participate in the program. In Fiscal Year 2001 the program collected $948,000 in premiums. In Fiscal Year 2000 and 1999 it collected $616,000 and $89,000 respectively. Co-payments that are required for the Share and Premium Categories are paid to providers and are kept by the providers.

KIDCARE ENROLLMENT

Public Aid includes children in KidCare enrollment figures that are within Medicaid income guidelines but not within the income guidelines of the new Children's Health Insurance Program. Fifty-six percent of enrollees as of December 1, 2001 were actually enrolled in the regular Medicaid program (97,036 of 174,778).

Exhibit 1-4
KIDCARE ENROLLMENT BY CATEGORY
As of December 1, 2001

Assist Expansion	48,510
Moms & Babies	7,171
Share	7,420
Premium	8,887
Rebate	5,754
Total	77,742
Initiative	97,036
Total including Initiative	174,778

Source: Public Aid data summarized by OAG.

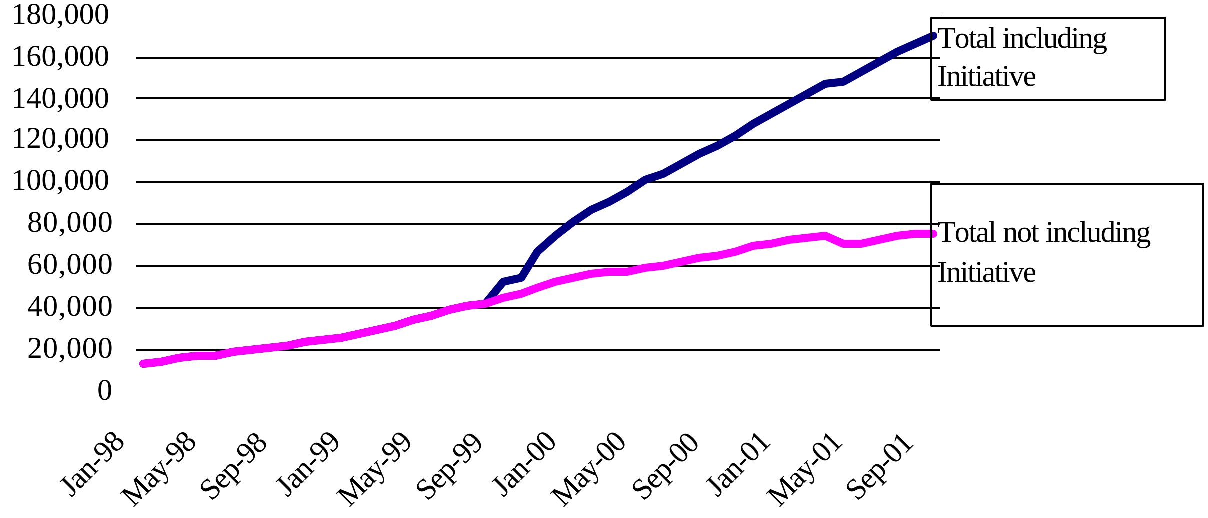
These children were eligible under the Medicaid income guidelines in place prior to implementation of SCHIP. Public Aid counts these children as KidCare enrollees because they were enrolled through the KidCare Central Bureau. Although the federal government encouraged outreach initiatives to find both Medicaid and SCHIP children, the federal government does not include these Medicaid children in its numbers when reporting on SCHIP enrollment.

Public Aid started including these children who came in through the Central Bureau as KidCare in September 1999. We refer to this sixth category as Initiative. Exhibit 1-4 shows the total KidCare enrollment broken down by category as of December 1, 2001. Exhibit 1-5 shows enrollment by month both including the Initiative category and excluding the Initiative category. The Initiative category has children that are in Medicaid based on the old pre-expansion income standards.

In February 2002, the federal Centers for Medicare & Medicaid Services (CMS) released the State Children's Health Insurance Program Annual Enrollment Report. This report presents enrollment figures for all 50 states and the District of Columbia. CMS enrollment figures include only SCHIP enrollees and not enrollees who were eligible under income guidelines in place prior to implementation of SCHIP. The report does note, however, that many states reported that SCHIP has had a significant impact on bringing children into their Medicaid programs. The KidCare enrollment process is discussed in more detail in Chapter Two of this report.

Exhibit 1-5

KIDCARE ENROLLMENT BY MONTH



Source: Public Aid data summarized by OAG.

KIDCARE SPENDING

Public Aid has spent $162 million for KidCare medical expenditures since the program was created in January 1998 through Fiscal Year 2001. An additional $36.8 million has been spent on administrative expenditures of KidCare. Consistent with our discussion of enrollment, this does not include expenditures for children enrolled in Medicaid through KidCare outreach initiatives. Public Aid's medical expenditures for Initiative enrollees were $182 million for Fiscal Years 1999 through 2001. Exhibit 1-6 shows medical expenditures by KidCare category since the program was started and also shows expenditures for Initiative enrollees.

Exhibit 1-6
MEDICAL EXPENDITURES FOR KIDCARE AND INITIATIVE
Fiscal Years 1998 to 2001 and Half of 2002 (in millions)

	FY1998	FY1999	FY2000	FY2001	6 months of FY2002
Assist Expansion Children	$3.9	$16.7	$25.4	$38.0	$18.2
Moms & Babies Pregnant Women 134-200%	$1.3	$7.7	$8.6	$12.8	$6.0
Moms & Babies Infants 134-200%	$1.1	$4.5	$9.9	$11.6	$5.4
Share	$0.0	$0.3	$2.6	$5.0	$2.9
Premium	$0.0	$0.3	$2.7	$5.8	$2.9
State-Only Rebate	$0.0	$0.2	$1.3	$2.5	$1.8
Total KidCare	$6.3	$29.7	$50.5	$75.7	$37.2
Initiative Children	$0.0	$0.5	$22.7	$50.2	$30.7
Initiative Pregnant Women	$0.0	$0.2	$28.0	$70.2	$38.4
Initiative Infants	$0.0	$0.1	$3.9	$6.1	$1.9
Total Initiative	$0.0	$0.8	$54.7*	$126.5	$71.0

* Does not add due to rounding.

Source: Public Aid data summarized by OAG.

Administrative Expenditures

Public Aid has spent $36.8 million on administrative expenditures related to the KidCare program through Fiscal Year 2001. Exhibit 1-7 shows administrative spending by fiscal year. The exhibit also shows the amount of the administrative expenditures that were submitted for enhanced federal match under SCHIP. The federal program limits administrative expenditures that can be claimed for enhanced match to ten percent of the total of administrative and medical expenditures. Some of the administrative expenditures which are not submitted for enhanced SCHIP match are submitted for the 50 percent match under Medicaid or enhanced match in another category. Expenses related to the State-only Rebate program are not eligible for federal match.

Exhibit 1-7
KIDCARE ADMINISTRATIVE EXPENDITURES AND AMOUNT SUBMITTED FOR ENHANCED FEDERAL MATCH
(in millions)

FY	Total	Federal Match
1998	$0.1	-0-
1999	$4.0	-0-
2000	$16.9	$4.3
2001	$15.8	$3.7

Source: Public Aid data summarized by OAG.

Rebate Category

A portion of the administrative expenditures for KidCare are paid from a separate line item appropriation. The appropriation is for KidCare expenditures including the Rebate program, which helps families to pay private insurance premiums. Expenditures have been about 80 percent administrative from Fiscal Years 1999 through 2001. Of the $21.8 million of expenditures from Fiscal Years 1999 through 2001, $4 million was for Rebate premium payments and $17.8 million was general administrative expenditures for KidCare. Exhibit 1-8 shows the appropriations, premium payments, administrative expenditures, percent administrative, and total expenditures by fiscal year. Most KidCare expenditures are made from the general appropriation for Medicaid.

Exhibit 1-8
KIDCARE SPECIFIC APPROPRIATIONS AND EXPENDITURES*
FY99 to FY01 (in millions)

	Appropriation	Rebate Premiums Paid	KidCare Administrative Expenditures	Percent Admin	Total Expenditures	Unspent Appropriation
FY99	$18.0	$.2	$2.1	92%	$2.3	$15.7
FY00	$11.8	$1.3	$9.9	89%	$11.2	$0.6
FY01	$8.8	$2.5	$5.8	70%	$8.3	$0.5
Total	$38.5**	$4.0	$17.8	82%	$21.8	$16.7**

* Most KidCare expenditures are made from the general appropriation for Medicaid.

** Does not add due to rounding.

Source: Public Aid data summarized by OAG.

KIDCARE FEDERAL MATCH

Like Medicaid, the cost of SCHIP programs are shared by the states and the federal government. States receive a federal match for SCHIP which is 30 percent higher than the matching rate for Medicaid. In Illinois, the Medicaid federal matching rate is 50 percent and the SCHIP enhanced rate is 65 percent. Enhanced match is available for the children’s expansion portion of the program that Illinois calls Assist Expansion, and for the stand alone portions of the program that Illinois calls Share and Premium. The Moms & Babies category is eligible for the regular Medicaid rate but not the enhanced rate. The State-only Rebate program is not matched with federal dollars.

Exhibit 1-9 shows the total expenditures that were claimed for federal SCHIP enhanced match by fiscal year and the federal match that was reimbursed. Federal match for Share and Premium did not begin until Fiscal Year 2000 when the program was approved by the federal government. However, because the program was approved retroactively, federal match for prior periods was claimed after approval starting in the quarter ending March 2000.

Exhibit 1-9
TOTAL EXPENDITURES CLAIMED FOR ENHANCED SCHIP FEDERAL MATCH (65%)
Fiscal Years 1998 to 2001 (in millions)

Expenditures:	Medical Assist Expansion	Medical Share and Premium	Subtotal Medical	Admin-istration	Total
Fiscal Year 1998	$4.8		$4.8		$4.8
Federal Share	*$3.1*		*$3.1*		*$3.1*
Fiscal Year 1999	$24.0		$24.0		$24.0
Federal Share	*$15.6*		*$15.6*		*$15.6*
Fiscal Year 2000	$30.5	$6.1	$36.6	$4.3	$40.9
Federal Share	*$19.8*	*$4.0*	*$23.8*	*$2.8*	*$26.6*
Fiscal Year 2001	$42.2	$13.8	$56.1*	$3.7	$59.8
Federal Share	*$27.5*	*$9.0*	*$36.5*	*$2.4*	*$38.9*
Total FY98 thru FY2001	$101.6*	$19.9	$121.5	$8.0	$129.6*
Total Federal Share	*$66.0*	*$13.0*	*$79.0*	*$5.2*	*$84.2*

* Does not add due to rounding.

Source: Public Aid data summarized by OAG.

SCHIP Federal Allotments

To fund SCHIP, an annual federal allotment was made available to states each year from 1998 through 2007. Title XXI allowed a three year window for the expenditure of the 1998 allotment but because many states (including Illinois) had not spent their allotments, a new section was added to redistribute and continue the availability of the 1998 allotment. Exhibit 1-10 shows SCHIP allotments for 1998 through 2001 and the portions of those allotments that have been used through December 2001. For Fiscal Year 2002 expenditures Illinois, as well as many other states, was still drawing against its 1999 allotment and had not used any of the 2000 or 2001 allotments.

Exhibit 1-10
ILLINOIS SCHIP ALLOTMENTS AND EXPENDITURES
Federal Fiscal Years 1998 through December 2001 (in millions)

	1998	1998 Reallocate	1999	1999 Reallocate	2000	2001
Federal SCHIP Allotments	$122.5	$44.6	$121.9	$51.1	$137.5	$159.8
Federal Share of:						
FY98 expenditures	$3.1		None		None	None
FY99 expenditures	$15.6		|		Yet	Yet
FY00 expenditures	$26.6		|		|	|
FY01 expenditures	$8.1	$30.7	|		|	|
FY02 expenditures	____	$13.9	|	$2.0	|	|
Subtotal Federal Share of expenditures	$53.5 (1)	$44.6	v	$2.0	v	v
Unspent Grant Awards	$69.1 (1)	$0	$121.9	$49.2 (1)	$137.5	$159.8
Current Grant Award	$0	$0	$0	$49.2	$137.5	$159.8
Expiration	9/30/00	9/30/02	9/30/01	9/30/02	9/30/02	9/30/03
Lapsed Allotment	$24.5 (2)	$0	$70.8 (3)	$0	$0	$0

Notes: (1) Does not add due to rounding.

(2) Unspent allotment less reallocation ($69.1 - $44.6 = $24.5).

(3) Unspent allotment less reallocation ($121.9 - $51.1 = $70.8).

Source: Public Aid data summarized by OAG.

SCOPE AND METHODOLOGY

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.

We obtained and reviewed information from the Department of Public Aid relating to the KidCare program. This included policies and procedures as well as documents requested and provided. We obtained electronic data from Public Aid which had all KidCare and Initiative cases that were active in December 2001. Based on that data we were able to analyze and identify some enrollment problems. We also used that data to analyze the demographic characteristics of the KidCare enrollee population.

In conducting the audit, we reviewed federal laws and regulations applicable to SCHIP, State statutes, administrative rules, and Public Aid policies governing the operations of KidCare. We also reviewed the State's SCHIP plan which was submitted to the federal government. We reviewed compliance with laws, rules, policies, and the SCHIP plan to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report. To identify how Illinois' program compares to other states, we reviewed research and studies. We also reviewed information and audits related to other states' SCHIP programs.

We reviewed the previous financial and compliance audits released by the Office of the Auditor General for Public Aid to identify any issues related to KidCare. We reviewed management controls relating to the audit objectives which were identified in Senate Resolution 152 (see Appendix A). This audit identified some weaknesses in those controls which are included as recommendations in this report. We also worked with other OAG auditors who were working on Public Aid's financial audit for Fiscal Year 2001 and OAG auditors who were working on the Statewide single audit. The SCHIP program was a major program for single audit testing purposes.

We tested random samples of cases from four different areas. The first area was Share, Premium, and Rebate case files that are maintained by Public Aid. The second and third areas were Assist Expansion case files and Initiative case files. Both types of case files are maintained by the Department of Human Services. All of these samples were selected from cases which were active in December 2001. In addition, we tested a random sample of applications that had been rejected from a list of rejections provided by Public Aid. Files for these cases are maintained by the Department of Public Aid.

To compare the overall health of enrolled children with the overall health of similar children we used data that Public Aid had reported to the federal Centers for Medicare and Medicaid Services to comparable data that we could identify. In particular we obtained data from the Illinois Health Care Cost Containment Council and verified data that was provided by the Department of Human Services.

REPORT ORGANIZATION

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

CHAPTER TWO – ELIGIBILITY AND ENROLLMENT

CHAPTER THREE – MARKETING AND OUTREACH

CHAPTER FOUR – KIDCARE PROFILES

Chapter Two

ELIGIBILITY AND ENROLLMENT

CHAPTER CONCLUSIONS

There were some problems in KidCare case files that we reviewed. Nine percent of case files tested (8 of 92) had exceptions related to determining income for KidCare, none of which affected eligibility. We also identified eight exceptions related to eligibility redetermination (8 of 61). This included six instances where redetermination was not performed as required at 12 months, and two instances where redetermined income was not determined properly. Although some of these problems were minor, Public Aid and Human Services should assure that KidCare income is properly determined and that redeterminations are done when required.

Less than half of KidCare applications in the case files that we reviewed were complete as initially submitted and required follow-up before approval. In addition, applicants failing to provide appropriate verifications with their applications was the second most common reason for denial. For the 20 month period from July 2000 to February 2002, 34 percent of denials were because applicants failed to provide verifications with their application or in follow-up. Verifications can include items like documentation of income.

Public Aid received federal approval in May 2000 to move from monthly paper eligibility cards to an electronically based system using permanent durable cards, but has not yet implemented a system. Enrollees in the KidCare program receive a new paper eligibility card in the mail each month. The State of Illinois currently mails out around 900,000 KidCare and other medical program cards each month, or about 10 million cards each year. Public Aid estimated that the cards cost approximately 38 cents each to produce and mail or about $4 million annually. Public Aid should continue its planned conversion to permanent durable eligibility cards in order to realize cost savings to the State and improved program effectiveness.

KIDCARE ENROLLMENT

The following narrative and the flow chart shown in Exhibit 2-1 help to explain the KidCare enrollment process. Applications are received at the KidCare Central Bureau from Kid Care Application Agents (KCAAs) or from families by mail. A sample KidCare application is included in Appendix C of this report. In our case file testing 57 percent of Share, Premium, and Rebate applications were mailed in, 28 percent came from KCAAs, and 15 percent came from the Department of Human Services. The application must include documentation on income, citizenship status (if applicable), deductible expenses, proof of pregnancy (if applicable), and social security number or proof of application for a social security number.

Next, applications are registered into the system. This process is performed both in the KidCare Central Bureau in Springfield and in Chicago where the normal applications are sent.

Normal includes all applications except those submitted by self-employed parents, non-citizen parents, or pregnant women, and applications where a child is an 18 year old.

The KidCare Central Bureau processes all of these special applications and also some normal applications depending on the workload. To register applications Public Aid employees enter information from the application into the client database and three different data checks are done automatically by the computer system. The data checks include:

1. Public Aid's own databases to check for past enrollment and for child support income.
2. A State Online Query which is connected to the Social Security Administration to verify social security numbers and determine whether the applicant receives any Social Security-related benefits.
3. An Illinois Department of Employment Security database to see if an applicant is receiving unemployment insurance. This system also has some quarterly income information.

The employees that register cases do not determine eligibility; rather they assess whether the application is complete and all required documentation is submitted. In the next step caseworkers actually determine eligibility. If the application is not complete, the applicant is notified of the problem and has 21 days to provide the information or request an extension. If the information is not provided, the application is sent to a caseworker for denial.

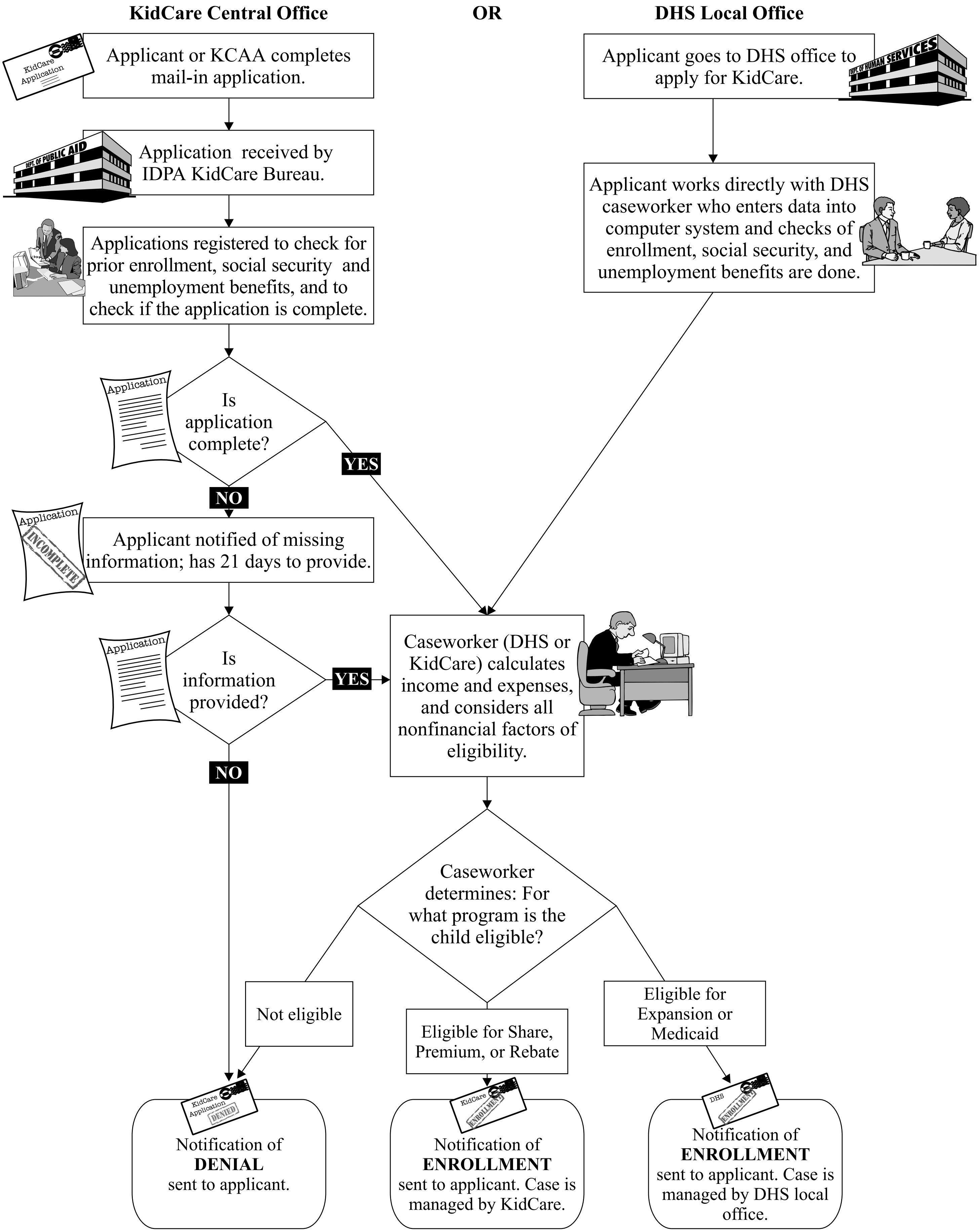
When all the information has been submitted, applications are assigned to caseworkers. The caseworkers calculate the adjusted income to be compared to the standard and also consider all nonfinancial factors of eligibility determination. The caseworkers again perform various electronic checks in determining eligibility. When an application is determined eligible, a notification of enrollment is generated by an automated system and mailed to the applicant. All cases that are part of Expansion (KidCare Assist or Moms & Babies) are sent to local Department of Human Services (DHS) offices for case maintenance.

