STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT OF THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM

AUGUST 2016

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

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

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

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

SIGNED ORIGINAL ON FILE

Frank J. Mautino
Auditor General

Springfield, Illinois
August 2016

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

REPORT DIGEST

PROGRAM AUDIT

For the Year Ended: June 30, 2015

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EXECUTIVE SUMMARY

Covering ALL KIDS Health Insurance Program

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act (215 ILCS 170/63) directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. This is the **seventh** annual audit (FY15), and follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. The audit found:

1. In FY15, children enrolled in EXPANDED ALL KIDS increased by 25% to 102,182.
2. The total number of recipients increased from 52,075 on June 30, 2014 (FY14) to 66,258 on June 30, 2015 (FY15). The number of undocumented immigrant recipients decreased from 30,441 in FY14 to 26,183 in FY15.
3. The number of citizen/documented immigrant recipients (Premium Level 2) almost doubled from 21,634 in FY14 to 40,075 in FY15.
4. Of the 29,881 EXPANDED ALL KIDS recipients that required an annual redetermination of eligibility in FY15, we found 3,715 (12%) were not redetermined annually as required.
5. We tested 40 initial eligibility cases from FY15, and determined HFS and DHS were missing documentation needed to verify residency in 30 percent of cases, birth/age in 38 percent of cases, and one month's income in 38 percent of cases.
6. We tested 40 cases redetermined in FY15, and determined HFS and DHS were missing documentation needed to verify residency in 20 percent of cases and birth/age in 78 percent of cases. Of the 35 cases tested where recipients reported having some income, we found 30 days of income was reviewed in all cases; however, we did identify 2 of the 35 cases (6%) where caseworkers did not calculate the income correctly.
7. In FY15, 157 recipients received 1,276 services totaling $104,704 after the month of their 19th birthday. Additionally, there were 477 individuals who were enrolled with more than one identification number.
8. We tested initial eligibility cases and cases redetermined during FY15. We found that 44 percent of the initial cases (17 of 39), and 23 percent of the redetermined cases (9 of 40), were coded as "undocumented" even though we found evidence supporting citizenship or documented immigrant status.
9. HFS and DHS did not identify the correct citizenship status for 5,999 recipients, and as a result, the State lost $2.8 million in federal matching Medicaid funds in FY15. This issue has been reported since the first ALL KIDS audit, which was for FY09.
10. In 2011, HFS made the procedures for orthodontic services less stringent, which increased orthodontia services from $322,892 in FY10 to $3.6 million by FY14. We recommended that HFS review and monitor eligibility for orthodontic services more effectively.

AUDIT SUMMARY AND RESULTS

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

Since the EXPANDED ALL KIDS program is a subset of a much larger ALL KIDS program, many of the recommendations in this report may be relevant to the program as a whole.

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

Since the EXPANDED ALL KIDS program is a subset of a much larger ALL KIDS program, **many of the recommendations in this report may be relevant to the program as a whole.**

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act (215 ILCS 170/63) directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. The Public Act was effective June 1, 2009. This is the seventh annual audit (FY15).

This FY15 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' and the Department of Human Services' actions to address prior audit findings. (pages 1-3)

ALL KIDS PROGRAM

The program included 102,182 EXPANDED ALL KIDS enrollees at any point during FY15, an increase of 25 percent from the previous year (FY14) when there were 81,440 enrollees.

According to HFS, in FY15, Illinois' ALL KIDS program as a whole had a total of 1.8 million enrollees and HFS paid almost $3.2 billion in claims. The program included 102,182 EXPANDED ALL KIDS enrollees at any point during FY15, an increase of 25 percent from the previous year (FY14) when there were 81,440 enrollees. On June 30, 2015, there were 66,258 enrollees as a result of the Covering ALL KIDS Health Insurance Act. Forty percent or 26,183 of the enrollees were classified as undocumented immigrants in the HFS data. Digest Exhibit 1 breaks out enrollment by fiscal year, by plan, and by whether the child was classified as a citizen/documented immigrant or as undocumented.

Digest Exhibit 1
EXPANDED ALL KIDS ENROLLMENT BY PLAN [2]
As of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY14	FY15	FY14	FY15
Assist $35,652[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		28,460	23,757
Share $38,076[1]			702	466
Premium Level 1 $50,688[1]			965	1,279
Premium Level 2 $77,112[1]	21,634[3]	40,075[3]	314	681
Totals [4]	**21,634**	**40,075**	**30,441**	**26,183**

Notes:
[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY15.
[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2014 and 2015. There were 81,440 enrollees eligible at some point during FY14 and 102,182 enrollees eligible at some point during FY15.
[3] HFS was notified on June 4, 2013, by the Centers for Medicare and Medicaid Services, that Illinois children up to 300% of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008.
[4] Total enrollees on June 30, 2014, was 52,075, which increased by 14,183, to 66,258 on June 30, 2015.
Source: ALL KIDS enrollment data provided by HFS.