Enrollment at the Department of Human Services

In addition to the eligibility determination process at Public Aid, DHS caseworkers can determine eligibility. In our case file testing, 15 percent of Share, Premium, and Rebate cases came from DHS and 68 percent of Expansion cases came from DHS. The main difference at DHS is that applicants may come in to the local office and actually work with a caseworker from the beginning. Applicants may walk in or mail an application to any of the 130 local DHS offices. At the local offices caseworkers process applications and determine eligibility. If an application is mailed in to DHS, the process works in a similar way as at Public Aid. Missing information will be requested from the applicant and if information is not provided the application is denied and a notice is mailed out.

At DHS the registration process of electronic clearances is done automatically by the computer system. Basically the same checks are performed as at Public Aid. Also, income verification is done in the same manner as by Public Aid. The applicant is asked to provide copies of pay stubs to verify income. Once eligibility is determined, notices are computer generated from the same system that KidCare uses. Assist/Moms & Babies cases are maintained in the DHS local offices and Share, Premium, and Rebate cases are sent to KidCare.

Exhibit 2-1
KIDCARE ENROLLMENT FLOWCHART



Source: Public Aid information summarized by OAG.

Eligibility Redetermination

KidCare eligibility redetermination is done every 12 months, but who performs the redetermination varies based on the enrollment category. Share, Premium, and Rebate cases are redetermined by the Public Aid KidCare Bureau Customer Service Unit. DHS local offices do the redeterminations for most Medicaid cases (Moms & Babies, Assist). The KidCare renewal application is a shortened version of the original application. Some of the information is preprinted (e.g. name, birthdate) and mailed to the family. However, the same income and expense questions that are on the original application must be answered and the same verifications must be attached.

MONTHLY PAPER ELIGIBILITY CARDS

Public Aid received federal approval in May 2000 to move from monthly paper eligibility cards to an electronically based system using permanent durable cards but has not yet implemented the electronically based system. Enrollees in the KidCare program receive a new paper eligibility card in the mail each month. The State of Illinois currently mails out around 900,000 KidCare and other medical program cards each month, or about 10 million cards each year. Public Aid estimated that the cards cost approximately 38 cents each to produce and mail or about $4 million annually. The current system raises concerns including:

- unnecessary operational costs,
- possible restrictions on access to medical care,
- non-durability of the card, and
- potential for fraud and abuse.

Public Aid officials have made plans to switch from monthly paper eligibility cards to permanent durable cards. In May 2000 Public Aid received approval for $8.8 million of federal financial participation to help offset the development costs of the project to the State. As of April 2002, Public Aid had put those plans on hold until its Internet eligibility verification website is completed. Public Aid officials indicated that they want to be sure that medical providers have several reliable options to verify eligibility before the switch to permanent durable cards is done. Public Aid's internal documents indicated that switching to a permanent durable card system could save the State $12.8 million in operational costs over five years.

Current KidCare Paper Eligibility Card System

Enrollees in the Illinois KidCare program receive a new paper eligibility card in the mail each month. There are no rules or regulations that require monthly cards to be used. The cards are actually one-third the size of a full sheet of typical plain paper stock, which makes them susceptible to destruction or damage. Each month more than 40,000 are returned to the State as undeliverable. Second and third mailings are successful only about 50 percent of the time. Returned paper cards can be an advantage to Public Aid if moving to a new address affects the client's eligibility.

Assist Expansion and Moms & Babies cards are white and Share and Premium cards are yellow. Rebate enrollees, who are in private insurance plans, are not issued cards. The eligibility cards contain name and address, case number, recipient identification numbers, coverage period, co-pay amounts if applicable, and dates of birth for all enrollees covered on the case. One KidCare eligibility card is sent to each case, rather than each enrollee in that particular case. Since there is only one card per case, when more than one enrollee in the case needs medical care at the same time, the card is not available for each of them.

The Comptroller's Office prints and mails the cards for Assist Expansion and Moms & Babies, and the Department of Human Services issues Share and Premium cards. The Comptroller's Office mails the cards because they mailed Medicaid cards along with cash assistance checks as part of the warrant process. KidCare eligibility cards are mailed after a "cut-off" date around the middle of the month to ensure that enrollees receive them by the first of the month. Enrollees are then eligible for services for the next full month even if a change in their status just after the cut-off would warrant otherwise.

Paper Card Advantages

Advantages of the paper card system include that medical providers are familiar with the current paper card system which assures them that the client is eligible for the period listed on the card. In addition, when paper cards are mailed, other general program information can be sent at the same time with no additional postage costs. The paper cards also contain a larger volume of information that could not be printed on a smaller permanent card.

Proposed System

Public Aid has made plans to eliminate the case-specific monthly paper card in favor of the more cost-effective enrollee-specific permanent card. These plans are part of its long-range modernization project, which it calls the Medical Electronic Data Interchange project.

Exhibit 2-2
MEDICAL ELIGIBILITY CARDS
MONTHLY PAPER vs. PERMANENT DURABLE:
PROJECTED OPERATIONAL COSTS AND SAVINGS

Year	Current Monthly Paper Card System	Permanent Durable Card System	Potential Cost Savings
1	$3,745,000	$3,550,000	$195,000
2	$3,894,000	$1,152,500	$2,742,000
3	$4,052,000	$1,025,000	$3,027,000
4	$4,218,000	$937,500	$3,280,500
5	$4,384,000	$850,000	$3,534,000
Total	$20,293,000	$7,515,000	$12,778,500

Source: Public Aid Advance Planning Document.

Public Aid submitted an Advance Planning Document (APD) to the federal government to request funding to help offset the development costs of its modernization project. The APD is a detailed document that contains several analyses to support its request for federal funding. In the APD, Public Aid acknowledged that the monthly paper card system was not a cost-effective approach. Its findings show that a permanent durable eligibility card system is the most feasible alternative to the current system.

The APD contains an important cost/benefit analysis section, which provides strong support for Public Aid to convert to permanent durable eligibility cards. It states the annual cost of the current system to be over $3.7 million. It is noteworthy that the largest portion of annual cost is postage, which accounts for $3 million of the total. The cost/benefit analysis also contains 5-year cost projections for both the monthly paper card system and a permanent durable card system. Public Aid's own data shows that the estimated operational cost savings from changing to a permanent durable card is nearly $12.8 million over five years.

In May 2000 Public Aid received approval for federal funding related to the APD. In that letter, the federal Department of Health and Human Services specified federal matching rates that would be used and approved total federal financial participation for the development cost of the Medical Electronic Data Interchange system of $8,776,823.

Other Permanent Card Advantages

There are several other advantages beyond the substantial cost savings that could be realized by the State if Public Aid were to adopt a system of permanent durable cards. The State of Texas released a study in January 2001 that described the advantages of permanent eligibility cards. According to the study, 20 states have already converted to permanent durable cards. The following are benefits that may be realized by the State if Public Aid converts to a permanent durable card system:

- Substantial administrative savings could be realized from the reduction in paper, processing, and postage and mailing costs.
- A shorter cut-off period could allow more eligibility changes to be processed and benefit levels appropriately adjusted.
- A plastic swipe card could reduce the use of benefits by ineligible persons. Such a card could include a Personal Identification Number to improve the security of the system.
- A permanent card is much more difficult to duplicate than the paper card.
- More precise and timely eligibility information could decrease the number of rejected claims, increasing provider confidence, and increasing provider participation.

PAPER ELIGIBILITY CARDS	
RECOMMENDATION 1	*The Department of Public Aid should continue its planned conversion to permanent durable eligibility cards in order to realize significant cost savings to the State as well as improved program effectiveness.*
PUBLIC AID RESPONSE	The Department intends to continue the conversion to a medical identification structure that requires less frequent mailings to realize administrative savings. However, the success of this conversion is dependent on the availability of quick, inexpensive, and widely available methods for providers to verify eligibility, including the Internet. It is unclear how durable cards will improve program effectiveness.
	Auditor Comment: *Examples of improved program effectiveness that the Department included in its Advance Planning Document were: reducing the current costs of issuing monthly cards, reducing the number of eligibility related rejected claims, and laying the foundation for advanced fraud and abuse detection measures.*

OTHER ELIGIBILITY ISSUES

Senate Resolution 152 asked us to look at two other eligibility issues: whether or not the Department enrolls children for benefits prior to verification of eligibility for benefits, and the Department's practice of allowing for one-time encounter enrollments. These issues are discussed in the following sections.

Enrollment for Benefits Prior to Verification of Eligibility or Presumptive Eligibility

There is a situation where individuals can receive benefits prior to verification of eligibility. It is referred to as Presumptive Eligibility and can only be used related to KidCare for pregnant women. The purpose of presumptive eligibility is to encourage early prenatal care to low-income pregnant women who otherwise may postpone or do without such care.

Physicians and other health care providers can approve enrollments of pregnant women through a process known as Medicaid Presumptive Eligibility. These pregnant women who receive coverage are given temporary cards, which are good through the end of the month following the health care visit. Presumptive Eligibility is limited to outpatient services only and deliveries are not covered. If a pregnant woman wants to obtain continuous coverage, she must submit a regular application and will be given a 90-day extension while the full application is processed.

In our testing of case files we reviewed nine Presumptive Eligibility cases, including three cases where the applications were subsequently denied. One of the denials had income which was too high to qualify and two cases did not provide needed verifications. All three of these cases would likely have had some medical services covered before their cases were denied.

One-Time Encounter Enrollment or Retroactive Benefit Payments

Under a federal mandate the regular Medicaid and Expansion plans must allow for benefit payments up to three months prior to applying for coverage each time an eligible person applies. For the Share and Premium plans retroactive payments are not federally mandated and the Illinois Children's Health Insurance Program Act allows prior coverage only once. Public Aid limits one-time retroactive benefit payments to only two weeks prior to applying for coverage.

This retroactive coverage is what is referred to in one audit determination as one-time encounter enrollment. According to a KidCare official, its purpose was to preclude problems that happen with Medicaid when eligible persons allow coverage to lapse until they need medical treatment. According to administrative rules (89 Ill. Adm. Code 125.240(g)(3)), in the Share and Premium categories of KidCare prior coverage is available for only two weeks before application rather than the three months mandated for Medicaid and Expansion. This Illinois provision is intended to encourage families to maintain continuous insurance coverage.

In addition, for Share and Premium cases, this retroactive coverage is only available one time, the first time an applicant enrolls. This is true even if the applicant did not use prior coverage. The limitation on one-time encounter enrollments from the Children's Health Insurance Program Act states:

> (e) An eligible child may obtain immediate coverage under this Program only once during a medical visit. If coverage lapses, re-enrollment shall be completed in advance of the next covered medical visit and the first month's required premium shall be paid in advance of any covered medical visit (215 ILCS 106/25(e)).

In our testing of Share and Premium cases we identified six cases where the applicants requested prior coverage and that coverage was approved. We also reviewed one case where the applicant requested coverage but was denied because it was a second prior coverage application.

ENROLLMENT CASE FILE TESTING

We tested samples of cases from three different areas to evaluate the KidCare eligibility determination and redetermination processes. The first area was Share, Premium, and Rebate case files that are maintained by Public Aid. The second area was Assist Expansion case files which are maintained by the Department of Human Services. Samples were selected from all cases which were active in December 2001. In the third area, we tested a random sample of applications that had been denied from a list of cases provided by Public Aid. Files for these denied cases are maintained by the Department of Public Aid. The results of our case file testing are shown in the following sections, including, discussions on determining income for eligibility, application processing times, redetermination, completeness of applications, and denied applications.

Determining Income for Eligibility

In nine percent of the cases we tested (8 of 92), we identified exceptions related to determining income for KidCare eligibility. This included cases from Share, Premium, and Rebate (4) and in Expansion categories (4).

In KidCare Share, Premium, and Rebate we identified four cases where income had not been properly determined in the enrollment process (4 of 67). In all of those cases the error did not affect the children's eligibility or the category of KidCare to which they were assigned.

In Assist Expansion and Moms & Babies we identified four total exceptions (4 of 25). For one of those cases, income was not determined appropriately but it did not affect the client's eligibility. In the three remaining exceptions, cases lacked sufficient documentation to tell if income was properly determined. For these three cases, DHS was able to confirm, during our exit review process, applicant income for the time period from a verification source. That information, which would not have been available at the time of the determination, showed that enrollees would have been eligible.

Application Processing Time

KidCare cases that we tested were generally processed within the timeliness requirements. Federal rules require that applications be processed within 45 days if additional information is not needed from the applicant. When information is requested from the applicant the clock stops. The average application processing time for Share, Premium, and Rebate cases was 44 days for cases when information was requested. The same categories had an average processing time of 23 days for cases when information was not requested. None of the Share, Premium, and Rebate cases where no additional information was requested took more than 45 days. One Assist Expansion case where no additional information was requested exceeded the 45 day processing requirement and took 75 days to complete.

KIDCARE CASE FILES	
RECOMMENDATION 2	*The Departments of Public Aid and Human Services should assure that income is properly determined and appropriate documentation is included in case files.*
PUBLIC AID RESPONSE **DHS response next page**	Assuring accuracy in determining eligibility has always been a high priority for the Department. The current quality assurance methods including monthly reviews of caseworker actions, policy training and policy reminders will continue. The Department will also examine other methods to encourage and assure accuracy. No documentation errors were noted within the case files created by the Department of Public Aid.

HUMAN SERVICES RESPONSE	Accepted. The Department continues to ensure income is accurately determined and documented in the case files. It is important to note that income is properly determined in the majority of cases maintained in local offices and although policies and procedures are in place, the system is subject to human error.

Eligibility Redetermination

The KidCare eligibility redetermination process had some weaknesses as there were six cases (6 of 61) which were not redetermined when required and two cases where income was not determined properly. KidCare administrative rules require that eligibility be reviewed at least annually (89 Ill. Adm. Code 125.250). Failing to review eligibility can result in services being covered for children that do not qualify for KidCare.

Case Example One
In redetermining eligibility, income was determined by considering a mother's semi-monthly paychecks as bi-weekly. This increased the income to be compared to the standard.

In our testing of 92 KidCare case files, there were 61 cases where redetermination was required. In those cases, we identified 6 instances where redetermination was not performed at least every 12 months as required.

We also found two cases where income was not properly determined when each cases' eligibility was redetermined. One of the errors did not affect eligibility but in one instance the case was placed into the wrong KidCare category.

REDETERMINATION	
RECOMMENDATION 3	*The Departments of Public Aid and Human Services should assure that KidCare redeterminations are done when required and income is properly determined.*
PUBLIC AID RESPONSE	Over the past year the Department has worked with the Department of Human Services to significantly reduce the backlog of overdue redeterminations of Assist cases. Again, the Department has numerous measures in place to ensure the accuracy of income determinations but will continue to explore additional methods to improve this aspect.
HUMAN SERVICES RESPONSE	Accepted. The Department has made it a priority to ensure KidCare cases maintained in local offices are redetermined at least every 12 months and will reinforce policy regarding timely re-determinations. Considering the number of cases the Department administers, we continue to believe timely re-determinations are performed at an excellent rate.

Completeness of Applications

Less than half of KidCare applications in the case files that we reviewed were complete as initially submitted (48% or 33 of 69 case files with applications). We considered an application complete if it was filled out properly with all required elements and all required verifications were provided. If additional information was requested, the application was not considered complete. However, in all of these cases the required information was eventually provided and eligible family members were enrolled. Overall, based on our testing, 63 percent of KCAA initial applications were properly completed compared to 43 percent of mail-in applications.

Denied Cases

Failing to provide appropriate verifications with applications was also a problem with denied cases. It was the second most common reason that KidCare applicants were denied. For the 20 month period of data that we analyzed, from July 2000 to February 2002, 34 percent were denied because applicants failed to provide verifications with their application or in follow-up. Verifications can include items like documentation of income. These reasons for denial are captured in codes by Public Aid when the case is denied.

The most common reason that cases were denied, with 36 percent, was that the family was already enrolled in Medicaid or KidCare. The third most common reason was that the family did not qualify because their income was too high. Exhibit 2-3 summarizes reasons for denial and the percent of denials for FY2001 and FY2002 to February.

We tested a random sample of 15 denied cases and found no exceptions in our testing. We confirmed that the electronic codes assigned to denied cases were correct.

Exhibit 2-3
REASON FOR DENIALS
July 2000 to February 2002

Reason Denied	**Percent**
Already Active	36%
Failed to Provide Verifications	34%
Over Income	24%
Citizenship/Residency	2%
Other Reasons	4%
Total Denials	28,903

Source: Public Aid data summarized by OAG.

Chapter Three

MARKETING AND OUTREACH

CHAPTER CONCLUSIONS

Although Public Aid had no formally written or approved plan for marketing KidCare, over time a three-stage strategy developed: Overarching Outreach on a Statewide basis; Promotions at the Community Level; and KidCare Application Agents. Public Aid had 76 contracts and paid $9.5 million on outreach and advertising efforts for the KidCare program. Public Aid also paid $2.9 million to KidCare Application Agents (KCAAs) who are paid $50 for each complete approved application.

While Public Aid had structured measurable deliverables into most of the KidCare contracts (71 of 76), some contracts had weaknesses. In addition to the five contracts without measurable deliverables, three additional contracts had other weaknesses including not beginning to draft a contract until after all of the services had been performed. When contracts do not have measurable deliverables it is difficult to monitor them and difficult to determine if they were effective.

Public Aid had established a good system for monitoring KidCare marketing and outreach contracts but some improvement was still needed. Sixty-three of the 70 contracts for which we reviewed monitoring documentation had been well monitored by Public Aid. Of the 65 KidCare contracts which had measurable deliverables for which we reviewed contract monitoring files, 37 contracts met or substantially met deliverables and 28 did not meet all contractual deliverables.

While a visual analysis shows that there may be some relationship between KidCare enrollment and print and broadcast media buys, a statistical analysis shows a very weak relationship. Public Aid spent over $3.3 million on advertising production and television, radio, and print media buys.

OUTREACH AND ADVERTISING

Public Aid spent about $12.3 million on outreach and advertising efforts for KidCare. According to Public Aid officials, there was no formally written or approved plan for marketing KidCare. However, they said that a strategy for marketing and outreach developed over time into a three-level approach that is shown in Exhibit 3-1.

Exhibit 3-1
PUBLIC AID OUTREACH CATEGORIES AND OAG CATEGORIES FOR ANALYSIS

Public Aid Categories	OAG Analysis Categories
1. Overarching Outreach (Statewide)	1. Media Contracts Marketing Contracts Printing Contracts
2. Promotions at the Community Level	2. Hard to Reach Contracts Targeted Contracts Other Contracts
3. KidCare Application Agents	3. KidCare Application Agents' (KCAA) Agreements

Source: Public Aid categories and OAG analysis.

For our analysis we used the same three categories plus some subcategories. This included two types of contracts: overarching outreach and promotions at the community level. There were a total of 76 contracts for $9.5 million in these two categories. Most of the contracts (71 of 76) included measurable deliverables. Exhibit 3-2 shows the number of contracts and dollars associated with those contracts by category.

Exhibit 3-2
OUTREACH AND MARKETING CONTRACTS SUMMARIZED BY CATEGORY

Overarching:	#	Contract Amount	Total Paid
Media	11	$3,520,973	$3,382,464
Marketing	2	$121,000	$121,000
Printing	8	$334,021	$332,185
Community Level:			
Hard to Reach	29	$1,951,749	$1,951,754
Targeted	14	$536,582	$459,860
Other	12	$3,958,387	$3,298,280

Source: Public Aid data summarized by OAG.

All of these contracts are listed in Appendix D. That appendix details the type of contract, the contract term, total contract amount, total amount paid, whether the contract was done through an RFP process, whether the contract had measurable deliverables, whether the contractor met those deliverables and whether Public Aid adequately monitored the contract.

The third analytical category included agreements with KidCare Application Agents (KCAAs). These entities have agreements with Public Aid but not contracts. The KCAAs which were paid $1,000 or more are listed in Appendix E. KCAAs focused on helping clients become enrolled in the program and were paid $50 per complete and approved application. There were 662 KCAAs who were paid $2,889,800 from April 1999 to September 2001. Our categories are discussed in greater detail in the following sections.

Overarching Contracts

Overarching contracts included media, marketing, and printing. These included public awareness and general purpose contracts intended to explain the program. Public Aid awarded 2 marketing contracts, 11 media and advertising contracts and 8 printing contracts. These 21 contracts totaled $3.8 million. The media contracts included developing an overall plan, producing print, radio and television ads, and buying media time.

In the overarching category there were four contracts that did not include measurable deliverables. Two of these contracts were marketing contracts that included only very general contract provisions. Although both of these marketing contracts mentioned KidCare, they also included non-KidCare program responsibilities including the two major functions handled by the Department of Public Aid, Medicaid and child support.

In the media category of Overarching outreach there were also two contracts that did not include measurable deliverables. Both were with the same individual and both included only general requirements.

Overarching Contracts - Media, Marketing, and Printing:	
Marketing:	Robinson, Eric (2)
Media:	Foote, Cone & Belding
	Hill & Knowlton
	Komnenich Films, Inc.
	Murphy, Melissa (2)
	R.J. Dale Advertising & Public Relations
	Rossi Enterprises (2)
	SMY Media Inc.
	Window to the World Communications (2)
Printing:	Gorhams Inc.
	Grafitti Graphics
	Production Press (2)
	Schnepp & Barnes (3)
	Unistat
Numbers in (parentheses) indicate number of contracts.	
More details on these contracts are included in Appendix D.	

Outreach at the Community Level

For our analysis we considered two groups of contracts that Public Aid awarded through a Request for Proposal (RFP) process as promotions at the community level. The first round of contracts awarded were called Hard to Reach and included 29 contracts totaling almost $2 million. The second round of contracts included 14 contracts which were paid a total of $459,860 and were called Targeted. Although these contracts and some other KidCare contracts were awarded using an RFP process, KidCare legislation actually excluded all KidCare contracts from the requirements of the Procurement Code. This is discussed later in this chapter.

In addition, we considered 12 other contracts totaling $3.3 million in Outreach at the Community Level. We categorized these contracts as Other. Many of these were large contracts with organizations to do general outreach or special services like developing databases or reaching employers.

Hard to Reach Contracts

Public Aid awarded 29 contracts for Hard to Reach clients to various organizations including health departments, hospitals, consortiums, and other organizations. The original contract periods for all the Hard to Reach contracts were between October 1999 and August 2000. All but two of the contracts were extended for two months to October 2000. Public Aid paid a total of $1,951,754 on these contracts (an average of $67,302 per contract). All Hard to Reach contracts included measurable deliverables such as family contacts or promotional events.

Hard to Reach Contracts:

Access Community Health Network	Hygienic Institute
Adams County Mental Health Center	Illinois Health Education Consortium
Alivio Medical Center	Illinois Hunger Coalition
The Baby Fold	Kane County Health Department
Cass County Health Department	Metropolitan Family Services
Catholic Charities, Joliet Diocese	Pike County Health Department
CEFS Economic Opportunity Corp.	Polish American Association
Chicago Department of Health	The Resurrection Project
Children's Memorial	Roseland Christian Health Ministries
Chinese American Service League *	SEIU - Local 880
Coordinated Youth & Human Servs.	Sinai Health System
The Fellowship House	Southern IL Healthcare Foundation *
Hancock County Health Department	St. Clair County Health Department
Heartland Alliance for Human Needs *	Whiteside County Health Department
* First of two contracts.	Zhuravlick, Inc. *

More details on these contracts are included in Appendix D.

The purpose of these contracts was to educate and inform potential clients about the KidCare program. Public Aid sought contractors with the knowledge and expertise to reach these hard-to-reach populations. Because the hard-to-reach populations may not be reached by traditional mass media advertisements already being run, the Department wanted to engage the services of community based organizations, that the population trusted and was familiar with, to increase the name recognition and awareness of the program. Hard to Reach contract proposals indicated that some of the barriers to reaching these populations included things like language barriers.

Targeted Contracts

Public Aid awarded a second series of 14 contracts aimed at targeted populations with contract periods between November 1, 2000 and October 31, 2001. Public Aid paid a total of $459,860 on these contracts (an average of $32,847 per contract). One difference between these contracts and the Hard to Reach contracts is that the Targeted contracts required potential contractors to present more detail on the targeted population they intended to reach. The RFP required contractors to provide an estimated number of complete applications they would submit by type of SCHIP program (Rebate, Assist, Moms & Babies, Share, Premium). All of the Targeted contracts included measurable deliverables such as family contacts, applications, or promotional events. The 14 contracts submitted a total of 2,242 applications, made 24,907 contacts, held 489 events, and made 523 presentations for KidCare.

Targeted Contracts:

Catholic Health Partners, Programa CIELO
Chinese American Service League *
Chinese Mutual Aid
Family Christian Health Center
Heartland Alliance for Human Needs *
Illinois Caucus for Adolescent Health
Korean American Services
St. Anthony's Health Center
Sarah Bush Lincoln Health Center
Southern IL Healthcare Foundation *
United Way of Lake County
Vietnamese Association of Illinois
YWCA CCR&R
Zhuravlick, Inc. *

* Second of two contracts

More details on these contracts are included in Appendix D.

Other Contracts

In outreach at the community level, we also looked at other contracts that we categorized as Other. Most of these contracts were focused on getting families to enroll in the KidCare program. However, they did not fit the boiler plate contract format used for outreach at the community level. The largest contract was to distribute KidCare applications and informational leaflets on report card pick-up dates. The same contractor also provided assistance in properly completing applications and forwarding them to Public Aid.

Other Contracts:

Chicagoland Chamber of Commerce
Chicago Public Schools
Cook County Bureau of Health Services
Day Care Action Council
Farm Resource Center
Healthcare Consortium of Illinois
Health Smart Partners
The Pastors Network (2 contracts)
Power of Change Christian Center
Rainbow PUSH
Shattuck & Associates

More details on these contracts are included in Appendix D.

Several of these Other contracts were for outreach similar to the Targeted and Hard to Reach contracts awarded through RFPs. In fact, these contractors submitted a total of 7,555 applications to Public Aid for approval. These contracts were larger than the Targeted and Hard to Reach contracts awarded through RFPs. Public Aid paid out $3,298,280 on Other contracts. They had varying contract terms between October 1998 and December 2001.

In the Other contract area there was one contract without measurable deliverables. It was a large contract for $858,500 with the Chicago Public Schools. When contracts do not have measurable deliverables it is very difficult to determine whether a contract was successful and it is difficult to monitor the contract effectively.

CONTRACTS SHOULD INCLUDE MEASURABLE DELIVERABLES	
RECOMMENDATION 4	*The Department of Public Aid should continue its efforts to assure that all contracts include measurable deliverables.*
PUBLIC AID RESPONSE	Of the contracts noted in the findings, a majority were consultant contracts procuring technical assistance, talent and expertise which are difficult to measure. For future consultant contracts, the Department will work to develop measurable deliverables.

KidCare Application Agents

The KidCare program also uses KidCare Application Agents (KCAAs) to encourage enrollment in the program. The KCAAs are paid $50 for each complete and approved application they submit. Typical KCAAs are agencies that would likely deal with clients eligible for the KidCare program and included county health departments, hospitals, health care providers, and community organizations. From April 1999 to September 2001, there were a total of 662 KCAAs who were paid a total of $2,889,800. County health departments were important partners in enrolling children in the KidCare program making up 37 percent of total payments. County health departments were paid over a million dollars during this time period.

In order to become a KCAA an entity must be incorporated under the laws of Illinois, an Illinois subdivision of government, or an insurance company or insurance producer under the Illinois Insurance Code. KCAAs have four responsibilities under their agreements. They must:

- identify children and pregnant women potentially eligible for KidCare;
- assist the applicant in completing the application and mailing it to the KidCare unit and explain to the applicant that the KCAA is not responsible for determining eligibility;
- obtain all required documentation from the applicant; and
- obtain the signature of the applicant and the date signed on the completed application.

A complete application is defined as "…one that has been signed and dated by the potential applicant, has all relevant questions answered and has all required documentation attached, including verifications when forwarded to Public Aid." Applications are sent to the KidCare Bureau unless other additional benefits are being applied for in which case the applications are sent to the local DHS office. If an application is sent to a local DHS office the KCAA does not receive payment.

There were some instances where Public Aid made $25 payments to child care resource and referral agencies for completed applications. In these cases the applicant completed a shortened version of the KidCare application because their primary application was filed with another agency service (i.e. subsidized daycare), with similar required documentation and income thresholds. Also, if a KCAA submitted an application that was not complete and Public Aid had to do additional work, no payment was made.

CONTRACT MONITORING

Public Aid had established a good system for monitoring KidCare marketing and outreach contracts but some improvement was still needed. Most of the contracts that Public Aid used for KidCare marketing and outreach included measurable deliverables (71 of 76). However, five contracts did not include measurable deliverables and three of the contracts with deliverables had other contract weaknesses. Sixty-three of the 70 contracts for which we reviewed monitoring documentation had been well monitored by Public Aid. Exhibit 3-3 summarizes contracts with deliverables, whether those deliverables were met, and whether Public Aid monitored the contracts well.

Although only a few contracts did not have deliverables, a larger portion of the contracts that were used to promote KidCare did not meet the measurable deliverables established in their contracts. Twenty-eight of 65 contracts with deliverables (43%) that we evaluated did not meet their established deliverables. However, a portion of those contracts were the Targeted contracts which included specific deliverables on how many applications that they would submit. Only one of the 14 Targeted contracts achieved application deliverables but the contractors did generally provide Targeted outreach. Six of the contracts were terminated early by Public Aid for lack of performance.

Exhibit 3-3
OUTREACH AND MARKETING CONTRACTS SUMMARY OF RESULTS

	Number of Contracts	Included Deliverables	Met Deliverables	Well Monitored
Media	11	9	8	8
Marketing [1]	2	0	0	0
Printing [2]	2	2	2	2
Hard to Reach	29	29	21	29
Targeted	14	14	1	14
Other	12	11	5	10
Total	70	65	37	63

Note [1]: Marketing contracts are not for KidCare only.
Note [2]: Monitoring materials were reviewed for two of eight printing contracts.
Source: OAG analysis of Public Aid contracts and monitoring.

Overarching Contracts

There were 21 contracts that addressed the Statewide outreach campaign which includes marketing (2), media (11), and printing (8) contracts. Contractors were paid a total of $3.8

million. We reviewed contracts to determine where media efforts were focused. A section later in this chapter discusses the media contracts and compares media efforts and KidCare enrollment.

Neither of the two marketing contracts was well monitored. These two contracts were both with the same individual and neither contract included clear measurable deliverables. As noted earlier, these contracts were not exclusively for KidCare.

We reviewed the monitoring records for media contracts to evaluate the Department's monitoring. Our review of the monitoring files indicated that the Department's monitoring of media contracts generally was good. Each contract had a designated contract manager who acted as the liaison between the contractor and the Department. Periodically, the Department compared the contractor's deliverables with contract requirements. However, there were three media contracts which were not well monitored. Two of these three contracts also lacked measurable deliverables.

In addition, two contracts were awarded to one contractor that had significant contract weaknesses. The first contract, for $63,000, was for media buys and the contract consisted only of a list of the media buy times and channels. The second contract, for $35,000, was for promotion at a Chicago event. That agreement was approved without a contract when a Public Aid employee signed a memo sent from the promoter. The weakness was discovered in Public Aid's internal review process but not until after the promotion had happened. A contract was developed and signed which included the media buys and the promotion along with required contractual elements but not until after all of the services had been provided.

Hard to Reach Contracts

Public Aid's monitoring of Hard to Reach contracts was good. The 29 contracts awarded for Hard to Reach clients each included a requirement that provided effective evaluative information to Public Aid. The contracts required the contractors to complete and submit a self-assessment at the conclusion of the contract period. The contractor's assessment was to note which outreach activities were successful in obtaining completed KidCare applications and which were not and why. Some self-assessments indicated the KidCare program was harder to sell to some potential clients due the perception that it was a Medicaid program. Another noted barrier to enrollment was the embarrassment of discussing private issues about insurance in a public setting or among co-workers.

In addition to the final self-assessment, each contractor was required to submit a monthly report that outlined the number of families contacted, the number of applications completed, and a chronological listing of events that were conducted each month. The monthly reports also included a section for the contractor to explain why they had fallen short of the goal they set in their proposals. Our reviews of the monitoring files indicated that the contractors submitted all of their monthly reports, with one exception. Public Aid monitoring files showed they reviewed the reports regularly and used the information to communicate with the contractors on their progress.

According to contractor monthly reports, these 29 contracts resulted in 429,760 contacts with potential KidCare clients and 9,667 completed applications submitted to Public Aid for approval. Public Aid paid an average of $4.54 per contact on these contracts or $201.90 per completed application. However, the primary purpose of the Hard to Reach contracts was not submission of applications. These contracts were designed primarily to provide information to Hard to Reach potential clients about the KidCare program. The request for proposals asked that potential contractors estimate the number of contacts to be made and did not require an estimate of complete applications to be submitted.

Targeted Contracts

Public Aid's monitoring of the Targeted contracts was also good. Public Aid awarded a second series of 14 contracts aimed at targeted populations with contract periods between November 1, 2000 and October 31, 2001. Based on monitoring, Public Aid terminated the contracts of six organizations before the contract term was complete. A total of $459,860 was paid on these 14 contracts.

The RFP required contractors to provide an estimated number of complete applications they would submit by type of SCHIP program (Rebate, Assist, Moms & Babies, Share, Premium). The contractors were required to strive for an accuracy rate of at least 90% for submitted applications.

In addition, these contracts required submission of two self-assessments, one mid-way through the contract and one at the conclusion of the contract. The self-assessments required in these contracts were to be narratives which included a discussion of which outreach activities were successful in obtaining completed KidCare applications, which were not and why. We requested the self-assessments for these contracts and received all 14 of the 6-month assessments and 8 end of the contract assessments. There were six contracts that Public Aid terminated because they fell short of the targeted number of applications and, therefore, no final assessments were required for those contracts. These self-assessments indicated that one of the barriers to enrollment in the program was that potential enrollees were already enrolled in Medicaid and did not realize that KidCare would duplicate those services.

These contracts also required the contractors to submit monthly reports showing the number of families contacted, the number of applications completed and the reason, if applicable, for not reaching goals stated in the contract proposal. The monitoring files for these contracts indicated that the monthly reports were all submitted and reviewed regularly and were used to communicate concerns to the contractors. Our review of monitoring records indicated contractors submitted 2,242 applications, made 24,907 contacts, held 489 events, and made 523 presentations for KidCare. Public Aid paid an average of $18.46 per contact on these contracts or $205.11 per completed application.

Other Contracts

Our review of the monitoring on the 12 Other contracts indicated that Public Aid had established a system of monitoring the contractors' progress toward proposed goals and contract deliverables. We noted correspondence with contractors regarding different aspects of their contracts including: submission and reviews of monthly reports; invoice reconciliation and review; and fulfillment of contractual requirements.

This category included:

1. A contract with deliverables that was well monitored but had a contract weakness;

2. Contracts that did not meet established deliverables but were well monitored; and

3. A contract that met established deliverables but was not well monitored.

The contract with deliverables that was well monitored but had a contract weakness was with an entity that was paid $50,000 dollars up front and then was to be credited for each application submitted. The agreement was similar to agreements signed by KCAAs but included a $50,000 payment up front. No other KCAAs were paid any money up front. The contractor submitted some applications but had not earned $45,950 of the $50,000 by the end of the contract term. The contractor was paid the initial payment in May 2001 and paid back the unearned portion in March 2002 based on a letter and reconciliation from Public Aid.

An example of a contract that did not meet established deliverables but was well monitored was the Cook County Bureau of Health Services. They were to transmit to Public Aid 12,000 KidCare applications. They submitted less than 7,000 applications. Although they did not meet their goals, our review indicated that the contract was well monitored including evidence that achievement was being monitored and that meetings were held with the contractor.

The contractor that met established deliverables but was not well monitored was with an organization that met most of their substantive deliverables but had a monitoring file that showed little contact with the contractor.

KidCare Application Agents

Because KidCare Application Agents (KCAA) are paid only for complete and approved applications, assuring a relationship between payment and results is simple. Some KCAAs submitted many applications. Fourteen KCAAs had been paid for over 1,000 KidCare applications.

MEETING CONTRACT REQUIREMENTS

Of the 65 KidCare contracts which had measurable deliverables for which we reviewed contract monitoring files, 37 contracts met or substantially met deliverables and 28 did not meet all contractual deliverables. The major category with the largest proportion of unmet deliverables was for outreach at the community level through the Hard to Reach and Targeted contracts. In addition, as was mentioned earlier, there were five contracts without measurable criteria whose effectiveness could not be judged. The following paragraphs discuss the results in the individual categories.

Overarching Contracts

Of the 15 overarching contracts we reviewed there was one media contract that did not meet the criteria established in the contracts. In addition to the contractor that did not fulfill required deliverables, one met most substantive deliverables but not all; and one did not meet one deliverable but was not paid for the unmet requirement. The contractor with unmet deliverables was supposed to promote KidCare at a major event. Part of the promotion was to broadcast 20 thirty-second television ads and 25 radio spots promoting the event. The monitoring files contain no documentation for the 20 television ads.

Hard to Reach and Targeted Contracts

Of the 29 Hard to Reach contracts, eight did not reach contractual goals. For these contracts the main deliverable measure was the number of families contacted compared to the number projected. Eight did not meet original projections of family contacts.

For Targeted contracts the main deliverable measure was the number of applications submitted compared to the number projected. Also included were the number of events, group presentations, and contacts made. The Targeted contracts generally did not meet the completed application projections that were included in the contracts.

Other Contracts

Six of the twelve Other contracts did not meet deliverables. Two contractors did not meet the application submission requirement. One of those was supposed to submit 12,000 applications but only submitted 6,996. The second was the entity that was paid money up front for applications but did not meet its target. The four other contracts had specific requirements which were not met even though some of the contractual requirements were met. Unmet deliverables for the contractors included:

- Not designating sufficient staff, not holding a sponsored event, not maintaining all required documentation, and not including all required information in monthly reports.

- Not submitting a self-assessment of effectiveness the last month and not identifying the required hotline operator.

- Not logging calls to the Hotline as required.

CONTRACT MONITORING	
RECOMMENDATION 5	*The Department of Public Aid should continue its efforts to assure that all contractors' performance is well monitored and that deliverables specified in the contract are achieved.*
PUBLIC AID RESPONSE	The Department will continue efforts to assure contract performance is well measured. The Department has instituted several procedures to improve maintenance of contract files in a manner that will result in better retention of contract monitoring documents.

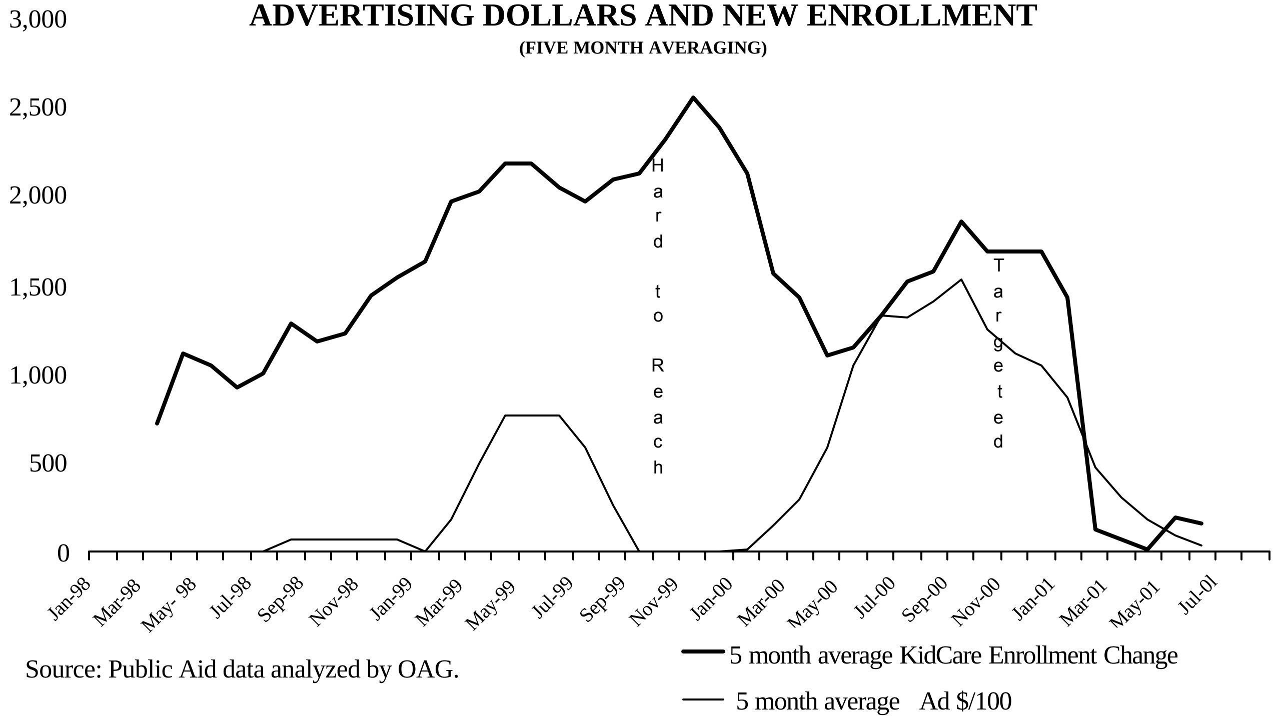
CONTRACTOR EFFECTIVENESS AND COST

The effectiveness of KidCare outreach efforts is difficult to determine; however, analysis can shed some light on how strategies have worked for the State. We will review the effectiveness of outreach efforts with a focus on the effectiveness of print and broadcast advertising and their relationship to enrollment. In addition, we will look at outreach efforts along with enrollment in the KidCare program.

Print and Broadcast Media Buys

There appears to be a visual relationship between KidCare enrollment and print and broadcast media buys. Public Aid spent over $3.3 million on advertising production and buys.

Exhibit 3-4
ADVERTISING DOLLARS AND NEW ENROLLMENT
(FIVE MONTH AVERAGING)



Source: Public Aid data analyzed by OAG.

The media buys were placed around the State, but 76 percent were in the Chicago area. To analyze media buys and enrollment, we graphed dollars of media buys by month along with the change in enrollment each month. To make the graphed lines less ragged we graphed a moving average of five months of enrollment change and five months of media buys. The resulting graph, shown in Exhibit 3-4, shows that media buys and enrollment seem to have a relationship. In addition to the enrollment and the advertising dollars, the chart also shows when the Hard to Reach and the Targeted contracts began. These contracts also could impact new enrollment. We also did a statistical analysis of monthly advertising dollars and monthly change in enrollment which showed a very weak relationship (R^2=.052). In case file testing that we did, 22 percent of applicants (18 of 81) who indicated where they heard about KidCare mentioned television, radio, or newspaper. Public Aid had not done any analysis of the effectiveness of its advertising efforts.

Costs and Enrollment

Using KidCare Application Agents appears to be an efficient way of bringing enrollees into the program. To analyze efficiency of outreach efforts on a dollars per application basis we looked at outreach efforts that tracked applications submitted. Several of the contract types lend themselves better to reviewing contract costs and enrollment. All of the Hard to Reach and Targeted contracts and all of the KCAA agreements specifically track application data related to the contract cost. In addition, five of the individual Other contracts tracked applications in their reports. Exhibit 3-5 below shows data on contract dollars along with applications, and contacts. Although contracts were not structured specifically to produce applications and enrollments, it is an important goal of the outreach and is presented for information.