In FY15, the cost for services increased by more than $16 million or 24 percent to almost $86.5 million.

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10, and to $89.3 million in FY11. During the next three years, the total cost for services dropped to $87.8 million in FY12, to $75.2 million in FY13, and to $70 million in FY14. Much of the decrease in the program in FY13 was due to the change in eligibility criteria, which eliminated Premium Level 3 through Level 8. In FY15, the cost for services increased by more than $16 million or 24 percent to almost $86.5 million.

In FY14, undocumented immigrants accounted for 60 percent of the total costs for the EXPANDED ALL KIDS program; however, in FY15, undocumented immigrants accounted for 44 percent of the total cost for services.

Digest Exhibit 2 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was classified by HFS as undocumented for both FY14 and FY15.

In the past, a large portion of the cost for services for the EXPANDED ALL KIDS Program was for undocumented immigrants. In FY14, undocumented immigrants accounted for 60 percent of the total costs for the EXPANDED ALL KIDS program; however, in FY15, undocumented immigrants accounted for 44 percent of the total cost for services.

The total cost for undocumented immigrants has decreased in each of the last three years. The cost for services for undocumented immigrants totaled: $54.9 million in FY09; $60.2 million in FY10; $54.9 million in FY11; $55.7 million in FY12; $48.8 million in FY13; $42.3 million in FY14; and $38.3 million in FY15.

Digest Exhibit 2
EXPANDED ALL KIDS COST OF SERVICES PROVIDED BY ALL KIDS PLAN
Fiscal Years 2014 and 2015

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY14	FY15	FY14	FY15	FY14	FY15
Assist $35,652[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$39,546,799	$35,590,141	$39,546,799	$35,590,141
Share $38,076[1]			$971,681	$607,404	$971,681	$607,404
Premium Level 1 $50,688[1]			$1,285,740	$1,422,136	$1,285,740	$1,422,136
Premium Level 2 $77,112[1]	$27,766,776[3]	$48,197,260	$473,790	$666,187	$28,240,566	$48,863,447
Totals [2]	**$27,766,776**	**$48,197,260**	**$42,278,010**	**$38,285,868**	**$70,044,785**	**$86,483,128**

Notes:
[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY15.
[2] Totals may not add due to rounding.
[3] The federal matching rate was 65% in FY14; therefore, the State's share for services was $9.7 million. The reimbursement rate in FY15 was 88.62%; therefore, the State's share was $5.5 million for FY15 services.
Source: ALL KIDS data provided by HFS.

HFS received $8.3 million in premiums from enrollees in FY14 and $13.4 million in FY15. As a result, the net cost of EXPANDED ALL KIDS, after premium payments, was approximately $61.7 million in FY14 and $73.1 million in FY15. (pages 7-15)

FOLLOW-UP ON FY14 RECOMMENDATIONS

In FY14, there were five recommendations which included areas related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment. All five issues from our previous FY14 audit released in February 2016 were repeated during the FY15 audit:

1. Redetermination of Eligibility

3,715 of the 29,881 (12%) were not redetermined annually as required by the Act.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY15, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 29,881 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY15. Our analysis of the data showed that 3,715 of the 29,881 (12%) were not redetermined annually as required by the Act. (pages 16-18)

2. ALL KIDS Data Reliability

477 individuals appeared to be enrolled with more than one identification number.

During our review of the FY15 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY15 data, we identified 477 individuals who appeared to be enrolled with more than one identification number. We also identified 157 recipients that received 1,276 services totaling $104,704 after the month of their 19th birthday. (pages 18, 19)

3. Classification of Documented Immigrants

During testing of eligibility determinations, we determined HFS and DHS did not identify the correct citizenship status for recipients, and as a result, the State is losing federal matching Medicaid funds. We found in past audits, and continue to find, EXPANDED ALL KIDS recipients coded as undocumented that should not be coded as undocumented. Many recipients had verified social security numbers, alien registration numbers, or a combination of both. According to DHS, "verified" means the social security number has been verified through an electronic match with the Social Security Administration. Recipients with verified social security numbers and/or alien registration numbers appear to be documented immigrants and would, therefore, be eligible for federal matching funds.

As a result of the miscoding errors, the State is annually losing federal matching dollars. In FY15, the total federal reimbursement lost was $2.8 million.