Exhibit 3-5
STATISTICS BY CONTRACT TYPE

	Hard to Reach	Targeted	Other (3)	KCAAs
Dollars	$1,951,754	$459,860	$887,313	$2,889,800
Contracts/Agreements	29	14	5	662
$ per Contract/Agreement	$67,302	$32,847	$177,463	$4,365
Total Contacts	429,760	24,907	37,546	Not tracked
Applications	9,667(2)	2,242(1)	7,555(2)	88,685(4)
$ per Application	$202	$205	$117	$33

Notes:
(1) Total applications (1,815 approved).
(2) Whether the applications were approved was generally not tracked.
(3) Includes contracts where applications were tracked. The associated applications and contacts for those contracts are shown.
(4) Includes all applications including those for which follow-up was required and the KCAA was not paid (57,806 paid, 17,566 not paid, and 13,313 denied).

Source: Public Aid data summarized by OAG.

Geographical Distribution

Public Aid used advertising dollars fairly equally around the State. Exhibit 3-6 shows locations around the State where television, radio and print advertising was done. Symbols represent the type of advertising used, with the largest-sized symbols (by Chicago) representing expenditures of over $100,000, the medium-sized symbols representing expenditures of over $10,000, and the small-sized symbols representing less than $10,000. In addition to expenditures shown on the exhibit, Public Aid paid $38,250 for Statewide advertising and some outreach contractors did advertising. Also, some television markets, like Chicago, could reach larger geographic areas.

BID STATUS OF CONTRACTS

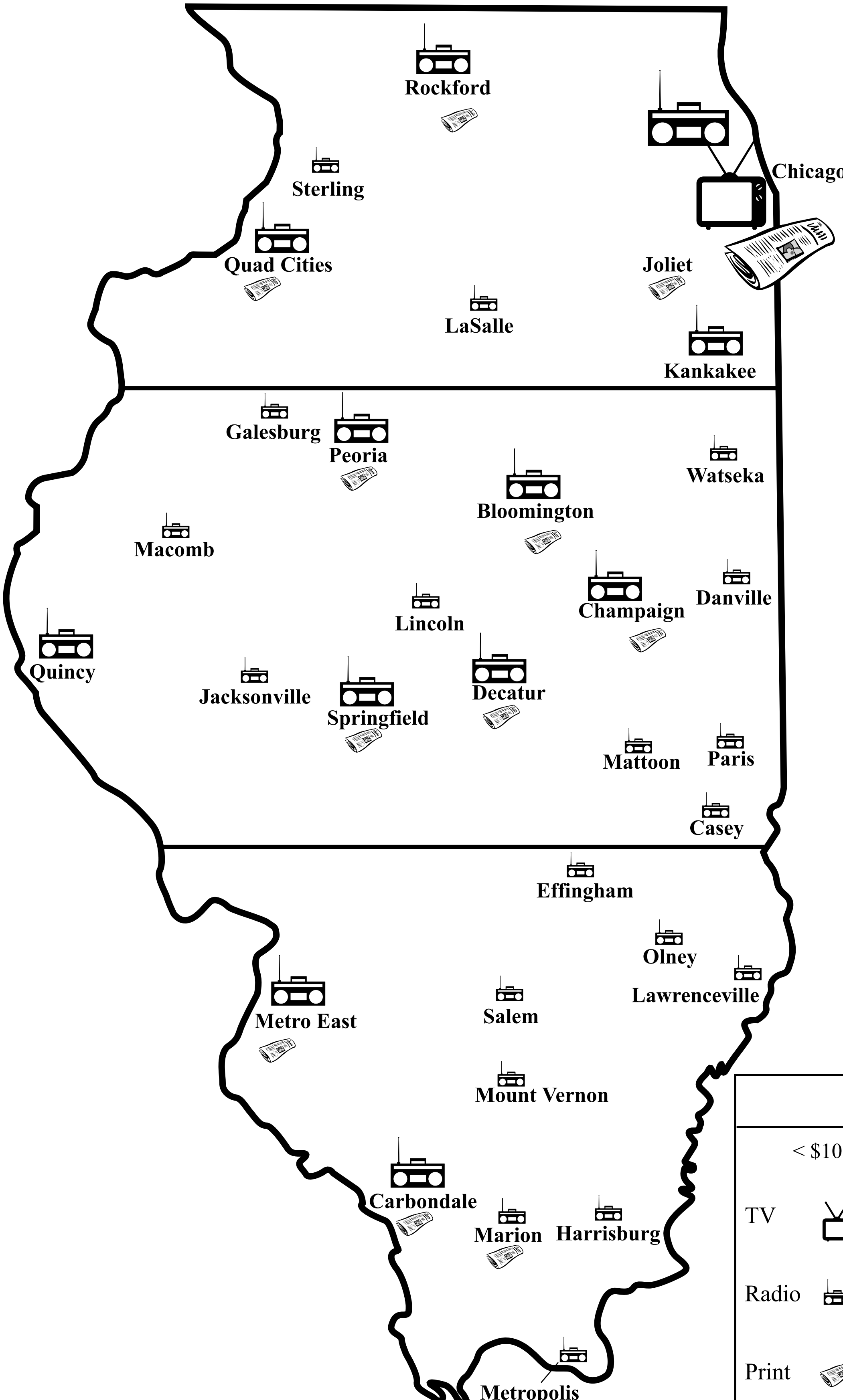
Contracts for KidCare are exempt from normal competitive processes established under the Illinois Procurement Code. According to Public Aid information, 45 of the 76 contracts used to do outreach services for the KidCare program were bid. This includes Hard to Reach contracts (29) and Targeted contracts (14) which were done through an RFP process plus one large contract which included many responsibilities relating to developing and carrying out outreach strategies, and a contract for marketing KidCare and other Public Aid programs.

The Illinois Procurement Code requires "…that the principles of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts by or for any State agency." However, the code provides exceptions for "purchase of care" and for contracts with other governments (30 ILCS 500/1-5,1-10). The State statute related to KidCare is the Children's Health Insurance Program Act, which states in Section 55:

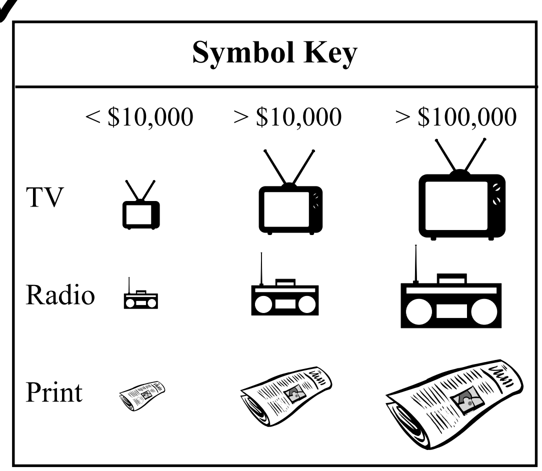
> Contracts with non-governmental bodies. All contracts with non-governmental bodies that are determined by the Department to be necessary for the implementation of this Act are deemed to be purchase of care as defined in the Illinois Procurement Code. (215 ILCS 106/55)

Because of this provision all contracts necessary for the implementation of the KidCare program were exempted from the Illinois Procurement Code.

Exhibit 3-6
KIDCARE ADVERTISING DOLLARS



Statewide	
TV	$406,112
Radio	$1,119,683
Print	$276,466
Chicago	
TV	$406,112
Radio	$737,650
Print	$223,832
Northern	
TV	$0
Radio	$76,793
Print	$18,366
Central	
TV	$0
Radio	$172,086
Print	$24,417
Metro East	
TV	$0
Radio	$46,958
Print	$2,606
Southern	
TV	$0
Radio	$47,947
Print	$7,244



Source: Public Aid expenditure data summarized by OAG.

Chapter Four

KIDCARE PROFILES

CHAPTER CONCLUSIONS

As directed by Senate Resolution 152, we prepared demographic profiles of KidCare enrollees. The largest racial categories in KidCare are Caucasian (45%), Hispanic (27%) and African-American (23%). The proportion of Caucasians generally increases as KidCare categories' income thresholds increase while the proportion of African-Americans declines. Fifty percent of KidCare enrollees are from two-parent households and the proportion of two-parent households increases with the increasing income thresholds of KidCare categories.

There were enrollees in the Moms & Babies category who were neither mothers nor babies. The Moms & Babies category is intended to cover pregnant women and babies for the first year of their lives. Because this category is not eligible for enhanced federal match it is to the State's advantage to have children moved into the appropriate children's category of KidCare as soon as possible.

The Assist Expansion category of KidCare included 365 adults when it should have included only children. These adults ranged in age from 19 to 22. The Departments of Public Aid and Human Services should assure that only children are enrolled in KidCare.

SOCIOECONOMIC/DEMOGRAPHIC PROFILES

Some characteristics of KidCare enrollees can be seen when they are analyzed based on the demographic codes that Public Aid captures in the electronic data from applications. For example, the largest racial categories are, in rank order, Caucasian (45%), followed by Hispanic (27%) and the third largest being African-American (23%). The codes for these three categories make up 95 percent of KidCare enrollment. Also, the proportion of Caucasians generally increases as KidCare categories' income thresholds increase while the proportion of African-Americans declines. A third characteristic is that 50 percent of enrolled children are from two-parent households. Again, the proportion of two-parent households increases with the income thresholds of KidCare categories. The following sections discuss the demographic breakdowns of KidCare enrollees including Race, Family Relationship, Age, Gender, Citizenship, Language, and Income.

Race

Based on Public Aid race codes, Caucasians make up the largest single group of all KidCare enrollees at 45 percent. As shown by Exhibit 4-1, Caucasians are followed by Hispanics and African-Americans at 27 percent and 23 percent respectively. The remaining five percent consists of other racial groups or enrollees without a race identified.

Exhibit 4-1
RACIAL BREAKDOWNS OF KIDCARE ENROLLEES BY CATEGORY
Data as of December 1, 2001

	KidCare Category					
Race	Assist Expansion	Share	Premium	Rebate	Moms & Babies	Enrollment Totals / % of Total
Caucasian	42%	44%	50%	65%	42%	34,201 / 45%
Hispanic	25%	29%	31%	16%	44%	20,631 / 27%
African-American	28%	19%	12%	11%	9%	17,207 / 23%
Other	4%	7%	8%	8%	5%	4,157 / 5%
Total Enrollment	47,691	7,264	8,681	5,668	6,892	76,196

Source: OAG analysis of Public Aid data.

KidCare program categories are income based and the racial breakdown of the categories varies among the KidCare enrollment categories. Sequentially, the children's enrollment categories of Assist Expansion, Share, and Premium each have a higher income threshold. An examination by category shows that as income increases the proportion of Caucasians generally increases and the proportion of African-American enrollees declines. Moms & Babies covers pregnant women up to the highest income of any categories but also covers the broadest category. That is because it covers all pregnancies from the Medicaid standard of 133 percent up to 200 percent of the federal poverty level. The income standards for categories are shown in Exhibit 4-2 as a percentage of the federal poverty level. Appendix F of this report includes the percentage by race of all KidCare enrollees by county. The appendix also has other KidCare specific and general children's data by county.

Exhibit 4-2
KIDCARE INCOME QUALIFICATION AS A PERCENT OF FEDERAL POVERTY LEVELS

Assist Expansion	#133%
Share	>133% to #150%
Premium	>150% to #185%
Rebate	>133% to #185%
Moms & Babies	> 133% to #200%

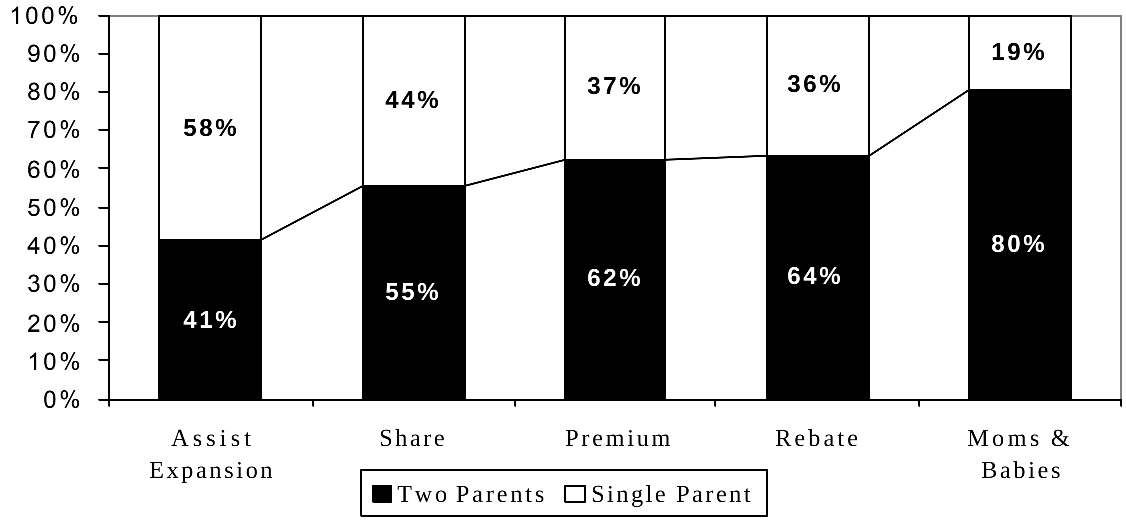
Source: Public Aid.

Family Relationships

Our analysis of Public Aid data revealed a clear pattern between KidCare categories and income and family relationships. For all KidCare categories combined there is a nearly equal distribution between single and two-parent households for KidCare enrollees. Children with two parents make up 50 percent while children with a single parent make up 49 percent. The remaining one percent are all other categories (like living with a relative). A closer examination of category specific data shows that as the income related to KidCare categories increases, the proportion of children from two-parent families also increases. Exhibit 4-3 shows this relationship graphically.

Exhibit 4-3

CHILDREN FROM ONE AND TWO PARENT FAMILIES BY KIDCARE CATEGORY



Source: Public Aid data compiled by OAG.

Age

As shown by Exhibit 4-4, 10-14 year olds make up the largest age group of KidCare enrollees at nearly one third of the KidCare population. The smallest age group for children is the very young, age 0-4. Adolescents 15-18 make up the next smallest group. Over 60 percent of the KidCare enrollee population falls within the two middle age brackets (5-9 and 10-14). Excluding the KidCare Assist Expansion and Moms & Babies categories, the average age of KidCare enrollees is relatively flat across category at about 8 years old. The Exhibit also shows average age by category.

Exhibit 4-4

AGE RANGE AND AVERAGE AGE OF KIDCARE ENROLLEES

	KidCare Category					
Age Range	Expansion	Share	Premium	Rebate	Moms & Babies	Total
0-4	0%	29%	28%	33%	0% & 98%	15%
5-9	32%	33%	31%	33%	0% & 0%	29%
10-14	40%	26%	28%	24%	0% & 0%	32%
15-18	27%	12%	13%	10%	8% & 1%	21%
Over 18	1%	0%	0%	0%	91% & 0%	3%
Average Age	*11.9*	*8.0*	*8.2*	*7.5*	*26.1 & 1.4*	
Total Enrolled	47,691	7,264	8,681	5,668	2,011 & 4,881	76,196

Source: OAG analysis of Public Aid data.

Moms & Babies

Adult enrollees are concentrated in the Moms & Babies category. However, we identified enrollees in the Moms & Babies category who were neither mothers nor babies. In fact, there were more than 2,000 enrollees classified as babies who were over the age of one. The Moms & Babies category is intended to cover pregnant women to 60 days past delivery and babies for the first year of their life. Because this category is not eligible for enhanced federal match it is to the State's advantage to have children moved into the appropriate children's category of KidCare as soon as possible. As discussed in Chapter One, medical expenditures for Moms & Babies are reimbursed by the federal government in the Medicaid Program at 50 percent. In the children's categories, medical expenditures are reimbursed under SCHIP at 65 percent. However, some one year olds coming from this category would not be eligible at all and some would be eligible for the State-only Rebate Program. Although it is difficult to estimate the financial effect of these transfers, several children with significant medical problems that are in the wrong category could have an effect. In our case file testing we reviewed two cases where babies who were initially in Moms & Babies category were not changed to a different category when they turned one year old.

Case Example Two
A child who was born in May 1998 was still in the Moms & Babies category when we reviewed the case file in April 2002.

CHILDREN IN MOMS & BABIES	
RECOMMENDATION 6	*The Department of Public Aid and the Department of Human Services should assure that children over age one are transferred out of Moms & Babies into the appropriate KidCare category.*
PUBLIC AID RESPONSE	This situation was intensified due to the volume of overdue KidCare Assist redeterminations at the time data was given to the auditors. Of the 4,300 infants currently enrolled in KidCare Moms & Babies Expansion, there are only 114 children (2.7%) ages 1 and older. These 114 will be placed in the appropriate KidCare program in the coming weeks. In addition, the Department has initiated implementation of a system edit to prevent future incidents.
HUMAN SERVICES RESPONSE	Accepted. At the direction of the Department of Public Aid, the Department of Human Services will implement system edits to automatically code children to the correct KidCare category when they turn age 1, 6 and 19. On-going redeterminations will continue to decrease the number of erroneously coded children until the edit is implemented.

Assist Expansion

We identified 365 adults in the Assist Expansion category which is intended for children only. Although most of the adults enrolled were age 19, there were people up to age 22. According to a Public Aid official, enrollees are supposed be automatically canceled within one month of their 19th birthday unless they are pregnant, disabled, or a parent. However, our analysis of data showed otherwise. Both State law and federal requirements prohibit most adults from being enrolled in the Medicaid program. Because Assist Expansion cases are maintained in local offices of the Department of Human Services, that agency is responsible for assuring that enrollees are still eligible for KidCare.

ADULTS SHOULD BE EXCLUDED FROM KIDCARE	
RECOMMENDATION 7	*The Department of Public Aid and the Department of Human Services should assure that when enrollees become too old to be enrolled that they are excluded from the KidCare program.*
PUBLIC AID RESPONSE	This situation was also intensified due to the volume of overdue KidCare Assist redeterminations that existed when the data was given to the auditors. Of the 46,000 persons enrolled in KidCare Assist Expansion, there are 225 adults (0.5%) whose eligibility must be reviewed. These adults will be placed in the appropriate Medicaid program in the coming weeks. In addition, the Department has initiated implementation of a system edit to prevent future incidents.
HUMAN SERVICES RESPONSE	Accepted. The Department of Human Services implemented a system edit at the direction of the Department of Public Aid on June 18, 2001 to prevent 19 year olds from continuing their KidCare eligibility unless they are pregnant, disabled or if the individual is a parent with income below the MANG standard. The system enhancements to be requested by DPA mentioned in the prior response will mitigate exceptions to the current edit as identified in the audit.

KidCare Assist Expansion enrollees as a group have a higher average age than enrollees in the other KidCare categories. The overall average age for children in the Assist Expansion category is 12 compared to around 8 for most other categories. This higher average age is because the expansion of eligibility affected more older children. That is because the eligibility standards before expansion covered young children (0-5) up to 133 percent of the federal poverty levels but covered older children (17 and 18) only to 50 percent of the same level. Children age 6-16 were covered to 100 percent. The new expansion standard covers all children up to 133 percent of the federal poverty level.

Gender

Each of the KidCare categories except Moms & Babies had a nearly even 50/50 split between males and females. In the Moms & Babies category, for pregnant women and newborns, enrollees are predominantly female (64 %).

Citizenship and Language

The vast majority of KidCare enrollees are U.S. citizens and speak English. Rebate enrollees had the highest percentage of citizens at 99 percent. Assist Expansion, Share and Premium had citizenship levels at 97, 96, and 95 percent respectively. Moms & Babies had the lowest percentage of citizens at 88 percent. Those enrollees who did not have U.S. citizenship still qualified for the KidCare program.

Among the KidCare categories there was very little variation in terms of Public Aid's language codes. All were at 100 percent of enrollees as English speaking or just fractions of a percent below 100 percent. However, Public Aid's language codes only apply to Hispanics and capture if they can read or speak English. Even considering this, the very small proportion of applicants speaking only Spanish seems low.

Income & Poverty

The income of KidCare enrollees falls in between the Illinois median household income and the Federal Poverty Level (FPL). According to U.S. Census Bureau data released in May 2002, Illinois median annual household income for 1999 was $46,590. Exhibit 4-5 shows the average income for KidCare enrollees by category with a projected yearly income. In terms of family size, upon which KidCare monthly income qualification levels are based, the average family unit size for each of the categories is four family members. This compares to the 2001 federal poverty level of $17,650 annually for a family of four.

Exhibit 4-5
AVERAGE KIDCARE ENROLLEE INCOME BY CATEGORY

KidCare Category	Average Income Monthly	Annualized Income
Assist Expansion	$1,624	$19,488
Share	$1,973	$23,676
Premium	$2,331	$27,972
Rebate	$2,415	$28,980
Moms & Babies	$2,124	$25,488

Source: OAG analysis of Public Aid data.

Poverty

Studies of poverty and health indicate that poor health status is linked to poverty. Geographically, southern Illinois counties tends to be the poorest region of the State. These same areas also have higher percentages of welfare income as a percentage of all income. For more detailed data by county, see Appendix F. In December of 2001, the U.S. Census Bureau published 1998 estimates of children in poverty. Illinois had 498,804 children age 0-17 in poverty. These are children below 100 percent of the FPL.

OVERALL HEALTH OF ENROLLED CHILDREN

Although it is difficult to compare the overall health of KidCare enrolled children with other children, there are some health measures that can be used to make an attempt. The Agency for Healthcare Research and Quality (AHRQ), the health services research arm of the U.S. Department of Health and Human Services, identified three conditions that they refer to as ambulatory care sensitive conditions or conditions for which hospitalization might be avoided through high quality primary care. Those three, pediatric asthma, pediatric gastroenteritis, and low birth weight for infants, are the three identified conditions related to the care of children. Public Aid reported KidCare statistics for asthma and gastroenteritis plus some non-KidCare specific data for very low birth weight.

Exhibit 4-6 **MEASURES OF OVERALL HEALTH**
<u>KidCare Specific Data</u>
Children immunized by age 2
EPSDT participation enrolled children
Asthma Indicators
Gastroenteritis Indicators
KidCare Enrolled Children
<u>KidCare and Medicaid Data</u>
Primary Health Provider
Preventive and Primary Care Office Visits
KidCare and Medicaid Enrolled children
# of children served
% of children served
Source: Public Aid data summarized by OAG.

Public Aid's Measures of Health

Public Aid has reported measures of the overall health of KidCare enrolled children to the federal Centers for Medicare and Medicaid Services. Some of the measures were specific to KidCare enrollees and some were for KidCare and Medicaid combined. In addition, Public Aid reported some Statewide statistics. Exhibit 4-6 shows the KidCare and Medicaid statistics that were health related.

These data elements have the potential for providing insight into potential positive effects of having children enrolled in a government run health care program like KidCare or Medicaid. Below we will discuss the KidCare specific indicators of EPSDT (Early and Periodic Screening, Diagnosis & Treatment), asthma, and gastroenteritis. After that we will discuss the broader indicators that look at combined KidCare and Medicaid data.

Asthma Data

Public Aid collected data on the number of KidCare and Medicaid enrollees with one of several asthma diagnoses and the number of children who were hospitalized for asthma with one of the same diagnoses. Asthma is an important medical condition to track. According to AHRQ, asthma is the most common chronic disease among U.S. children. However, asthma can be treated effectively and consistent treatment can minimize the need for emergency hospital care. AHRQ suggests that:

> Many hospitalizations might be avoided if children diagnosed with asthma received adequate primary care.

Although many factors affect asthma and its appropriate treatment, poor children are at especially high risk of hospitalization for asthma. Other factors noted by AHRQ as important are: race, ethnicity, insurance status, age and sex.

Exhibit 4-7
ASTHMA DATA
Calendar Year 2000

	Title XIX Expansion	Share and Premium	Illinois Children
Enrollment/Population	78,119	23,274	3,245,451(1)
Diagnosed	3,108	929	not available
% Diagnosed	3.98%	3.99%	not available
Hospitalized	157	55	8,925(2)
% of Diagnosed Hospitalized	5.05%	5.92%	not available
% of Population Hospitalized	.20%	.24%	.28%

Source: Expansion, Share and Premium data from Public Aid and other data from (1) Voices for Illinois Children, and (2)Illinois Health Care Cost Containment Council.

Public Aid gathered statistics that showed that just over five percent of asthma cases for Medicaid Expansion children were hospitalized in 2000 and just under six percent of asthma cases for KidCare (Title XXI) children were hospitalized. Exhibit 4-7 summarizes the asthma data from Public Aid and reports some other data on asthma from the Voices for Illinois Children and the Illinois Health Care Cost Containment Council. KidCare enrolled children in Expansion or Share and Premium have a slightly lower percentage of population hospitalized than Illinois children in general.

The Illinois Health Care Cost Containment Council also was able to provide data based on hospital discharge data that they maintain. Those data can be broken into various payor types and broken by the source of the hospital admission. Based on that, we were able to identify the percentage of hospitalizations by payor type which were from the hospital emergency room. Emergency room admissions, compared to admissions from a physician's referral, may be an indication that the person does not have appropriate primary health care services available to them. As the data in Exhibit 4-8 show, uninsured

Exhibit 4-8
PERCENT OF CHILDREN'S ASTHMA HOSPITALIZATIONS FROM THE EMERGENCY ROOM BY PAYMENT SOURCE
Calendar 1999 to 2001

Payment source:	1999	2000	2001
Private Insurance	57.8%	60.6%	60.0%
Medicaid	68.4%	67.3%	68.1%
Uninsured	70.6%	69.5%	68.5%

Source: Illinois Health Care Cost Containment Council data summarized by OAG.

children have the highest proportion of admissions through the emergency room and children with private insurance have the lowest proportion of hospital admissions through the emergency room.

Gastroenteritis Data

Public Aid also collected data on the number of KidCare and Medicaid enrollees with one of several gastroenteritis diagnoses and the number of children who were hospitalized with one of the same diagnoses. Like asthma, pediatric gastroenteritis is an important medical condition to track. According to AHRQ, acute gastroenteritis, manifested by vomiting and diarrhea, is a common illness among children, with roughly two episodes annually for each child less than 5 years of age in the United States. Exhibit 4-9 shows Public Aid's gastroenteritis data and shows that KidCare enrollees in Expansion and Share and Premium have a similar but slightly higher percentage of population hospitalized than the general population.

Exhibit 4-9
GASTROENTERITIS DATA
Calendar Year 2000

	Title XIX Expansion	Share and Premium	Illinois Children
Enrollment/ Population	78,119	23,274	3,245,451[(1)]
Diagnosed	2,402	889	not available
% Diagnosed	3.07%	3.82%	not available
Hospitalized	60	19	2,330[(2)]
% of Diagnosed Hospitalized	2.50%	2.14%	not available
% of Population Hospitalized	.08%	.08%	.07%

Source: Expansion, Share and Premium data from Public Aid and other data from (1) Voices for Illinois Children, and (2)Illinois Health Care Cost Containment Council.

The Illinois Health Care Cost Containment Council also provided data for children hospitalized for Gastroenteritis using the same diagnosis codes as Public Aid. Exhibit 4-10 shows the percent of children's hospitalizations by payor which came from the emergency room. In this case, children with private health insurance have the lowest incidence of admissions from the emergency room and children who are uninsured have the highest incidence. Most non-emergency room admissions come from a physician referral.

Exhibit 4-10
PERCENT OF CHILDREN'S GASTROENTERITIS HOSPITALIZATIONS FROM THE EMERGENCY ROOM BY PAYMENT SOURCE
Calendar 1999 to 2001

Payment Source:	1999	2000	2001
Private Insurance	44.3%	48.1%	50.5%
Medicaid	58.4%	63.9%	62.2%
Uninsured	58.7%	67.1%	65.7%

Source: Illinois Health Care Cost Containment Council data summarized by OAG.

Very Low Birth Weight

Public Aid officials did not have KidCare specific data on low or very low birth weight babies and did not have KidCare specific data on Infant Mortality. However, Public Aid reported data to federal authorities on teen mothers who delivered very low birth weight babies based on Illinois Department of Public Health data. That data segregated very low birth weight statistics between cases with WIC and/or case management and cases without WIC and/or case management.

Exhibit 4-11
PERCENTAGE OF TEEN MOTHERS WITH VERY LOW BIRTH WEIGHT DELIVERIES

Group	1998	1999
1. Teen mothers on Medicaid with very low birth weight babies without WIC or case management	4.21%	4.94%
2. Teen mothers on Medicaid with very low birth weight babies with WIC and/or case management	1.54%	1.54%
3. Teen mothers <u>not</u> on Medicaid with very low birth weight babies and not on case management or WIC or TANF.	2.67%	3.49%

Source: Illinois Departments of Public Health and Human Services data reported to federal officials by Public Aid.

Public Aid obtained the data from the Department of Human Services (DHS) which matches birth data from the Illinois Department of Public Health with data from a DHS computer system used by DHS and Public Aid. Exhibit 4-11 shows full explanations of the data that Public Aid reported to the federal CMS. The data show that being in WIC or case management seems to have a positive effect on the percentage of low birth weight deliveries, but do not show that being in KidCare or on Medicaid has a positive effect. Although the effect of WIC and case management may be encouraging, more KidCare specific data would be needed to draw conclusions.

Lead Poisoning

Public Aid had reported data to the federal government on lead poisoning from the Department of Public Health Lead Poisoning Prevention Program. They reported the percentage of children screened for lead poisoning which was above the established lead level. Exhibit 4-12 shows the data that Public Aid reported.

Exhibit 4-12
LEAD POISONING STATISTICS

Calendar Year	Percent with Lead Poisoning
1996	1.9%
1997	1.6%
1998	1.1%
1999	.9%
2000	.7%

Source: Data reported by Public Aid.

The Illinois Health Care Cost Containment Council provided data on children's hospitalizations for lead poisoning including characteristics noted before like payment source and source of admission. In addition they have other information related to the hospitalization and to where the patient was discharged. Exhibit 4-13 below summarizes the data that we requested and the Council provided. As the data show, Medicaid children generally have the highest proportion of hospital stays that began with an admission through the emergency room. For lead poisoning related stays, Medicaid generally has a higher proportion than uninsured.

Exhibit 4-13
LEAD POISONING HOSPITALIZATION DATA
Calendar Years 1999 to 2001

	Private Insurance	Medicaid	Uninsured	Other	Total
1999 Discharges	77	30	9	5	121
% from ER	18%	37%	11%	20%	22%
2000 Discharges	91	36	9	2	138
% from ER	13%	22%	22%	0%	16%
2001 Discharges	95	40	10	1	146
% from ER	19%	20%	10%	0%	19%

Source: Illinois Health Care Cost Containment Council data summarized by OAG.

Early and Periodic Screening, Diagnosis and Treatment

Public Aid had not met its goal for the proportion of young children receiving immunizations or its goal for well child visits. One of the measures of these screenings is the number or proportion of children who have received immunizations. Public Aid reported that 58 percent of all Medicaid (Title XIX) 2 year olds and 55 percent of KidCare (Title XXI) 2 year olds who had been active in Medicaid or KidCare for at least one year had received vaccinations. Public Aid fell significantly short of its goal of 80 percent for this measure but noted that some children may have received immunizations from another source that were not recorded in its systems (like local public health departments). By comparison, the Children's Defense Fund reported that of two year olds overall, 77.4 percent were immunized in Illinois and 78.6 percent were immunized in America in 1999.

A second EPSDT measure that Public Aid reported was the percentage of children who participated in EPSDT and received a well child visit. Public Aid had a goal of 80 percent of children but about 70 percent of Medicaid (Title XIX) children met this measure. Among KidCare (Title XXI) children, Public Aid was close to its goal with over 78 percent of children participating. Reported Public Aid data also indicated that, among Medicaid and KidCare children combined, only 53 percent of children were served during Fiscal Year 2000. This may demonstrate that having children enrolled in a health insurance type program is not the only barrier to children actually receiving appropriate medical services.

Other KidCare/Medicaid Specific Measures

Public Aid reported other data for KidCare and Medicaid children combined together without detail on the KidCare portion alone. Those statistics include data for calendar years 1999 and 2000 for primary care office visits and number of children served along with total enrolled children. Exhibit 4-14 breaks out those statistics. Most of these statistics do not have comparable statistics for insured or uninsured children. However, Public Aid's reported number of enrollees for 2000, 830,085, can be compared to U.S. Census figures for Illinois children of 3,245,451. Based on those statistics, 26 percent of Illinois children were enrolled in Medicaid or KidCare with 1.3 percent in the Medicaid Expansion, and .3 percent enrolled in Title XXI. Less than 1/10th of one percent of children were enrolled in the State-only Rebate program.

Exhibit 4-14
STATISTICS FOR MEDICAID/KIDCARE ENROLLED CHILDREN COMBINED

STATISTIC	1999	2000
# of preventive and primary care office visits	941,150	1,060,888
Preventive and primary care office visits per enrollee	1.2	1.3
# of children served	411,748	442,600
% of children served	52.35%	53.32%
Enrolled children	786,497	830,085

Source: Public Aid data and OAG analysis.

Primary Health Provider

Public Aid officials also reported that they had achieved their goal of having 60 percent of enrolled children with a primary health provider. This figure was based on combined Medicaid and KidCare enrollees. The count of children having a primary health care provider included the total number of children with certain primary care claims over a 3 year period. However, Public Aid data also indicated that only 53% of enrolled children were served in 2000.

APPENDICES

APPENDIX A
Senate Resolution 152

STATE OF ILLINOIS
NINETY-SECOND GENERAL ASSEMBLY
SENATE
Senate Resolution No. 152
Offered by Senator Dave Syverson

WHEREAS, Public Law 105-33 established in Subtitle J, the State Children's Health Insurance Program which provides federal funding to states to create programs to provide health insurance for low-income uninsured children; and

WHEREAS, Public Act 90-736, effective August 12, 1998, created the Illinois Children's Health Insurance Program Act and the Illinois program known as KidCare; and

WHEREAS, The Illinois Children's Health Insurance Program Act directs the Illinois Department of Public Aid to provide a program of health benefits and health insurance rebates for children in families with incomes at or below 185% of the federal poverty level and for pregnant women and their infants with incomes up to 200% of the federal poverty level; and

WHEREAS, Presently, there are 153,024 children and pregnant women enrolled in the children's health insurance program; and

WHEREAS, While the Illinois State Senate has demonstrated its commitment to the health of the children of the State of Illinois we have a further obligation to these same children to ensure the effectiveness and efficiency of the KidCare program; and

WHEREAS, Like young children, the KidCare program is due for a "check-up" and "physical evaluation"; therefore, be it

RESOLVED, BY THE SENATE OF THE NINETY-SECOND GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that pursuant to the Illinois State Auditing Act, the Illinois State Senate directs the Auditor General to conduct a program and management audit of the Illinois Department of Public Aid's KidCare program; and be it further

RESOLVED, That the Auditor General, in the course of the program and management audits, is directed to specifically audit and evaluate the following:

1. The Department of Public Aid's compliance with federal and State laws, the State of Illinois' Children's Health Insurance Plan submitted to the Health Care Finance Administration, and rules, regulations and policies adopted by the Department of Public Aid;

2. The Department of Public Aid's adherence to eligibility requirements, including evaluating the eligibility of enrolled children, whether or not the Department enrolls children for benefits prior to verification of eligibility for benefits, the Department's practice of allowing for onetime encounter enrollments, and the Department's adherence to income verification procedures;

3. The effectiveness of the Department's marketing strategies, including the effectiveness of bid and no-bid outreach contracts, broadcast and print advertising and other outreach advertising mechanisms targeted to increase enrollment in the program and the correlation between each strategy and the number of children enrolled that are attributed to that specific contract or strategy;

4. The compliance and effectiveness of all KidCare outreach contracts issued by the Department of Public Aid since the creation of the KidCare program including the amounts of the contracts, the bid status of the contracts, the terms of the contracts, the responsibilities outlined in the contracts, the fulfillment of the contractors' responsibilities, and verification of required contract documentation;

5. The application and enrollment process to ensure that the families of enrolled children have properly completed applications, which include all proof of information and documentation required pursuant to the KidCare application;

6. Summarize and compare the socio-economic profile of applicants and enrolled children and their families based on information required on the application form;

7. Evaluate the efficiency of the process by which monthly paper eligibility cards are issued to enrollees;

8. Evaluate the effectiveness and efficiency of the eligibility redetermination process;

9. Using recognized public health standards, compare the overall health of enrolled children with the overall health of (i) privately insured children of the same socio-economic status and (ii) uninsured children of the same socio-economic status; and be it further

RESOLVED, That the Auditor General shall report his findings to the Illinois General Assembly by July 1, 2002; and be it further

RESOLVED, That a suitable copy of this preamble and resolution be presented to the Auditor General and the Director of the Department of Public Aid.

Adopted by the Senate, May 24, 2001.

President of the Senate

Secretary of the Senate

APPENDIX B
Audit Sampling and Methodology

APPENDIX B
AUDIT SAMPLING AND METHODOLOGY

We obtained and reviewed information from the Department of Public Aid relating to the KidCare program. This included policies and procedures as well as documents requested and provided. We obtained electronic data from Public Aid which had all KidCare and Initiative cases which were active in December 2001. Based on that data we were able to analyze and identify some problems with enrollees. We also used that data to analyze the demographic characteristics of the KidCare enrollee population.

In conducting the audit, we reviewed federal laws and regulations applicable to SCHIP, State statutes, administrative rules, and Public Aid policies governing the operations of KidCare. We also reviewed the State's SCHIP plan which was submitted to the federal government. We reviewed compliance with laws, rules, policies, and the SCHIP plan to the extent necessary to meet the audit's objectives. Any instances of non-compliance we identified are noted as recommendations in this report. To identify how Illinois' program compares to other states, we reviewed research and studies. We also reviewed information and audits related to other states' SCHIP programs.

We reviewed the previous financial and compliance audits released by the Office of the Auditor General for Public Aid to identify any issues related to KidCare. We reviewed management controls relating to the audit objectives which were identified in Senate Resolution 152 (see Appendix A). This audit identified some weaknesses in those controls which are included as recommendations in this report. We also worked with other OAG auditors who were working on Public Aid's financial audit for Fiscal Year 2001 and OAG auditors who were working on the Statewide single audit. The SCHIP program was a major program for single audit testing purposes.

TESTING AND ANALYTICAL PROCEDURES

We tested random samples of cases from four different areas. The first area was Share, Premium, and Rebate case files that are maintained by Public Aid. This group of cases had a universe of 12,388 cases and we tested 67 cases which provided a confidence level of 90% with an error rate of .10. The second and third areas were Assist Expansion case files and Initiative case files. For Assist Expansion we reviewed a random sample of 25 cases and for Initiative we reviewed a random sample of 15 cases. Both types of case files are maintained by the Department of Human Services. All of these samples were selected from the universe of KidCare cases which were active in December of 2001. In addition, we tested a random sample of 15 applications that had been rejected from a list of rejections provided by Public Aid. Files for these cases are maintained by the Department of Public Aid.

To evaluate the compliance and effectiveness of KidCare outreach contracts issued by the Department of Public Aid we reviewed all of the contracts and related payments. We also reviewed contract monitoring files for 70 of the 76 total contracts. The monitoring files that we did not review were for printing. All of the monitoring files for more complex contracts related to marketing, media, and outreach efforts were reviewed.

To compare the overall health of enrolled children with the overall health of similar children we used data that Public Aid had reported to the federal Centers for Medicare and Medicaid Services to comparable data that we could identify. In particular we obtained data from the Illinois Health Care Cost Containment Council and verified data that was provided by the Department of Human Services.

We requested and the Council provided data in three different areas for calendar years 1999, 2000, and 2001. Information was provided on children with hospitalizations for asthma, for gastroenteritis, and for lead poisoning. The Council provided data on hospital discharges by payment source including Medicaid, commercial, and self pay. The data were also broken down by the source of the hospital admission including whether the patient came from an emergency room or from a physician referral.

Asthma and gastroenteritis discharges were identified based on specific primary diagnosis codes that Public Aid had used in its analysis of health status of KidCare enrollees. Lead poisoning discharges were based on primary or secondary diagnosis codes that Council officials suggested.

APPENDIX C
KidCare Application

KidCare™

Keeping your kids healthy

Health Insurance for Illinois Children

George H. Ryan, Governor

KC 2378KC (R-4-02) IL478-2437

KidCare Plans

KidCare is a health insurance program for Illinois children 18 or younger and pregnant women that helps to pay for the health care they need. The plan you get depends on your income. For example, a family of four may get KidCare if their income is about $34,000 or less per year. Only children and pregnant women may apply on this application for health benefits.

KIDCARE REBATE PLAN

If you already have health insurance or you can get it through your employer or you want to buy other private health insurance for your children, the KidCare Rebate plan may be the plan for your family. KidCare Rebate can pay you for some or all of the premiums you pay for your children's health insurance. With KidCare Rebate, your children could enroll in the same health plan, receive the same benefits and use the same doctors as you do. *Families who get KidCare Assist can't get KidCare Rebate. For example, a family of four may get KidCare Assist if their income is about $24,000 or less per year. See KidCare Assist below.*

To apply for KidCare Rebate, fill out the application and complete the Rebate Form on page 5. KidCare workers will match your children's plan to your income.

KIDCARE SHARE PLAN and KIDCARE PREMIUM PLAN

If you can't or don't want to get health insurance for your children through your employer or other private plan, your children can be covered by the KidCare Share or KidCare Premium plans. The plan your children get will depend on your income. These plans are run by the state and cover most medical care.

Under KidCare Share, you will usually make a $2.00 co-payment each time your children visit a doctor, clinic or hospital or get a prescription filled.

Under KidCare Premium, you will usually pay a $3.00 or $5.00 co-payment for medical visits and prescriptions and $25.00 for non-emergency care received in an emergency room. You will also pay a low premium each month of $15 for one child, $25 for two children or $30 for three or more children. If you don't pay your monthly premium, your children's coverage will be cancelled. If this happens, you will have to reapply and your coverage can't begin for at least three months.

With KidCare Share and KidCare Premium, well-child visits and shots are offered at no cost to your family.

KIDCARE ASSIST PLAN

KidCare Assist is run by the state and covers most of your children's health care including well-child visits and shots at no cost to your family.

KIDCARE MOMS & BABIES PLAN

Pregnant women can apply for the KidCare Moms & Babies plan. This plan is run by the state and covers health care including prenatal visits, delivery services, well-baby care and shots for pregnant women and their babies up to one year of age at no cost to their family.

To apply for KidCare Share, KidCare Premium, KidCare Assist or KidCare Moms & Babies, fill out the application. KidCare workers will match your children's plan to your income.

If your children have one of the following:

- CHILD SUPPORT OR SOCIAL SECURITY INCOME
- A STEPPARENT IN THE HOME
- HIGH MEDICAL BILLS

It may be better for you to apply at your local Department of Human Services (DHS) office. For more information, call toll-free 1-866-4-OUR-KIDS (1-866-468-7543) (TTY: 1-877-204-1012 for persons using a teletypewriter).

KidCare Application

Please print in ink or type. If more space is needed to answer any question, please attach an extra sheet.

Applicant's Last Name ______________________________ First Name ______________________________
(The applicant is usually the person filling out this form; a child's parent, guardian or relative or a pregnant woman.)

Birth Date (month, day, year) ____________________ Social Security Number ***(optional)*** ____________________

Address ______________________ City ________________ State ___ Zip Code _______ County __________

Home Phone (   ) ______________________ Work Phone (   ) ______________________

If no phone, name a contact person: Name ______________________________ Phone (   ) ______________

Language Preference of Applicant: ❑ English ❑ Spanish ❑ Other (Specify) ____________________

Race or Ethnic Group: *(This information is optional. It will not affect your eligibility.)*
❑ White ❑ Black ❑ Hispanic ❑ American Indian or Alaska Native ❑ Asian or Pacific Islander ❑ Other __________

Complete the following information for all CHILDREN AND PREGNANT WOMEN living with you who want health benefits. (If you need more space, attach an extra sheet.)