We determined the FY15 eligibility data contained 5,999 "undocumented" recipients who had social security numbers that were verified, of which 614 also had an alien registration number. We reviewed the services provided to the 5,999 "undocumented" recipients in FY15 and determined they had 105,695 services for a total cost of almost $5.3 million. This recommendation related to the miscoding of documented immigrant status has been an issue since the first ALL KIDS audit, which was for FY09. It continues to be an issue that has not been adequately addressed by either HFS or DHS. As a result of the miscoding errors, the State is annually losing federal matching dollars. In FY15, the total federal reimbursement lost was $2.8 million.

Initial Eligibility Testing

17 of 39 new recipients sampled (44%) were coded as undocumented but were likely citizens or documented immigrants.

During our testing of 40 new cases that were approved during May and June 2015, only one was not classified as undocumented. We found that 17 of the cases were coded as undocumented but likely should have been coded as citizens/documented immigrants, as there was documentation to support citizenship or documented immigrant status for each of the 17 classified as undocumented. Many of the cases had documentation verifying the recipient's social security number and/or alien status. Therefore, a total of 17 of 39 recipients sampled (44%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.

Eligibility Testing for Redetermination

9 of the 40 (23%) recipients that were redetermined were coded as undocumented even though the enrollees had a verified social security number or other evidence supporting they were likely citizens or documented immigrants.

During our review of 40 recipients that were redetermined during May or June 2015, we found 9 of the 40 (23%) were coded as undocumented even though the enrollees had a verified social security number or other evidence supporting they were likely citizens or documented immigrants. We provided these nine to DHS, and DHS officials agreed they were likely documented. (pages 19-21)

4. Eligibility Documentation

HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and immigration/citizen status. During our review of the new and continued eligibility process for EXPANDED ALL KIDS, we determined the data matching component used by the Integrated Eligibility System (IES) or the Illinois Medicaid Redetermination Project cannot be utilized for the undocumented recipients in the EXPANDED ALL KIDS program. Electronic data matches and searches based on social security numbers are ineffective for the undocumented portion of this population because they do not have social security numbers. Therefore, in many instances, the auditors, along with DHS officials, searched through IES for scanned copies of documents to determine residency, income, birth/age, and immigration/ citizenship status for all recipients, including undocumented recipients.

Residency was not verified in 12 of the 40 (30%) of the initial eligibility cases tested, and birth/age information was not verified in 15 of the 40 (38%) cases tested.

Initial Eligibility Testing

We randomly selected 40 of the 409 new cases approved during May and June 2015 and found significant issues. Residency was not verified in 12 of the 40 (30%) cases tested, and birth/age information was not verified in 15 of the 40 (38%) cases tested. Of the 40 cases tested, only 13 reported having some income. We found 30 days of income was not reviewed in 38 percent (5 of 13) of the cases where income was reported.

Eligibility Redetermination Testing

Residency was not verified in 8 of the 40 (20%) of the redetermination cases tested, and birth/age information was not verified in 31 of the 40 (78%) cases tested.

We tested 40 of the medical only redeterminations that occurred during May and June 2015 and found issues regarding Illinois residency, birth/age, and income documentation. Residency was not verified in 8 of the 40 (20%) cases tested, and birth/age information was not verified in 31 of the 40 (78%) cases tested. Of the 35 cases tested where recipients reported having some income, 30 days of income was reviewed in all cases. However, we did identify 2 of the 35 cases (6%) where caseworkers did not calculate the income correctly. (pages 21-26)

5. Policies Covering Orthodontic Treatment

Expenditures by the State for orthodontic services for children in EXPANDED ALL KIDS increased dramatically from FY10 to FY14. In FY10, the EXPANDED ALL KIDS program paid for only $322,892 in orthodontic services. By FY14, 4,020 EXPANDED ALL KIDS recipients

had orthodontic services totaling $3.6 million. This increase corresponds to the time when the scoring tool used to determine medical necessity for orthodontic services was revised. A review conducted by the HFS Office of the Inspector General concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity.

HFS agreed with this recommendation and indicated it would review the issues raised and take appropriate action. Since our FY14 audit was released in February 2016, and the audit period for this audit ended earlier on June 30, 2015, this part of the recommendation is repeated and we will follow up during our next audit which covers FY16. (pages 26-30)

RECOMMENDATIONS

The audit report contains five recommendations. Two recommendations were specifically for the Department of Healthcare and Family Services. Three recommendations were for both the Department of Healthcare and Family Services and the Department of Human Services. The Department of Human Services agreed with its three recommendations. The Department of Healthcare and Family Services agreed with all five of its recommendations. Appendix F to the audit report contains the agency responses.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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AUDITORS ASSIGNED: This performance audit was conducted by the staff of the Office of the Auditor General.

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COVERING ALL KIDS HEALTH INSURANCE PROGRAM

BACKGROUND

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act (215 ILCS 170/63) directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter (see Appendix A). The Public Act was effective June 1, 2009. This is the seventh annual audit (FY15), and follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. The previous six annual audits covered FY09 through FY14.