"Person" refers to each child or pregnant woman	Person #1	Person #2	Person #3
1. Name (last, first)			
2. Sex	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
3. Birth Date	month/day/year	month/day/year	month/day/year
4. Social Security Number (optional for pregnant women)			
5. Relationship to Applicant (son, daughter, self, etc.)			
6. Is this person an American Indian or Alaska Native?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
7. U.S. Citizen? If no, write alien registration number and attach documentation. No number or documentation is needed for pregnant women.	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
8. For children, write: a. mother's full name b. father's full name For pregnant women 18 or older, write N/A	a. b.	a. b.	a. b.
9. Has this child or pregnant woman received any medical care in the past 3 months you want the State to pay for? If yes, which months?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
10. Is this person pregnant?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

"Person" refers to each child or pregnant woman	Person #1	Person #2	Person #3
11. Is this child or pregnant woman covered by health or hospital insurance (including Medicare) now or in the last three months? If yes, complete the following.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
a. Date Coverage Began	a.	a.	a.
b. Date Coverage Ended	b.	b.	b.
c. Insurance Company	c.	c.	c.
d. Name of Policyholder	d.	d.	d.
e. Policyholder's SSN (optional)	e.	e.	e.
f. Employer Name and Phone Number	f.	f.	f.
g. Policy Number and Group Number	g.	g.	g.
h. If the insurance was cancelled, why?	h.	h.	h.

12. How many people live with you? _______ Only include yourself, your spouse, children applying for KidCare and their brothers and sisters 18 or younger. Also include the parents of children and pregnant women 18 or younger who are not applying and who live with you. Do not include yourself or your spouse if you are applying for your grandchild.

13. Complete the information below for the people you counted in #12 above who are **not** applying for KidCare. Do not complete the information for yourself if you are the "Applicant" on page 1. (Attach an extra sheet if necessary.)

Name______________________________ Social Security Number (optional)__________________

Birth Date (month/day/year) ______________ Relationship to Applicant ______________________

Name______________________________ Social Security Number (optional)__________________

Birth Date (month/day/year) ______________ Relationship to Applicant ______________________

14. Is any parent, stepparent, spouse or pregnant woman named on page 1 of this form or in #13 above currently employed?
☐ Yes ☐ No If yes, complete the following **and attach proof** (see page 4). Is anyone self-employed? ☐ Yes ☐ No

Name of Person ______________________ Employer ______________________

Employer Address ______________________________ Employer Phone ______________

Number of Hours Worked Weekly__________ Amount Paid (including tips) before taxes $__________ How Often Paid ________

Name of Person ______________________ Employer ______________________

Employer Address ______________________________ Employer Phone ______________

Number of Hours Worked Weekly__________ Amount Paid (including tips) before taxes $__________ How Often Paid ________

15. Is any child, parent, stepparent, spouse or pregnant woman named on page 1 of this form or in #13 above RECEIVING 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, complete the following **and attach proof** (see page 4).

Name of Person__________________ Source __________________ Monthly Amount $__________

Name of Person__________________ Source __________________ Monthly Amount $__________

If income is from rental property, is the person receiving the income also the property manager? ☐ Yes ☐ No

16. Is any parent, stepparent, spouse or pregnant woman named on page 1 of this form or in #13 above PAYING child support or spousal support? ☐ Yes ☐ No If yes, complete the following **and attach proof** (see page 4).

Name of Person ______________________________ Monthly Amount $______________

Name of Person ______________________________ Monthly Amount $______________

17. Is any parent, stepparent, spouse or pregnant woman named on page 1 of this form or in #13 above PAYING for day care so they can work? ☐ Yes ☐ No If yes, complete the following **and attach proof** (see page 4).

Name of Child(ren) in Day Care______________________ Name of Care Giver______________

Person Paying Day Care______________________________ Monthly Amount $______________

Relationship of Care Giver to Child (if any) ______________________

Read and Sign:

- I understand that if the children I am applying for are approved for KidCare Share or KidCare Premium, I am responsible for paying the appropriate premiums and co-payments.
- I understand that if the children I am applying for are approved for KidCare Rebate, the State of Illinois is not responsible for additional premiums, deductibles or co-payments required by the employer or private health insurance policy.
- If I am approved for KidCare Assist or KidCare Moms & Babies, both also called medical assistance, I give my right to collect medical support payments to the State of Illinois. I also must cooperate with the State of Illinois to establish paternity of (if necessary) and obtain medical support payments for members of my family receiving KidCare Assist or KidCare Moms & Babies, unless I am declared exempt for a good cause. I understand that failure to cooperate will not affect any child's eligibility for KidCare.
- If my application is approved, I give the State of Illinois the right to recover, under the terms of any private or public health care coverage, any amount for which I or a member of my household approved for benefits may be eligible.
- I authorize the State of Illinois to release information concerning medical services I or my dependents have received through any program paid for by KidCare or medical assistance for any purpose authorized by law.
- Officials with responsibilities for the health benefits program for which I or the members of my household have applied may verify all information on this form. I understand that I must cooperate in these efforts to verify information. I understand that verification may occur through electronic means. I understand this does not apply to immigration status for any person for whom I left question #7 blank.
- I agree to inform KidCare within 10 days if I move or if anyone who gets KidCare moves out of Illinois, dies, or goes to jail or prison.
- I understand that anyone who knowingly misuses the health benefits card issued by the State of Illinois may be committing a crime.

I understand that if I have given false information or intentionally failed to disclose information for this application, I may be subject to criminal prosecution, civil action or both. I certify under penalty of perjury that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature ______________________________ Date ____________
(If unable to sign, make a mark and have a witness sign next to your mark.)

If someone completed this application on behalf of the Applicant, they must sign and complete the information below.

Signature ______________________________ Date ____________

Name (print) ______________________ Relationship to Applicant ____________

Address ______________ City ____________ State ___ Zip Code ______ Phone ________

It would be helpful to know where you heard about KidCare. Please check all boxes that apply.

☐ Radio Ad	☐ Doctor's Office	☐ School	☐ Employer
☐ TV Ad	☐ Clinic	☐ Government Office/Agency	☐ Labor Union
☐ Newspaper Ad or Story	☐ Hospital	☐ Mail Sent to My Home	☐ Internet/Website
☐ Billboard or Bus Poster	☐ WIC site	☐ Friend or Relative	☐ Other ____________

Please keep for your records. If your children have **CHILD SUPPORT OR SOCIAL SECURITY INCOME** or if there is **A STEPPARENT IN THE HOME** or if your children have **HIGH MEDICAL BILLS**, it may be better for you to apply at your local Department of Human Services (DHS) office. For more information, call toll-free 1-866-4-OUR-KIDS (1-866-468-7543) (TTY: 1-877-204-1012 for persons using a teletypewriter).

If you are not satisfied with the actions taken on this application, you have the right to a fair hearing. You can ask for a fair hearing by writing your local office, or by writing DPA Fair Hearings, 401 South Clinton Street, 6th Floor, Chicago, IL 60607 or by calling 1-800-435-0774 (TTY: 1-877-734-7429 for persons using a teletypewriter). **Use these numbers only to file an appeal.** All other calls and inquires should be directed to the numbers at the bottom of this page.

KidCare is 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.

Important Information to Include with Your KidCare Application

To get KidCare health insurance, you must provide proof for some of the information you give. Below are descriptions of the documents to send in with your application. You must send all that apply to you.

❒ **PROOF OF INCOME: Send proof of each type of income you list on the application. This may include:**

- Copies of pay stubs for income received and proof of tips received during the last month. If anyone is self-employed, provide detailed business records that include income and expenses for the last month.
- Copies of checks for the last month or award letters for Unemployment Benefits, Social Security Benefits and Veteran's Benefits.
- Copies of checks for the last month for child support or spousal support received.
- Proof of other income including income from trusts, pensions, rental property, etc. Also send proof of expenses tied to rental income.

If you list more than one type of income on the application, send proof of each type.

❒ **PROOF OF PAYMENT for child support or spousal support you paid:** To get credit for child support or spousal support payments listed on the application, you must send proof of those payments made in the last month.

❒ **PROOF OF PAYMENT for day care expenses you paid:** To get credit for day care expenses you pay so you can work, send proof of payments made in the last month.

❒ **IMMIGRATION DOCUMENTS for non-citizens: NON-CITIZENS WHO ARE PREGNANT ARE NOT REQUIRED TO PROVIDE PROOF OF IMMIGRATION STATUS FOR THEMSELVES.** If you are applying for anyone who is not a citizen, the State of Illinois will contact the U.S. Immigration and Naturalization Service (INS) to verify their legal immigration status if you write an alien registration number on the application.

If you do not want to have the immigration status of a person verified, leave question #7 blank for that person. Unless the State can verify their immigration status, non-citizen children may only be eligible for emergency medical services. **ADULTS DO NOT NEED TO PROVIDE PROOF OF LEGAL IMMIGRATION STATUS FOR THEMSELVES.**

Providing an alien registration number for anyone in question #7 means you will need to supply proof of their status, such as copies of any of the following:

- **Alien Registration Receipt Card/Permanent Resident Card/Green Card (INS AR-3A)**
- **Passport with the following stamps or attachments:** Arrival-Departure Record including the stamp showing status (I-94), or Resident Alien Form (I-551) or Temporary Resident Card (I-688)
- **A court-ordered notice for Asylees**
- **Other proof of lawful immigration status**

Non-citizens who are related to active or honorably discharged members of the U.S. armed services may qualify to receive KidCare by sending proof of such status. This includes spouses and unmarried dependent children.

❒ **PROOF OF PREGNANCY:** If anyone you list on the application is pregnant, send a signed statement from her doctor or health clinic which includes the date she is expected to deliver and the number of babies expected.

❒ **PROOF OF APPLICATION for a Social Security Number:** If anyone you are applying for does not have a Social Security Number, you must send a signed statement from the Social Security Administration that application has been made.

NOTE: Pregnant women are not required to send proof of a Social Security Number.

Mail your completed application with copies of Important Information (see above) to:

KIDCARE UNIT
P.O. BOX 19122
SPRINGFIELD, IL 62794-9122

***REMEMBER: If your address or other information changes, please notify the KidCare Unit by calling toll-free 1-866-4-OUR-KIDS (1-866-468-7543) (TTY: 1-877-204-1012 for persons using a teletypewriter).**

KidCare Rebate Form

Complete this form if your children are already covered by health insurance by your employer or other private health insurance plan or if you have arranged for health insurance for them to begin soon. Follow the steps below:

1) Complete Part A;
2) Have the policyholder's employer or personal insurance agent complete Part B and return it to you; and
3) Attach this completed form to the completed KidCare Application prior to mailing.

Part A - Employee/Policyholder Section - *To be completed by the employee/policyholder.*

Employee/Policyholder's Last Name____________________ First Name____________

Address ____________________ City____________ State___ Zip______

Social Security Number____________________ Phone ( ) ____________

(SSN is required in order for the state to make payments to the policyholder.)

Name(s) of children for whom you are applying for KidCare Rebate: ____________________

Employee/Policyholder Attestation and Signature - I agree to notify the KidCare Hotline immediately at toll-free 1-866-4-OUR-KIDS (1-866-468-7543) (TTY: 1-877-204-1012) if the insurance is terminated, persons are added to or deleted from the policy or the coverage or policyholder changes. I authorize my employer, plan administrator and insurance company to provide the information requested in Part B below for the purpose of determining eligibility for KidCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below at any time during my participation in KidCare.

Signature of Employee/Policyholder ____________________

Part B - Employer/Insurance Agent Section - *To be completed by the employer or by the policyholder's insurance agent if the policy is not provided through an employer.*

Note to Employer/Insurance Agent: The above named employee/policyholder is applying for a program called KidCare that may help cover the cost of their children's health insurance premiums. Please assist them by completing the information below about their coverage and returning the form to the employee/policyholder as soon as possible. (As used below, employee applies to an employee or private policyholder.)

Employer (if employer policy) ____________________

Employer Address ____________________ City____________ State___ Zip______

Person completing this form ____________ Phone ( ) ________ Fax ( ) ________

Insurance Company____________ Policy Number________ Group Number________

Check which of the following benefits are covered: ☐ Physician Services ☐ Hospital Inpatient Services

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/Begins________

Date of Next Scheduled Change in Premium ____________

Authorized Signature of Employer/Agent____________________ Date________

KidCare™

Keeping your kids healthy

For more information or assistance in completing this application call:

toll-free 1-866-4-OUR-KIDS

(1-866-468-7543)

(TTY: 1-877-204-1012 for persons using a teletypewriter)

George H. Ryan

Governor

KidCare Website: www.kidcareillinois.com

APPENDIX D
Summary of KidCare Contracts

Appendix D

SUMMARY OF KIDCARE CONTRACTS

Contractor	Type	Contract Term	Contract Amount	Total Paid	RFP Process?	Measurable Deliverables?	Deliverables Documented?	Good Contract Monitoring?
Foote, Cone & Belding (ICG)	Media	07/20/98 to 07/19/99	$1,090,645	$981,275	Y	Y	Y	Y
SMY Media Inc	Media	06/13/00 to 09/30/00	$500,000	$496,365	N	Y	Y	Y
Rossi Enterprises	Media	11/01/99 to 06/30/00	$364,650	$364,650	N	Y	Y	Y
Rossi Enterprises	Media	08/01/00 to 06/30/01	$492,835	$486,378	N	Y	Y	Y
R.J.Dale Advertising & Public Relations	Media	08/01/00 to 10/31/00	$475,000	$469,678	N	Y	Y (1)	Y
Komnenich Films, Inc.	Media	07/01/00 to 01/30/01	$400,000	$387,400	N	Y	Y (2)	Y
Hill & Knowlton	Media	07/01/99 to 06/30/00	$70,593	$70,593	N	Y	Y	Y
Window to the World Communications	Media	04/01/99 to 06/30/99	$63,000	$63,000	N	Y	Y	Y
Window to the World Communications	Media	07/01/00 to 07/10/00	35,000	$35,000	N	Y	N	N
Murphy, Melissa	Media	06/01/00 to 09/01/00	$11,250	$11,250	N	N	N/A	N
Murphy, Melissa	Media	10/15/00 to 01/14/01	$18,000	$16,875	N	N	N/A	N
Robinson, Eric (4)	Marketing	02/01/00 to 06/30/00	$25,000	$25,000	N	N	N/A	N
Robinson, Eric (4)	Marketing	08/08/00 to 08/07/01	$96,000	$96,000	Y	N	N/A	N
Chicago Public Schools	Other	10/01/98 to 12/31/99	$858,500	$858,500	N	N	N/A	N
Rainbow PUSH	Other	07/01/00 to 06/30/01	$763,200	$545,110	N	Y	N	Y
Cook County Bureau of Health Services	Other	08/01/00 to 07/31/01	$749,849	$618,498	N	Y	N	Y

Source: Public Aid Data Summarized by OAG.

Appendix D

SUMMARY OF KIDCARE CONTRACTS

Contractor	Type	Contract Term	Contract Amount	Total Paid	RFP Process?	Measurable Deliverables?	Deliverables Documented?	Good Contract Monitoring?
Health Smart Partners	Other	11/01/00 to 01/31/01	$512,281	$457,218	N	Y	Y(1)	Y
Shattuck & Associates	Other	06/01/99 to 06/30/01	$286,036	$230,288	N	Y	Y(1)	N
Farm Resource Center	Other	01/01/00 to 12/31/00	$248,781	$228,765	N	Y	N	Y
Chicagoland Chamber of Commerce	Other	06/01/99 to 06/30/01	$233,740	$153,418	N	Y	N	Y
Healthcare Consortium of Illinois	Other	11/01/99 to 10/31/00	$155,000	$146,433	N	Y	Y	Y
Day Care Action Council	Other	01/01/01 to 12/31/01	$95,000	$4,050	N	Y	N(3)	Y
The Pastors Network	Other	04/15/99 to 12/31/99	$20,000	$20,000	N	Y	N	Y
The Pastors Network	Other	08/01/00 to 07/31/01	$18,000	$18,000	N	Y	Y(1)	Y
Power of Change Christian Center	Other	08/01/00 to 07/31/01	$18,000	$18,000	N	Y	Y(1)	Y
Alivio Medical Center	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,728	Y	Y	Y	Y
Illinois Hunger Coalition	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,728	Y	Y	Y	Y
Access Community Health Network	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
Catholic Charities, Joliet Diocese	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	N	Y
Chicago Department of Health	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
Children's Memorial	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	N	Y
Hygienic Institute	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y

Source: Public Aid Data Summarized by OAG.

Appendix D

SUMMARY OF KIDCARE CONTRACTS

Contractor	Type	Contract Term	Contract Amount	Total Paid	RFP Process?	Measurable Deliverables?	Deliverables Documented?	Good Contract Monitoring?
Kane County Health Department	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
SEIU - Local 880	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
Southern IL Healthcare Foundation (#1)	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
St. Clair County Health Department	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
The Resurrection Project	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	N	Y
Zhuravlick, Inc. (#1)	Hard to Reach	10/01/99 to 10/31/00	$82,727	$82,727	Y	Y	Y	Y
CEFS Economic Opportunity Corp.	Hard to Reach	10/01/99 to 10/31/00	$76,936	$76,936	Y	Y	N	Y
Coordinated Youth & Human Servs.	Hard to Reach	10/01/99 to 10/31/00	$76,818	$76,818	Y	Y	Y	Y
The Baby Fold	Hard to Reach	10/01/99 to 10/31/00	$72,347	$72,347	Y	Y	Y	Y
Polish American Association	Hard to Reach	10/01/99 to 10/31/00	$69,556	$69,556	Y	Y	N	Y
Sinai Health System	Hard to Reach	10/01/99 to 10/31/00	$69,135	$69,135	Y	Y	Y	Y
Metropolitan Family Services	Hard to Reach	10/01/99 to 10/31/00	$66,828	$66,829	Y	Y	N	Y
Illinois Health Education Consortium	Hard to Reach	10/01/99 to 10/31/00	$59,180	$59,179	Y	Y	N	Y
The Fellowship House	Hard to Reach	10/01/99 to 10/31/00	$59,091	$59,091	Y	Y	Y	Y
Heartland Alliance for Human Needs (#1)	Hard to Reach	10/01/99 to 10/31/00	$57,719	$57,719	Y	Y	Y	Y
Adams County Mental Health Center	Hard to Reach	10/01/99 to 10/31/00	$57,513	$57,513	Y	Y	Y	Y

Source: Public Aid Data Summarized by OAG.

Appendix D

SUMMARY OF KIDCARE CONTRACTS

Contractor	Type	Contract Term	Contract Amount	Total Paid	RFP Process?	Measurable Deliverables?	Deliverables Documented?	Good Contract Monitoring?
Chinese American Service League (#1)	Hard to Reach	10/01/99 to 10/31/00	$57,388	$57,388	Y	Y	Y	Y
Cass County Health Department	Hard to Reach	10/01/99 to 10/31/00	$37,818	$37,819	Y	Y	Y	Y
Roseland Christian Health Ministries	Hard to Reach	10/01/99 to 10/31/00	$37,085	$37,086	Y	Y	Y	Y
Hancock County Health Department	Hard to Reach	10/01/99 to 10/31/00	$34,848	$34,849	Y	Y	Y	Y
Whiteside County Health Department	Hard to Reach	10/01/99 to 8/31/00	$30,000	$30,000	Y	Y	Y	Y
Pike County Health Department	Hard to Reach	10/01/99 to 8/31/00	$14,036	$14,036	Y	Y	N	Y
Illinois Caucus for Adolescent Health	Targeted	11/01/00 to 10/31/01	$50,000	$50,000	Y	Y	N	Y
Zhuravlick, Inc. (#2)	Targeted	11/01/00 to 10/31/01	$50,000	$50,000	Y	Y	N	Y
Southern IL Healthcare Foundation (#2)	Targeted	11/01/00 to 10/31/01	$47,500	$47,500	Y	Y	N	Y
Sarah Bush Lincoln Health Center	Targeted	11/01/00 to 10/31/01	$40,977	$40,977	Y	Y	N	Y
Heartland Alliance for Human Needs (#2)	Targeted	11/01/00 to 7/16/01	$49,500	$35,063	Y	Y	N(5)	Y
YWCA CCR&R	Targeted	11/01/00 to 6/15/01	$50,000	$31,250	Y	Y	N(5)	Y
Chinese American Service League (#2)	Targeted	11/01/00 to 10/31/01	$48,600	$48,600	Y	Y	N	Y
United Way of Lake County	Targeted	11/01/00 to 6/15/01	$38,800	$25,705	Y	Y	N(5)	Y
Catholic Health Partners, Programa CIELO	Targeted	11/01/00 to 10/31/01	$35,620	$35,620	Y	Y	N	Y
Vietnamese Association of Illinois	Targeted	11/01/00 to 6/15/01	$34,685	$21,678	Y	Y	N(5)	Y

Source: Public Aid Data Summarized by OAG.

Appendix D
SUMMARY OF KIDCARE CONTRACTS

Contractor	Type	Contract Term	Contract Amount	Total Paid	RFP Process?	Measurable Deliverables?	Deliverables Documented?	Good Contract Monitoring?	
Korean American Services	Targeted	11/01/00 to 10/31/01	$21,000	$21,000	Y	Y	N	Y	
St. Anthony's Health Center	Targeted	11/01/00 to 10/31/01	$35,000	$35,000	Y	Y	Y	Y	
Chinese Mutual Aid	Targeted	11/01/00 to 6/15/01	$20,000	$12,500	Y	Y	N(5)	Y	
Family Christian Health Center	Targeted	11/01/00 to 6/15/01	$14,900	$4,967	Y	Y	N(5)	Y	
Schnepp & Barnes	Printing	10/28/99 to 06/30/00	$156,565	$156,532	N	Y	Y	Y	
Unistat	Printing	03/26/99 to 06/30/99	$38,050	$36,324	N	Y	Y	Y	
Schnepp & Barnes	Printing	10/22/98 to 11/11/98	$11,445	$11,445	N	Y	N/A	N/A	Responses to contract monitoring for these printing contracts is N/A because we did not review monitoring documentation.
Schnepp & Barnes	Printing	05/04/99 to 06/30/99	$29,321	$29,244	N	Y	N/A	N/A	
Production Press	Printing	12/18/98 to 06/30/99	$29,350	$29,350	N	Y	N/A	N/A	
Production Press	Printing	09/03/99 to 06/30/00	$39,405	$39,405	N	Y	N/A	N/A	
Grafitti Graphics	Printing	08/19/99 to 06/30/00	$15,785	$15,785	N	Y	N/A	N/A	
Gorhams Inc.	Printing	08/06/99 to 06/30/00	$14,100	$14,100	N	Y	N/A	N/A	
Total Contracts	76	**Total Dollars**	$10,422,712	$9,545,543	45	71	37	63	**Total Yes**
				Summary of Results	31	5	28	7	**Total No**
					0	0	11	6	**Total N/A**

Footnotes:

(1) Contractor met most substantive deliverables but not all.
(2) Contractor met most substantive deliverables and was not paid for unmet deliverables.
(3) Contractor was paid $50,000 but repaid the portion that related to unmet deliverables.
(4) Contract is not for KidCare only.
(5) Contractor failed to meet deliverables and Public Aid terminated the contract early.

Source: Public Aid Data Summarized by OAG.

APPENDIX E
KidCare Application Agents (KCAAs) With Payments More Than $999

Appendix E

KCAAs WITH PAYMENTS MORE THAN $999

KCAA NAME	Number Paid	Dollars Paid	Approved w/out Pmt	Denied	Total Apps
ADAMS COUNTY HEALTH DEPT	90	$4,500	38	29	157
ADOLESCENT HEALTH CENTER	27	$1,350	11	4	42
ADVOCATE RAVENSWOOD HOSP	99	$4,950	40	22	161
ADVOCATE NORTHSIDE	115	$5,750	21	32	168
ALBANY PARK COMMUNITY CENTER	24	$1,200	18	7	49
ALIA SIDDIQI MD	58	$2,900	0	0	58
ALIVIO MEDICAL CENTER	2,288	$114,400	458	486	3,232
AUNT MARTHA YTH SERV HLTHY KID	65	$3,250	32	37	134
AUNT MARTHAS YTH SERV VINCENNE	285	$14,250	43	30	358
AUNT MARTHAS YTH SERV WESTERN	28	$1,400	27	30	85
AURORA PUBLIC HEALTH CENTER	1,961	$98,050	502	344	2,807
AUSTIN PEOPLES ACTION CENTER	31	$1,550	8	8	47
BERWYN PUBLIC HEALTH DISTRIC	52	$2,600	26	33	111
BHS FANTUS HEALTH CENTER	2,086	$104,300	872	534	3,492
BHS JOHN SENGSTACKE PROF BLD	160	$8,000	79	88	327
BLOOM TOWNSHIP	29	$1,450	12	17	58
BOND CO HEALTH DEPT	110	$5,500	50	22	182
C E F S ECONOMIC OPP CORP	65	$3,250	18	20	103
CALHOUN CO HEALTH DEPT	31	$1,550	9	8	48
CAPITOL COMMUNITY HEALTH CTR	148	$7,400	35	29	212
CARE CENTER OF SPRINGFIELD INC	82	$4,100	26	40	148
CASS COUNTY HEALTH DEP	200	$10,000	38	21	259
CCDPH MIDSOUTH HEALTH CENTER	304	$15,200	140	81	525
CCDPH NORTH DISTRICT OFFICE	1,870	$93,500	431	177	2,478
CCDPH SOUTH DISTRICT OFFICE	640	$32,000	161	109	910
CCDPH WEST DISTRICT OFFICE	1,216	$60,800	447	164	1,827
CCDPH WIC	185	$9,250	47	35	267
CDHP SOUTHWEST DISTRICT OFFICE	713	$35,650	266	132	1,111
CENTRO DE INFORMACION	126	$6,300	16	22	164
CGH MEDICAL CENTER	71	$3,550	13	21	105
CHAMPAIGN URBANA PUBLIC HLTH	906	$45,300	276	207	1,389
CHICAGO FAM HLTH CTR ROSLAND	119	$5,950	28	24	171
CHICAGO FAM HLTH CTR SO CHI	455	$22,750	115	62	632
CHICAGO HLTH OUTREACH HOMELESS	52	$2,600	59	30	141
CHILDRENS CENTER CICERO BERWYN	123	$6,150	53	99	275
CHINESE AMERICAN SERV LEAGUE	147	$7,350	19	4	170

Source: Public Aid data summarized by OAG.

Appendix E

KCAAs WITH PAYMENTS MORE THAN $999

KCAA NAME	Number Paid	Dollars Paid	Approved w/out Pmt	Denied	Total Apps
CHRISTIAN CO HEALTH DEPT	87	$4,350	39	16	142
CIRCLE FAMILY CARE CENTER	55	$2,750	55	65	175
CLARK COUNTY HEALTH DEPT	62	$3,100	16	13	91
CLAY COUNTY HEALTH DEPT	93	$4,650	28	38	159
CLINTON COUNTY HEALTH DEPT	55	$2,750	14	12	81
COLES COUNTY PUBLIC HLTH DEPT	246	$12,300	69	68	383
COLUMBUS LAKEVIEW CLINIC	920	$46,000	141	103	1,164
COMM HEALTH IMPROVEMENT CTR	116	$5,800	42	52	210
COMM HOSP OF OTTAWA	20	$1,000	5	10	35
COMMUNITY HEALTH CARE INC	97	$4,850	17	11	125
COMMUNITY NURSE HEALTH ASSOCIATION	30	$1,500	14	10	54
COMMUNITY OUTREACH	94	$4,700	27	33	154
COORDINATED YOUTH HUMAN SERV	60	$3,000	8	6	74
COORDINATED YOUTH SERVICES	29	$1,450	2	1	32
COORDINATED YOUTH WIC PROG	234	$11,700	60	56	350
CRAWFORD COUNTY HEALTH DEPT	74	$3,700	25	20	119
CRUSADER CLINIC	238	$11,900	85	74	397
CUMBERLAND COUNTY HEALTH DEPT	31	$1,550	29	24	84
DEKALB COUNTY HLTH DEPT	322	$16,100	59	58	439
DEVELOPMENTAL SPC OF SE IL INC	29	$1,450	3	10	42
DIVERSEY CEDA WIC PROGRAM	46	$2,300	14	19	79
DOUGLAS COUNTY HEALTH DEPT	39	$1,950	43	29	111
DR JORGE PRIETO HEALTH CENTER	849	$42,450	160	88	1,097
DUPAGE CTY HEALTH DEPT	4,121	$206,050	437	385	4,943
EDGAR COUNTY HEALTH DEPT	247	$12,350	27	19	293
EFFINGHAM COUNTY HEALTH DEP	128	$6,400	55	46	229
EGYPTIAN HEALTH DEPT	254	$12,700	106	80	440
EL CENTRO DE SERVICIOS MEDICO	453	$22,650	92	67	612
EL HOGAR DEL NINO	53	$2,650	49	29	131
ELGIN PUBLIC HEALTH CENTER	1,584	$79,200	418	319	2,321
ENGLEWOOD NEIGHBORHOOD H C	540	$27,000	131	145	816
ERIE WESTSIDE FAMILY HEALTH	1,524	$76,200	600	409	2,533
EVANSTON HEALTH DEPT	204	$10,200	51	44	299
FAMILY PRAC COMM WEST LOGAN SQ	177	$8,850	33	29	239
FAMILY PRACTICE COM WESTERN	81	$4,050	66	35	182
FAYETTE COUNTY HLTH DEPT	107	$5,350	37	25	169

Source: Public Aid data summarized by OAG.

Appendix E

KCAAs WITH PAYMENTS MORE THAN $999

KCAA NAME	Number Paid	Dollars Paid	Approved w/out Pmt	Denied	Total Apps
FORD IROQUOIS PUB HLTH DEPT	113	$5,650	28	23	164
FRANKLIN WILLIAMSON HLTH DEPT	429	$21,450	126	111	666
FRIEND FAMILY HEALTH CENTER	93	$4,650	59	57	209
FULTON COUNTY HLTH DEPT	44	$2,200	32	24	100
GILEAD OUTREACH AND REFERRAL	39	$1,950	15	10	64
GRAND BOULEVARD MCH CENTER	24	$1,200	8	25	57
GREENE COUNTY HEALTH DEPT	93	$4,650	37	25	155
GRUNDY COUNTY HEALTH DEPT	50	$2,500	10	4	64
HAMILTON COUNTY HEALTH DEPT	56	$2,800	20	9	85
HANCOCK COUNTY HEALTH DEPT	47	$2,350	29	12	88
HENRY BOOTH HOUSE	32	$1,600	16	18	66
HENRY COUNTY HEALTH DEPT	91	$4,550	50	43	184
HOLY CROSS HOSPITAL	40	$2,000	29	10	79
HOWARD AREA COMMUNITY CENTER	35	$1,750	8	8	51
ILLINOIS MASONIC MED CTR	255	$12,750	110	61	426
INFANT WELFARE SOCIETY OF CHICAGO	1,073	$53,650	154	75	1,302
JACKSON COUNTY HEALTH DEPT	286	$14,300	52	56	394
JAMES JORDAN BOYS GIRLS CLFLC	24	$1,200	5	3	32
JASPER CO HEALTH DEPT	80	$4,000	33	25	138
JERSEY COUNTY HEALTH DEPT	54	$2,700	30	13	97
JO DAVIESS CO HEALTH DEPT	139	$6,950	37	34	210
KASKASKIA WORKSHOP INC	282	$14,100	97	74	453
KENDALL CO HLTH AND HUMAN SERV	108	$5,400	53	34	195
KNOX COUNTY HEALTH DEPT	134	$6,700	37	57	228
LAKE CO H D WAUKEGAN CLINIC	1,744	$87,200	761	252	2,757
LAWNDALE CHRISTIAN HLTH	785	$39,250	407	299	1,491
LAWRENCE CO HEALTH DEPT	62	$3,100	13	22	97
LEE COUNTY HEALTH DEPT	90	$4,500	35	37	162
LITTLE VILLAGE FMLY HLTH CTR	25	$1,250	7	9	41
LIVINGSTON CO PUBLIC HLTH DEPT	218	$10,900	71	47	336
LOWER WEST SIDE HEALTH CENT	799	$39,950	335	163	1,297
MACON COUNTY HEALTH DEPT	429	$21,450	100	81	610
MACOUPIN COUNTY HEALTH DEPT	57	$2,850	18	11	86
MACOUPIN COUNTY PHD GILLESPI	57	$2,850	22	25	104
MACOUPIN COUNTY PUBLIC HEALTH	29	$1,450	15	7	51
MADISON MEDICAL CENTER	31	$1,550	12	9	52

Source: Public Aid data summarized by OAG.

Appendix E

KCAAs WITH PAYMENTS MORE THAN $999

KCAA NAME	**Number Paid**	**Dollars Paid**	**Approved w/out Pmt**	**Denied**	**Total Apps**
MARION RURAL HLTH CLNC	62	$3,100	26	23	111
MARYVILLE ACADEMY CEDA WIC	31	$1,550	20	13	64
MASON COUNTY HEALTH DEPT	30	$1,500	11	10	51
MCDONOUGH COUNTY HEALTH DEPT	152	$7,600	78	63	293
MCHENRY COUNTY DEPT OF HEAL	869	$43,450	239	125	1,233
MCLEAN COUNTY HEALTH DEPT	462	$23,100	119	119	700
MERCER COUNTY HEALTH DEPT	37	$1,850	26	14	77
MERCY DIAGNOSTIC TREATMENT CTR	175	$8,750	44	16	235
MEXICAN COMM LYRP OUTRCH PROJ	22	$1,100	10	2	34
MICHAEL REESE MEDICAL CENTER	65	$3,250	17	22	104
MILE SQUARE HEALTH CENTER	159	$7,950	90	105	354
MONROE RANDOLPH BI CO HLTH	21	$1,050	3	5	29
MONTGOMERY CO HLTH DEPT	108	$5,400	26	18	152
MORGAN COUNTY HLTH DEPT	80	$4,000	40	17	137
NAZARETH FAMILY CENTER	46	$2,300	43	19	108
NEAR NORTH HEALTH SERV KOMED	314	$15,700	49	41	404
NEAR WEST FAMILY CENTER	129	$6,450	64	19	212
NEW CITY HEALTH CENTER INC	22	$1,100	0	18	40
NEW LIFE EDUCATION CENTER	248	$12,400	88	79	415
NORTHEAST PALATINE COMM CTR	21	$1,050	1	1	23
NORWEGIAN AMERICAN HOSP	927	$46,350	172	115	1,214
OAK PARK HEALTH DEPT	61	$3,050	45	31	137
OGLE COUNTY HEALTH DEPT	131	$6,550	51	25	207
OSF SFMC PEDS AMBULATORY CTR	20	$1,000	3	9	32
OUTREACH UNIT	125	$6,250	51	60	236
PCC COMMUNITY WELLNESS CEN	80	$4,000	37	42	159
PEORIA CITY COUNTY HLTH DEPT	856	$42,800	149	169	1,174
PERRY CO HLTH DEPT	69	$3,450	45	39	153
PIKE COUNTY HEALTH DEPT	74	$3,700	26	21	121
PLANNED PARENTHOOD	206	$10,300	49	42	297
POLISH AMERICAN ASSN NORTH SIDE	336	$16,800	138	25	499
POLISH AMERICAN ASSN SOUTH SIDE	50	$2,500	28	15	93
PROGRAMA CIELO	180	$9,000	46	23	249
PUERTA	310	$15,500	194	195	699
ROBBINS HLTH CTR OF COOK CNT	46	$2,300	18	3	67
ROCK ISLAND COUNTY HLTH DEPT	561	$28,050	275	224	1,060

Source: Public Aid data summarized by OAG.

Appendix E

KCAAs WITH PAYMENTS MORE THAN $999

KCAA NAME	Number Paid	Dollars Paid	Approved w/out Pmt	Denied	Total Apps
ROOSEVELT HIGH SCHOOL	28	$1,400	6	7	41
ROSELAND ALTGELD ADOL PARENT	20	$1,000	13	9	42
ROSELAND CHRISTIAN	31	$1,550	30	26	87
ROSELAND NEIGHBORHOOD H CENTER	416	$20,800	84	88	588
RURAL HEALTH INC	73	$3,650	22	26	121
RUSH ADOLESCENT FAMILY CENT	43	$2,150	20	11	74
SAINT ANTHONYS HLTH CTR	42	$2,100	14	12	68
SANAD	33	$1,650	14	22	69
SANGAMON CO DEPT PUBLIC HEALTH	136	$6,800	40	40	216
SCHUYLER CO PUBLIC HLTH DEPT	42	$2,100	13	7	62
SHELBY COUNTY HEALTH DEPT	125	$6,250	39	35	199
SIHF ALTON HEALTH CENTER	72	$3,600	14	21	107
SIHF MOTHER AND CHILD CENTER	391	$19,550	116	133	640
SIHF WASHINGTON PARK HLTH CT	20	$1,000	12	13	45
SINAI HEALTH SYSTEM	1,311	$65,550	393	293	1,997
SO CHICAGO MCH HEALTH CLINIC	530	$26,500	261	177	968
SOUTH LAWNDALE MCH CENTER	749	$37,450	509	189	1,447
SOUTHERN IL HEALTHCARE	44	$2,200	11	11	66
SOUTHERN SEVEN HEALTH DEPT	203	$10,150	98	91	392
SOUTHWEST FAMILY HEALTH CENTER	27	$1,350	29	21	77
SPRINGFIELD DEPT OF PUBLIC HLT	48	$2,400	27	50	125
SPRINGFIELD PLANNED PARENTHOOD	92	$4,600	17	16	125
ST ANTHONY HLTH BRIGHTON PARK	66	$3,300	30	13	109
ST ANTHONY HOSPITAL	247	$12,350	91	57	395
ST CLAIR COUNTY HEALTH DEPT	239	$11,950	88	103	430
ST ELIZABETH HOSPITAL	72	$3,600	20	33	125
ST FRANCIS COMM HEALTH CENT	169	$8,450	89	28	286
ST JOSEPH HOSP LABOURE CLINIC	36	$1,800	51	72	159
ST MARY OF NAZARETH HOSP CTR	104	$5,200	52	41	197
STEPHENSON CO HEALTH DEPT	114	$5,700	58	33	205
SWEDISH COVENANT HOSPITAL	25	$1,250	9	4	38
TAZEWELL COUNTY HLTH DEPT	290	$14,500	88	63	441
THE CLINIC IN ALTGELD INC	94	$4,700	27	38	159
UIC DSCC CHAMPAIGN RO	23	$1,150	9	10	42
UIC DSCC DUPAGE RO	34	$1,700	11	19	64
UIC DSCC EAST ST LOUIS RO	23	$1,150	9	4	36

Source: Public Aid data summarized by OAG.

KCAAs WITH PAYMENTS MORE THAN $999

KCAA NAME	Number Paid	Dollars Paid	Approved w/out Pmt	Denied	Total Apps
UIC DSCC MARION RO	23	$1,150	15	22	60
UIC DSCC NORTHEASTERN RO	20	$1,000	27	39	86
UIC DSCC ROCKFORD RO	27	$1,350	7	20	54
UIC DSCC SPRINGFIELD RO	42	$2,100	11	23	76
UNITED NEIGHBORHOODS ORGANIZATION	60	$3,000	36	42	138
UNIVERSITY OF IL AT CHIC HOSP	66	$3,300	23	11	100
UPTOWN NEIGHBORHOOD H CENT	1,451	$72,550	250	292	1,993
VERMILION COUNTY HEALTH DEPT	307	$15,350	109	75	491
WARREN COUNTY SITE	40	$2,000	13	9	62
WAYNE COUNTY HEALTH DEPT	105	$5,250	25	17	147
WCHD WIC PROGRAM	42	$2,100	11	12	65
WEST TOWN NEIGHBORHOOD H CTR	1,315	$65,750	259	298	1,872
WHITESIDE COUNTY HEALTH DEPT	362	$18,100	109	124	595
WILL CO COMM HEALTH CTR	1,215	$60,750	302	220	1,737
WILL CO HEALTH DEPT NORTHERN B	64	$3,200	20	11	95
WINFIELD MOODY HEALTH CENTER	623	$31,150	201	225	1,049
WINNEBAGO CO HLTH DEPT	385	$19,250	84	57	526
WOOD RIVER TWP HOSPITAL	231	$11,550	37	42	310
JOSEPH ANTONIO	160	$8,000	18	16	194
PADOWSKI BOGUMILA	41	$2,050	26	9	76
SHAHBAZ AKHTAR	158	$7,900	36	22	216
SHAW GLADYS	21	$1,050	5	1	27
TOMPKINS SHERRY	83	$4,150	14	45	142
WAYLAND DALE	20	$1,000	9	9	38
Totals for >$999 KCAAs	56,165	$2,808,250	16,744	12,453	85,362
Totals for all KCAAs	**57,806**	**$2,889,800**	**17,566**	**13,313**	**88,685**

insurance agents

Source: Public Aid data summarized by OAG.