- The first audit (FY09) was released in May 2010 and contained 13 recommendations.
- The second audit (FY10) was released in April 2011 and contained 14 recommendations.
- The third audit (FY11) was released in October 2012 and contained 11 recommendations.
- The fourth audit (FY12) was released in December 2013 and contained 10 recommendations.
- The fifth audit (FY13) was released in August 2014 and contained 8 recommendations.
- The sixth audit (FY14) was released in February 2016 and contained 5 recommendations.

The recommendation related to the miscoding of documented immigrant status has been an issue since the first ALL KIDS audit, which was for FY09 and was released in May 2010. It continues to be an issue that has not been adequately addressed by either HFS or DHS. As a result of the miscoding errors, the State is annually losing federal matching dollars. In FY15, the total federal reimbursement lost was $2.8 million.

Six Years of Audit Recommendations

Many of the recommendations during the past six years have centered on eligibility and annual eligibility redeterminations. Other recommendations have included areas such as:

1. miscoding of documented immigrants;
2. failure to terminate coverage when premiums were not paid;
3. failure to require individuals who are self-employed to provide detailed business records;
4. duplicate enrollees and enrollees over the allowable age of 18 within the data;
5. billing irregularities with dental, optical, preventive medicine, and transportation claims;
6. payment for excluded non-emergency transportation services; and
7. lacking policies and documentation related to orthodontic services.

HISTORY OF THE ALL KIDS AUDITS CONDUCTED BY THE OAG

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and State Children's Health Insurance Program (SCHIP) populations, **was expanded** by the Covering ALL KIDS Health Insurance Act (Act) to include all

uninsured children not previously covered. The expansion added children whose family income was greater than 200 percent of the federal poverty level and all undocumented immigrant children. At that time, the KidCare program was renamed ALL KIDS.

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

Throughout our audits, we refer to the portion of the ALL KIDS program that serves the uninsured children not previously covered by KidCare (prior to FY07) as "EXPANDED ALL KIDS." Since the EXPANDED ALL KIDS program is a subset of the ALL KIDS program as a whole, many of the recommendations are relevant to the ALL KIDS program as a whole.

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

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

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

STATE STATUTES RELATED TO ALL KIDS

The Covering ALL KIDS Health Insurance Act (215 ILCS 170) was effective July 1, 2006. The Act expanded program benefits to cover **all uninsured children** in families regardless of family income. The provisions in the Act prior to the passage of Public Act 96-1501 defined a child as a person under the age of 19. The eligibility requirements for the program prior to Public Act 96-1501 were as follows:

1) must be a resident of the State of Illinois;

2) must be ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act; and

3) must have been uninsured for an extended period of time as set forth by Department rule or meet certain exceptions such as losing insurance due to job loss.

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

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

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

ILLINOIS ADMINISTRATIVE CODE FOR ALL KIDS

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

The administrative rules reiterate some of the eligibility criteria set forth by the Act and expand on some of the eligibility exclusions and reasons for termination of coverage. The rules note that covered services are those that are covered by the Children's Health Insurance Program, minus service exclusions that include non-emergency medical transportation and over-the-counter drugs. The rules also have several important provisions that specifically relate to this audit. These include:

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

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

RECENT CHANGES AFFECTING THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM AUDIT

Four events in recent years have had a significant impact on the EXPANDED ALL KIDS program and our audits. These events are detailed below.

1) The Covering ALL KIDS Health Insurance Act was changed to limit the household income to be eligible for the EXPANDED ALL KIDS program.

The first was the passage of Public Act 96-1501, which added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income was above 300 percent of the federal poverty level (FPL) were no longer eligible. Children enrolled as of July 1, 2011, could remain enrolled in the program until June 30, 2012. As a result, there are fewer EXPANDED ALL KIDS participants and expenditures to be audited.

2) Illinois was approved to receive federal reimbursement for some EXPANDED ALL KIDS program recipients.

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

Until the FY13 audit, our prior EXPANDED ALL KIDS audits had only included children whose medical care was totally State-funded. In FY13 and FY14, with this change, the federal government reimbursed 65 percent of eligible costs for this population (children from families with income between 200 and 300 percent of FPL). Now, in FY15, the reimbursement rate for the Premium Level 2 recipients increased to 88.62 percent due to provisions found in the Affordable Care Act (ACA). Additionally, in FY13, the State was granted retroactive reimbursement dating back to July 1, 2008. According to HFS officials, as of October 29, 2015, HFS had recouped a total of $40.4 million.

HFS was also given retroactive reimbursement for documented immigrants back to April 1, 2009. This allowed federal reimbursement for documented immigrants regardless of their time in the country. Prior to this, for the State to receive federal reimbursement, documented

immigrants had to be in the country for five years. HFS officials estimate $30 million was recouped as of June 30, 2015.

3) Changes to HFS' payment cycle changed the audit methodology for reporting payments by fiscal year.

The third event affecting our audit is changes in HFS' payment cycle for EXPANDED ALL KIDS claims. When we identified a large decrease in payments in FY12, HFS indicated that the decrease was due to the payment cycle and not a decrease in services. This means that the services were provided in FY12, but were not paid until after the end of the fiscal year.

As a result, beginning with our FY13 audit, we began reporting on all costs for services that occurred during the fiscal year regardless of when they were paid. Therefore, the primary focus now is on services provided during the fiscal year since payments are impacted by cash flow issues and do not accurately depict program activity when there are payment cycle delays.

4) HFS and DHS started using Modified Adjusted Gross Income (MAGI) budgeting to determine eligibility for certain households requesting or receiving medical assistance.

The fourth and most recent change requires a new budgeting methodology for determining ALL KIDS eligibility effective on October 1, 2013. The ACA required all states apply a new budget methodology based on MAGI to determine eligibility for certain households requesting or receiving medical assistance. The purpose of using the MAGI budgeting methodology is to align financial eligibility rules with the Health Insurance Marketplace. Even though much of the EXPANDED ALL KIDS population is not federally funded, to avoid confusion, HFS uses the same budgeting methodology for all its medical programs. On October 1, 2013, HFS and DHS began using MAGI budgeting standards for new applications received. In addition, MAGI rules for redeterminations became effective on April 1, 2014. The MAGI methodology applies to several groups including children under 19 in ALL Kids Assist, Share, and Premium Levels 1 and 2.

The ACA required states to convert income standards and take into account that certain types of income (i.e., child support, workers' compensation, educational scholarships and grants, veterans' benefits, and supplemental security income (SSI)) will no longer apply under the MAGI budgeting methodology. MAGI budgeting determines how to count income and who to include in the income standard, known as the Eligibility Determination Group (EDG). The MAGI budgeting methodology documents:

- how to count income based on federal tax rules for determining adjusted gross income with some modifications; and

- whom to include in each person's EDG is determined by one of two sets of rules: tax filer rules or relationship rules.

According to DHS officials, the hardest part of determining eligibility is applying the MAGI budgeting methodology. Based on our review of the MAGI process, we also believe that

determining who to include in each person's EDG is the most complicated part of the MAGI eligibility determination process.

As shown in Exhibit 1, in FY13, a family of four qualified for ALL KIDS Assist at 133 percent of the Federal Poverty Level (FPL) ($31,321.50 annually); however, the same family of four qualified at 147 percent of the FPL ($35,064 annually in FY14 and $35,652 in FY15). Therefore, the way DHS processed both new ALL KIDS applications and annual redeterminations changed during our FY14 audit period. Exhibit 1 shows the annual applicable federal poverty income guidelines for a family of four by plan for each of the last three fiscal years. The FY13 figures are prior to the implementation of the MAGI standards.

Exhibit 1
ANNUAL FEDERAL POVERTY LEVEL (FPL) FOR FAMILY OF FOUR COMPARISON
Fiscal Years 2013, 2014, and 2015

EXPANDED ALL KIDS Plan	FY13 Percent of FPL	Annual FY13 Maximum Income	FY14/FY15 Percent of FPL[1]	Annual Maximum Income[1]	
				FY14	FY15
Assist	133%	$31,321	147%	$35,064	$35,652
Share	150%	$35,325	157%	$37,440	$38,076
Premium Level 1	200%	$47,100	209%	$49,848	$50,688
Premium Level 2	300%	$70,650	318%	$75,840	$77,112

Note: [1] Does not include certain types of excluded income (child support, workers' compensation, veterans' benefits, SSI, etc. –see text for complete list).

Source: DHS eligibility documentation.

Revised Initial Eligibility Determination

On October 1, 2013, HFS and DHS replaced the Automated Intake System with the newly created Integrated Eligibility System (IES). IES automatically calculates the income and other eligibility factors from a series of matches and from information entered by the caseworker. As part of the new IES, Illinois implemented the MAGI budgeting standards for new applications received as of October 1, 2013.

Applications for ALL KIDS can be submitted online, via telephone, by mail, or in person at a local DHS office. Once the application is uploaded into IES, the caseworker scans and uploads the supporting documentation. IES also uses electronic data matches or clearances (listed below) to verify eligibility. Client social security numbers are used to extract information from the following sources:

- **Federal Data Hub** –used to verify U.S. citizenship and immigration status;
- **State Online Query (SOLQ)** –Social Security Administration information used to verify social security number, date of birth, date of death, and current federal benefits;
- **Automated Wage Verification System (AWVS)** –used to verify income and unemployment benefits from the Illinois Department of Employment Security;

- **Illinois Secretary of State** –used to verify Illinois residency;
- **Third Party Liability** –used to identify other health insurance coverage; and
- **The Work Number** –used to verify earned income found in the Equifax database.