APPENDIX F
Children's Demographic Data by County

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

Statistics for Childen in Illinois……………………………………………

County	Children Under 18	Estimate of Children Age 0-17 in Poverty	Estimated % of Children in Poverty	Births	Infant Deaths 2000	Infant Mortality Rate	Teen Births	% Teen Births
data source notes >	***1***	***2***	***3***	***4***	***4***	***5***	***4***	***3***
Adams	17,001	2,849	17%	825	6	7.3	76	9%
Alexander	2,476	939	38%	132	2	15.2	30	23%
Bond	3,862	561	15%	184	2	10.9	25	14%
Boone	12,446	1,107	9%	587	3	5.1	61	10%
Brown	1,234	178	14%	63	0	0.0	8	13%
Bureau	8,785	1,162	13%	434	4	9.2	52	12%
Calhoun	1,166	164	14%	51	0	0.0	7	14%
Carroll	4,046	579	14%	170	3	17.6	25	15%
Cass	3,473	550	16%	181	1	5.5	34	19%
Champaign	37,819	5,654	15%	2,260	23	10.2	212	9%
Christian	8,521	1,401	16%	404	7	17.3	58	14%
Clark	4,233	672	16%	189	0	0.0	26	14%
Clay	3,483	605	17%	187	0	0.0	33	18%
Clinton	8,836	1,040	12%	439	1	2.3	43	10%
Coles	10,477	1,839	18%	615	5	8.1	93	15%
Cook	1,397,819	273,245	20%	85,503	819	9.6	11,022	13%
Crawford	4,664	792	17%	240	1	4.2	35	15%
Cumberland	2,976	497	17%	120	0	0.0	17	14%
Dekalb	20,569	1,859	9%	1,118	8	7.2	89	8%
Dewitt	4,126	663	16%	206	1	4.9	34	17%
Douglas	5,388	767	14%	287	3	10.5	27	9%
DuPage	241,832	13,687	6%	13,528	84	6.2	613	5%
Edgar	4,701	929	20%	199	3	15.1	33	17%

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

…………………..………..Statistics for Childen in KidCare

KidCare Enrollment	KidCare Enrollment as a % of Children in Poverty	% Caucasian	% Hispanic	% African American	% Single Parent Families	% Two Parent Families	County
6	*3*	*6*	*6*	*6*	*6*	*6*	*< data source notes*
648	23%	92%	1%	4%	42%	57%	**Adams**
112	12%	39%	0%	56%	59%	38%	**Alexander**
150	27%	93%	1%	6%	27%	72%	**Bond**
221	20%	65%	31%	1%	45%	54%	**Boone**
32	18%	100%	0%	0%	44%	56%	**Brown**
288	25%	88%	9%	0%	42%	58%	**Bureau**
38	23%	100%	0%	0%	21%	79%	**Calhoun**
172	30%	95%	3%	2%	23%	77%	**Carroll**
158	29%	86%	12%	0%	30%	70%	**Cass**
1,034	18%	62%	3%	26%	53%	46%	**Champaign**
457	33%	98%	0%	0%	42%	57%	**Christian**
172	26%	100%	0%	0%	45%	54%	**Clark**
142	23%	99%	0%	1%	28%	71%	**Clay**
226	22%	92%	3%	1%	43%	55%	**Clinton**
465	25%	95%	1%	2%	42%	57%	**Coles**
33,397	12%	14%	44%	35%	53%	46%	**Cook**
191	24%	97%	2%	0%	31%	68%	**Crawford**
134	27%	98%	0%	0%	40%	60%	**Cumberland**
438	24%	71%	16%	10%	48%	52%	**Dekalb**
179	27%	94%	4%	0%	39%	60%	**Dewitt**
164	21%	91%	6%	0%	37%	63%	**Douglas**
2,276	17%	43%	36%	9%	44%	55%	**DuPage**
178	19%	96%	0%	0%	42%	57%	**Edgar**

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

Statistics for Childen in Illinois……………………………………………

County	Children Under 18	Estimate of Children Age 0-17 in Poverty	Estimated % of Children in Poverty	Births	Infant Deaths 2000	Infant Mortality Rate	Teen Births	% Teen Births
data source notes >	***1***	***2***	***3***	***4***	***4***	***5***	***4***	***3***
Edwards	1,607	268	17%	95	0	0.0	9	9%
Effingham	9,784	1,242	13%	440	5	11.4	59	13%
Fayette	5,188	963	19%	268	2	7.5	48	18%
Ford	3,671	467	13%	191	2	10.5	23	12%
Franklin	8,958	2,362	26%	495	3	6.1	81	16%
Fulton	8,414	1,646	20%	431	1	2.3	45	10%
Gallatin	1,431	380	27%	75	1	13.3	16	21%
Greene	3,758	762	20%	170	1	5.9	24	14%
Grundy	9,994	811	8%	493	4	8.1	34	7%
Hamilton	2,067	428	21%	100	1	10.0	15	15%
Hancock	4,946	771	16%	259	1	3.9	28	11%
Hardin	981	246	25%	37	0	0.0	10	27%
Henderson	1,898	334	18%	77	0	0.0	11	14%
Henry	12,918	1,769	14%	601	7	11.6	73	12%
Iroquois	7,974	1,173	15%	367	2	5.4	34	9%
Jackson	11,482	2,846	25%	667	8	12.0	76	11%
Jasper	2,620	515	20%	110	3	27.3	12	11%
Jefferson	9,696	2,121	22%	476	3	6.3	84	18%
Jersey	5,508	832	15%	211	0	0.0	23	11%
JoDavies	5,162	598	12%	246	2	8.1	23	9%
Johnson	2,363	474	20%	162	1	6.2	19	12%
Kane	122,295	9,863	8%	7,844	56	7.1	779	10%
Kankakee	28,107	5,109	18%	1,561	21	13.5	239	15%

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

……………………..………...Statistics for Childen in KidCare

KidCare Enrollment	KidCare Enrollment as a % of Children in Poverty	% Caucasian	% Hispanic	% African American	% Single Parent Families	% Two Parent Families	County
6	*3*	*6*	*6*	*6*	*6*	*6*	*< data source notes*
115	43%	92%	1%	0%	23%	77%	**Edwards**
358	29%	97%	1%	0%	35%	64%	**Effingham**
232	24%	99%	0%	0%	30%	69%	**Fayette**
117	25%	93%	4%	0%	38%	62%	**Ford**
405	17%	99%	0%	0%	36%	62%	**Franklin**
381	23%	97%	0%	1%	36%	64%	**Fulton**
62	16%	98%	0%	0%	24%	76%	**Gallatin**
170	22%	98%	0%	0%	33%	67%	**Greene**
130	16%	82%	15%	0%	47%	53%	**Grundy**
133	31%	99%	0%	0%	22%	78%	**Hamilton**
155	20%	100%	0%	0%	37%	62%	**Hancock**
36	15%	100%	0%	0%	19%	78%	**Hardin**
61	18%	100%	0%	0%	23%	77%	**Henderson**
402	23%	89%	4%	3%	41%	59%	**Henry**
320	27%	89%	10%	1%	43%	57%	**Iroquois**
381	13%	73%	3%	20%	44%	53%	**Jackson**
127	25%	98%	1%	0%	32%	67%	**Jasper**
423	20%	93%	0%	6%	41%	59%	**Jefferson**
199	24%	99%	0%	1%	33%	66%	**Jersey**
129	22%	91%	3%	0%	22%	78%	**JoDavies**
121	26%	98%	1%	0%	33%	66%	**Johnson**
3,071	31%	21%	61%	12%	42%	57%	**Kane**
643	13%	57%	7%	33%	58%	40%	**Kankakee**

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

Statistics for Childen in Illinois……………………………………………

County	Children Under 18	Estimate of Children Age 0-17 in Poverty	Estimated % of Children in Poverty	Births	Infant Deaths 2000	Infant Mortality Rate	Teen Births	% Teen Births
data source notes >	***1***	***2***	***3***	***4***	***4***	***5***	***4***	***3***
Kendall	16,083	728	5%	879	7	8.0	42	5%
Knox	12,306	2,250	18%	626	4	6.4	77	12%
La Salle	28,052	3,933	14%	1,488	8	5.4	173	12%
Lake	189,364	14,549	8%	10,562	48	4.5	808	8%
Lawrence	3,510	774	22%	143	1	7.0	23	16%
Lee	8,727	1,033	12%	409	4	9.8	51	12%
Livingston	9,918	1,305	13%	524	3	5.7	76	15%
Logan	6,824	1,014	15%	349	2	5.7	37	11%
Macon	28,171	5,915	21%	1,445	10	6.9	251	17%
Macoupin	12,064	2,014	17%	520	1	1.9	60	12%
Madison	64,437	10,054	16%	3,376	27	8.0	434	13%
Marion	10,622	2,214	21%	534	3	5.6	89	17%
Marshall	3,098	472	15%	131	0	0.0	13	10%
Mason	3,909	796	20%	166	0	0.0	27	16%
Massac	3,492	808	23%	177	1	5.6	32	18%
McDonough	5,818	1,136	20%	327	0	0.0	31	9%
McHenry	78,496	3,468	4%	4,056	22	5.4	240	6%
McLean	35,292	3,832	11%	1,990	6	3.0	140	7%
Menard	3,314	451	14%	150	0	0.0	16	11%
Mercer	4,206	580	14%	178	0	0.0	11	6%
Monroe	7,304	456	6%	350	3	8.6	20	6%
Montgomery	7,275	1,373	19%	363	0	0.0	55	15%
Morgan	8,344	1,344	16%	430	5	11.6	55	13%

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

…………………..………..Statistics for Childen in KidCare

KidCare Enrollment	KidCare Enrollment as a % of Children in Poverty	% Caucasian	% Hispanic	% African American	% Single Parent Families	% Two Parent Families	County
6	*3*	*6*	*6*	*6*	*6*	*6*	*< data source notes*
153	21%	73%	23%	3%	34%	66%	**Kendall**
538	24%	88%	2%	7%	50%	49%	**Knox**
633	16%	81%	13%	1%	43%	56%	**La Salle**
2,518	17%	27%	50%	19%	46%	53%	**Lake**
188	24%	97%	1%	1%	34%	66%	**Lawrence**
220	21%	93%	4%	3%	48%	51%	**Lee**
304	23%	97%	1%	1%	42%	57%	**Livingston**
254	25%	96%	0%	2%	44%	56%	**Logan**
826	14%	68%	1%	27%	55%	44%	**Macon**
384	19%	96%	0%	2%	31%	68%	**Macoupin**
1,646	16%	78%	1%	18%	54%	44%	**Madison**
416	19%	92%	0%	6%	43%	56%	**Marion**
75	16%	88%	8%	4%	57%	41%	**Marshall**
156	20%	100%	0%	0%	33%	67%	**Mason**
103	13%	90%	0%	10%	39%	59%	**Massac**
234	21%	96%	0%	1%	29%	71%	**McDonough**
706	20%	58%	34%	2%	42%	57%	**McHenry**
834	22%	73%	6%	16%	53%	47%	**McLean**
135	30%	99%	1%	0%	47%	53%	**Menard**
179	31%	97%	0%	0%	36%	64%	**Mercer**
75	16%	100%	0%	0%	48%	47%	**Monroe**
367	27%	97%	0%	1%	30%	69%	**Montgomery**
343	26%	91%	1%	6%	49%	50%	**Morgan**

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

Statistics for Childen in Illinois……………………………………………

County	Children Under 18	Estimate of Children Age 0-17 in Poverty	Estimated % of Children in Poverty	Births	Infant Deaths 2000	Infant Mortality Rate	Teen Births	% Teen Births
data source notes >	***1***	***2***	***3***	***4***	***4***	***5***	***4***	***3***
Moultrie	3,670	407	11%	204	1	4.9	21	10%
Ogle	14,023	1,359	10%	600	6	10.0	58	10%
Peoria	46,109	9,464	21%	2,688	22	8.2	371	14%
Perry	5,083	987	19%	242	0	0.0	35	14%
Piatt	4,115	366	9%	191	4	20.9	17	9%
Pike	4,188	814	19%	194	1	5.2	31	16%
Pope	949	200	21%	29	0	0.0	5	17%
Pulaski	1,996	646	32%	104	1	9.6	25	24%
Putnam	1,527	148	10%	60	0	0.0	6	10%
Randolph	7,507	1,239	17%	387	4	10.3	50	13%
Richland	3,964	816	21%	199	1	5.0	23	12%
Rock Island	35,524	6,363	18%	1,921	22	11.5	287	15%
Saline	6,414	1,545	24%	297	6	20.2	54	18%
Sangamon	47,147	7,321	16%	2,646	18	6.8	331	13%
Schuyler	1,658	261	16%	79	1	12.7	5	6%
Scott	1,392	201	14%	72	1	13.9	12	17%
Shelby	5,728	738	13%	244	2	8.2	30	12%
St. Clair	70,925	16,127	23%	3,734	38	10.2	569	15%
Stark	1,591	241	15%	75	0	0.0	12	16%
Stephenson	12,351	1,749	14%	594	2	3.4	73	12%
Tazewell	31,347	3,946	13%	1,585	20	12.6	180	11%
Union	4,237	984	23%	202	0	0.0	23	11%
Vermilion	20,972	4,244	20%	1,207	11	9.1	213	18%

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

…………………..………..Statistics for Childen in KidCare

KidCare Enrollment	KidCare Enrollment as a % of Children in Poverty	% Caucasian	% Hispanic	% African American	% Single Parent Families	% Two Parent Families	County
6	*3*	*6*	*6*	*6*	*6*	*6*	*< data source notes*
114	28%	98%	0%	2%	39%	61%	**Moultrie**
357	26%	82%	14%	1%	46%	54%	**Ogle**
1,415	15%	57%	4%	33%	59%	40%	**Peoria**
210	21%	98%	0%	1%	36%	64%	**Perry**
147	40%	95%	1%	0%	34%	65%	**Piatt**
231	28%	98%	0%	1%	24%	76%	**Pike**
37	19%	100%	0%	0%	38%	62%	**Pope**
120	19%	66%	0%	33%	55%	43%	**Pulaski**
43	29%	93%	7%	0%	49%	51%	**Putnam**
238	19%	95%	0%	3%	34%	64%	**Randolph**
187	23%	98%	0%	0%	46%	53%	**Richland**
994	16%	67%	18%	12%	59%	40%	**Rock Island**
262	17%	95%	0%	3%	37%	63%	**Saline**
1,300	18%	71%	1%	25%	65%	34%	**Sangamon**
68	26%	99%	0%	0%	22%	78%	**Schuyler**
76	38%	99%	0%	0%	22%	76%	**Scott**
251	34%	97%	0%	0%	31%	69%	**Shelby**
1,750	11%	40%	2%	54%	70%	29%	**St. Clair**
63	26%	94%	0%	0%	37%	63%	**Stark**
369	21%	80%	2%	17%	54%	45%	**Stephenson**
837	21%	97%	0%	1%	47%	53%	**Tazewell**
234	24%	94%	6%	0%	30%	69%	**Union**
827	19%	80%	3%	13%	48%	51%	**Vermilion**

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

Appendix F

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

Statistics for Childen in Illinois..

County	Children Under 18	Estimate of Children Age 0-17 in Poverty	Estimated % of Children in Poverty	Births	Infant Deaths 2000	Infant Mortality Rate	Teen Births	% Teen Births
data source notes >	***1***	***2***	***3***	***4***	***4***	***5***	***4***	***3***
Wabash	3,133	541	17%	132	0	0.0	18	14%
Warren	4,342	727	17%	214	1	4.7	35	16%
Washington	3,837	392	10%	179	2	11.2	21	12%
Wayne	4,072	696	17%	183	2	10.9	28	15%
White	3,311	804	24%	158	0	0.0	24	15%
Whiteside	15,187	2,045	13%	771	2	2.6	126	16%
Will	150,711	10,853	7%	8,213	56	6.8	584	7%
Williamson	14,051	3,018	21%	674	5	7.4	105	16%
Winnebago	73,526	10,562	14%	4,021	40	9.9	535	13%
Woodford	9,483	784	8%	433	3	6.9	22	5%
Statewide	3,245,451	498,806	15%	185,003	1,527	8.3	21,108	11%

data source notes:

1 *U.S Census Bureau data based on the 2000 census.*

2 *U.S Census Bureau estimate of children living in poverty in 1998. Data released December 2001. Note that this is children in families below the federal poverty level and KidCare covers families up to 185 % of the federal poverty level.*

3 *Calculated data based on other data in this appendix.*

4 *Illinois Department of Public Health data for 2000.*

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

CHILDREN'S DEMOGRAPHIC DATA BY COUNTY

……………………..………...Statistics for Childen in KidCare

KidCare Enrollment	KidCare Enrollment as a % of Children in Poverty	% Caucasian	% Hispanic	% African American	% Single Parent Families	% Two Parent Families	County
6	***3***	***6***	***6***	***6***	***6***	***6***	***< data source notes***
152	28%	95%	1%	1%	23%	77%	**Wabash**
160	22%	88%	3%	3%	36%	64%	**Warren**
100	26%	99%	1%	0%	41%	58%	**Washington**
191	27%	98%	1%	0%	35%	65%	**Wayne**
150	19%	97%	1%	0%	28%	72%	**White**
568	28%	84%	12%	2%	45%	54%	**Whiteside**
1,660	15%	42%	28%	25%	53%	46%	**Will**
544	18%	94%	2%	3%	32%	67%	**Williamson**
1,562	15%	58%	14%	24%	58%	41%	**Winnebago**
200	26%	99%	1%	0%	31%	69%	**Woodford**
76,147	15%	45%	27%	23%	49%	50%	**Statewide**

	data source notes
Infant deaths per 1,000 live births calculated based on other data in this appendix. However, Public Health does not calculate this rate for most counties where a small number of occurences may make the rate unreliable.	***5***
Public Aid electronic data on KidCare enrollees in Expansion, Share, Premium , and Rebate.	***6***

Source: OAG analysis of Public Aid, Public Health, and U.S. Census data.

APPENDIX G
Agency Responses

Note: This Appendix contains the complete written responses of the Departments of Public Aid and Human Services. Following the Agency Responses is one numbered Auditor Comment. The number for the comment appears in the margin of the Agency Response.

Illinois Department of Public Aid

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

George H. Ryan, Governor
Jackie Garner, Director

June 19, 2002

Ed Wittrock
Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, Illinois 62703

Dear ~~Mr. Wittrock~~ Ed,

As requested, attached are the responses to the recommendations from your audit of the KidCare program. As a result of our exit conference and subsequent conversations, we are responding to the 7 recommendations as changed within the June 13th correspondence received from you.

In addition, we are informing you that any applicant or recipient information that is being maintained in your working papers, is prohibited from public disclosure in accordance with 42 CFR 431.300 *et seq*.; 305 ILCS 5/11-9. Please call me at 557-4705 if you have any questions or you need additional information.

Sincerely,

Elvin Lay
Chief Auditor

Attachment

E-mail: dpawebmaster@mail.idpa.state.il.us

Internet: http://www.state.il.us/dpa/

OAG Audit of KidCare
DPA Responses to OAG Recommendations

Recommendation 1 - The Department of Public Aid should continue its planned conversion to permanent durable eligibility cards in order to realize significant cost savings to the State as well as improved program effectiveness.

Response - The Department intends to continue the conversion to a medical
identification structure that requires less frequent mailings to realize
administrative savings. However, the success of this conversion is
dependent on the availability of quick, inexpensive, and widely
available methods for providers to verify eligibility, including the 1
Internet. It is unclear how durable cards will improve program
effectiveness.

Recommendation 2 - The Departments of Public Aid and Human Services should assure that income is properly determined and appropriate documentation is included in case files.

Response - Assuring accuracy in determining eligibility has always been a high priority for the Department. The current quality assurance methods including monthly reviews of caseworker actions, policy training and policy reminders will continue. The Department will also examine other methods to encourage and assure accuracy. No documentation errors were noted within the case files created by the Department of Public Aid.

Recommendation 3 - The Departments of Public Aid and Human Services should assure that KidCare redeterminations are done when required and income is properly determined.

Response - Over the past year the Department has worked with the Department of Human Services to significantly reduce the backlog of overdue redeterminations of Assist cases. Again, the Department has numerous measures in place to ensure the accuracy of income determinations but will continue to explore additional methods to improve this aspect.

Recommendation 4 - The Department of Public Aid should continue its efforts to assure that all contracts include measurable deliverables.

Response - Of the contracts noted in the findings, a majority were consultant

contracts procuring technical assistance, talent and expertise which are difficult to measure. For future consultant contracts, the Department will work to develop measurable deliverables.

Recommendation 5 - The Department of Public Aid should continue its efforts to assure that all contractors performance is well monitored and that deliverables specified in the contract are achieved.

Response - The Department will continue efforts to assure contract performance is well measured. The Department has instituted several procedures to improve maintenance of contract files in a manner that will result in better retention of contract monitoring documents.

Recommendation 6 - The Department of Public Aid and the Department of Human Services should assure that children over age one are transferred out of Moms and Babies into the appropriate KidCare category.

Response - This situation was intensified due to the volume of overdue KidCare Assist redeterminations at the time data was given to the auditors. Of the 4,300 infants currently enrolled in KidCare Moms & Babies Expansion, there are only 114 children (2.7%) ages 1 and older. These 114 will be placed in the appropriate KidCare program in the coming weeks. In addition, the Department has initiated implementation of a system edit to prevent future incidents.

Recommendation 7 - The Department of Public Aid and the Department of Human Services should assure that when enrollees become too old to be enrolled that they are excluded from the KidCare Program.

Response - This situation was also intensified due to the volume of overdue KidCare Assist redeterminations that existed when the data was given to the auditors. Of the 46,000 persons enrolled in KidCare Assist Expansion, there are 225 adults (0.5%) whose eligibility must be reviewed. These adults will be placed in the appropriate Medicaid program in the coming weeks. In addition, the Department has initiated implementation of a system edit to prevent future incidents.

George H. Ryan, *Governor*

Illinois Department of Human Services

Linda Reneé Baker, *Secretary*

509 West Capitol • Springfield, Illinois 62704

June 19, 2002

Mr. Ed Wittrock
Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, IL 62703-3154

Dear Mr. Wittrock:

Attached are the Department's responses to the OAG Audit of the KidCare Program.

If you have any questions, please contact me.

Thank you.

Sincerely,

James R. Donkin

James R. Donkin, CIA
Chief Internal Auditor

JRD:lb
Attachment

OAG Audit of the KidCare Program
Department of Human Services' Responses

Recommendation #2:	The Departments of Public Aid and Human Services should assure that income is properly determined and appropriate documentation is included in the case files.
Response:	Accepted. The Department continues to ensure income is accurately determined and documented in the case files. It is important to note that income is properly determined in the majority of cases maintained in local offices and although policies and procedures are in place, the system is subject to human error.
Recommendation #3:	The Departments of Public Aid and Human Services should assure that KidCare re-determinations are done when required and income is properly determined.
Response:	Accepted. The Department has made it a priority to ensure KidCare cases maintained in local offices are redetermined at least every 12 months and will reinforce policy regarding timely re-determinations. Considering the number of cases the Department administers, we continue to believe timely re-determinations are performed at an excellent rate.
Recommendation #6:	The Department of Public Aid and the Department of Human Services should assure that children over age one are transferred out of Mom's and Babies into the appropriate KidCare category.
Response:	Accepted. At the direction of the Department of Public Aid, the Department of Human Services will implement system edits to automatically code children to the correct KidCare category when they turn age 1, 6 and 19. On-going redeterminations will continue to decrease the number of erroneously coded children until the edit is implemented.

Recommendation #7: The Department of Public Aid and the Department of Human Services should assure that when enrollees become too old to be enrolled that they are excluded from the KidCare Program.

Response: Accepted. The Department of Human Services implemented a system edit at the direction of the Department of Public Aid on June 18, 2001 to prevent 19 year olds from continuing their KidCare eligibility unless they are pregnant, disabled or if the individual is a parent with income below the MANG standard. The system enhancements to be requested by DPA mentioned in the prior response will mitigate exceptions to the current edit as identified in the audit.

AUDITOR COMMENT

1 Examples of improved program effectiveness that the Public Aid included in its Advance Planning Document were: reducing the current costs of issuing monthly cards, reducing the number of eligibility related rejected claims, and laying the foundation for advanced fraud and abuse detection measures.