Revised Redetermination of Eligibility

Annual redeterminations for ALL KIDS are completed as part of the Illinois Medicaid Redetermination Project (IMRP), which began in February 2014. MAGI rules for redeterminations became effective on April 1, 2014. The IMRP uses the Max-IL system to store all: 1) redetermination forms mailed to the recipient; 2) returned redetermination documents; 3) electronic data matching results; 4) requests by the Department for missing information; and 5) verifications provided by the recipient. The Max-IL system collects electronic data from various sources about the case and makes an automated recommendation about ongoing eligibility.

Although the third party vendor (Maximus) no longer helps make eligibility redeterminations, Maximus mails the redetermination forms, pre-populates the redetermination form with known information, and stores electronic copies of forms, notices, and returned verifications.

The recipients receive a pre-populated redetermination form two months before it is due. They are asked to provide any new information (household members, income sources and amounts, etc.) and proof for any of the new information. Using electronic data matching, caseworkers make eligibility decisions based on verifications using social security numbers to determine income, residence, and citizenship.

ALL KIDS PROGRAM

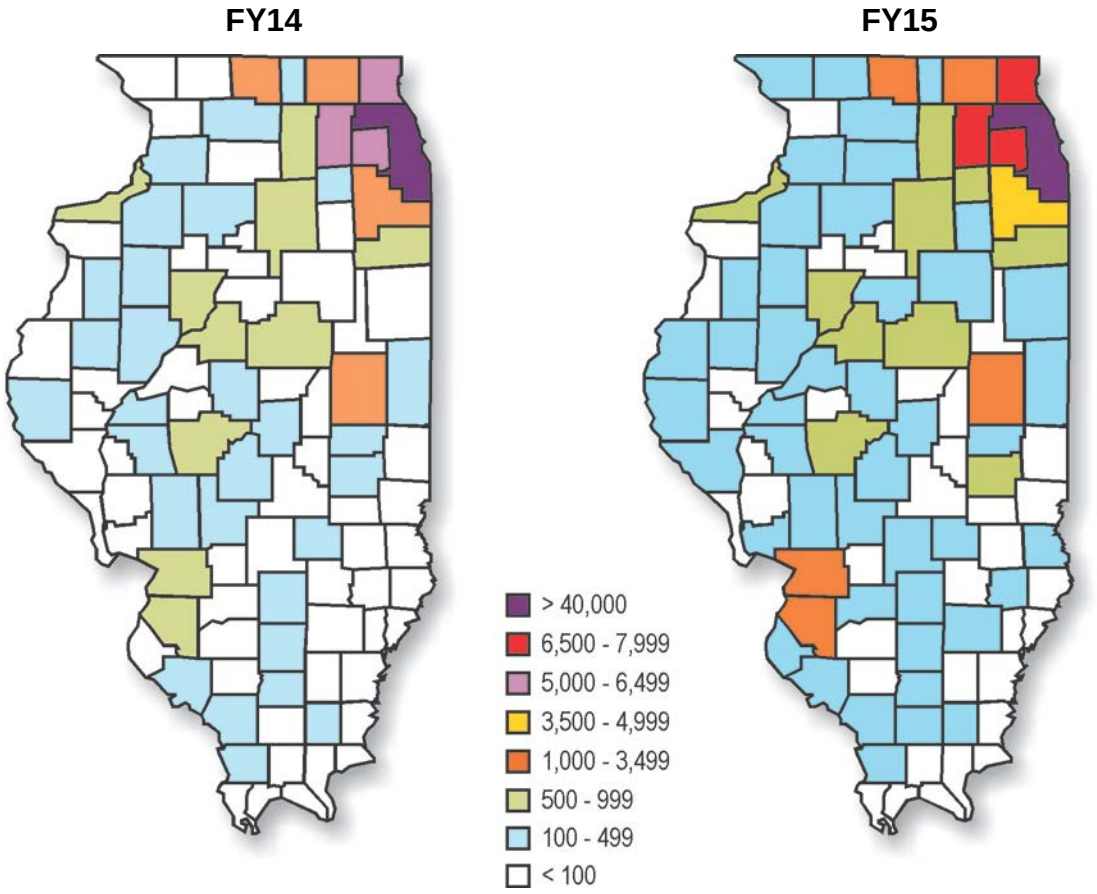
According to HFS, in FY15, Illinois' ALL KIDS program as a whole had a total of 1.8 million enrollees and HFS paid almost $3.2 billion in claims. The program included 102,182 EXPANDED ALL KIDS enrollees **at any point** during FY15, an increase of 25 percent from the previous year (FY14) when there were 81,440 enrollees.

EXPANDED ALL KIDS PROGRAM STATISTICS

	FY14	FY15
Enrollees at any point	81,440	102,182
Enrollees on June 30	52,075	66,258
Total Cost of Services Provided	$70,044,785	$86,483,128
Total Net Cost of Services after Premium Payments	$61,726,571	$73,115,178

As shown in Exhibit 2, the EXPANDED ALL KIDS population increased in several counties in FY15 with the majority of the enrollees living in Cook County (47,191). The other counties with large populations of EXPANDED ALL KIDS enrollees included: DuPage (7,900); Kane (7,116); Lake (7,028); and Will (4,626).

Exhibit 2
EXPANDED ALL KIDS ENROLLMENT BY COUNTY
Fiscal Years 2014 and 2015



Note: Cook County (Purple >40,000) increased from 40,380 in FY14 to 47,191 in FY15.

Source: FY14 and FY15 eligibility data provided by HFS.

ALL KIDS Enrollment

On June 30, 2015, there were 66,258 enrollees as a result of the Covering ALL KIDS Health Insurance Act. Forty percent or 26,183 of the enrollees were classified as undocumented immigrants in the HFS data. Until this increase in FY15, total enrollment had decreased from 74,975 at the end of FY11 to 52,075 at the end of FY14. There was a 22,900 enrollee decrease from FY11 to FY14, some of which was due to the elimination of Premium Levels 3 through 8 after June 30, 2012, as required by Public Act 96-1501.

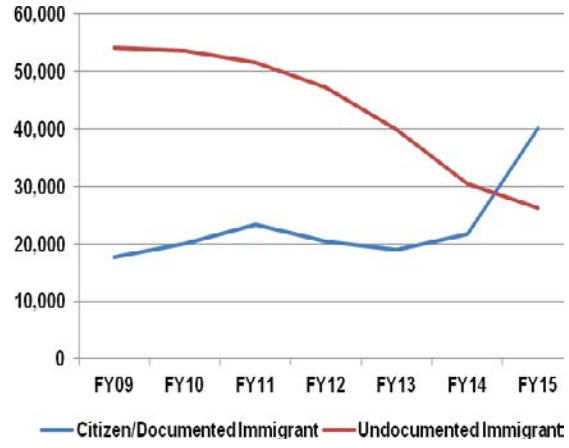
During the last six years, the number of undocumented enrollees decreased from 54,073 in June 2009 to 26,183 in June 2015 (see Exhibit 3), while the number of citizen/documented immigrant EXPANDED ALL KIDS recipients (Premium Level 2) stayed around 20,000.

However, during the next fiscal year, the number of citizen/documented immigrant recipients (Premium Level 2) almost doubled from 21,634 in FY14 to 40,075, in FY15.

The large increase in the Level 2 citizen/documented immigrant population is a change that has not occurred during the last six fiscal years. As shown in Exhibit 4, 30,578 of the 40,075 recipients in the Level 2 citizen/documented immigrant category were new to EXPANDED ALL KIDS in FY15. Therefore, 9,497 of the recipients continued their eligibility in FY15 that were eligible in FY14, while the remaining 30,578 were new to the EXPANDED ALL KIDS program.

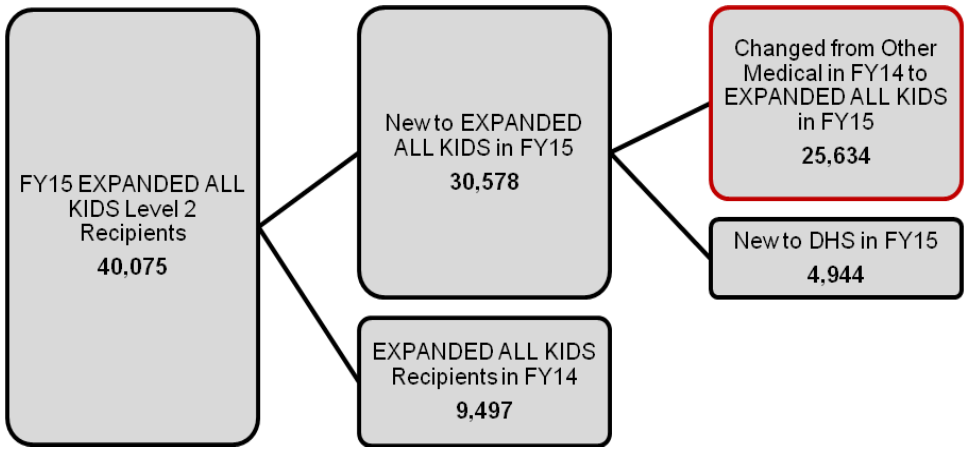
We requested FY15 eligibility data from HFS and looked specifically at the new 30,578 EXPANDED ALL KIDS recipients and determined that 25,634 of them were eligible for some other State medical benefits prior to FY15 (see Exhibit 4). Therefore, only 4,944 were new enrollees who had not had any State medical benefits in FY14.

Exhibit 3
EXPANDED ALL KIDS ENROLLMENT
As of June 30 for Fiscal Years 2009 - 2015



Source: ALL KIDS enrollment data provided by HFS.

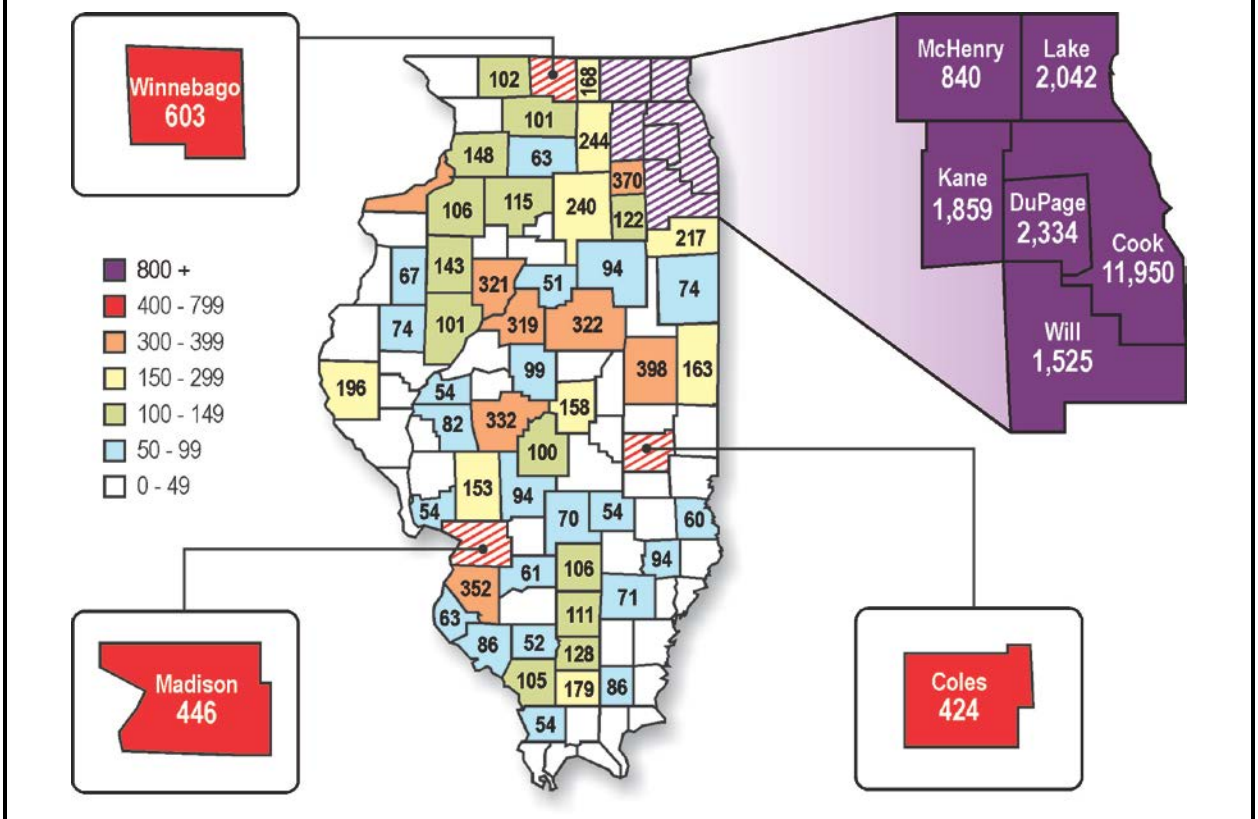
Exhibit 4
INCREASE IN LEVEL 2 CITIZEN/DOCUMENTED IMMIGRANT POPULATION
Fiscal Year 2015



Source: ALL KIDS enrollment data provided by HFS.

Exhibit 5 breaks out the 30,578 Level 2 citizen/documented immigrant recipients that were new to EXPANDED ALL KIDS in FY15 by county. The data shows that there were a large numbers of new recipients in several counties. As a result, we concluded the increase in Level 2 enrollees was not isolated to specific geographic areas of the State.

Exhibit 5
FY15 INCREASE IN LEVEL 2 CITIZEN/DOCUMENTED IMMIGRANT ENROLLEES
By County



Source: FY14 and FY15 enrollment data provided by HFS and summarized by the OAG.

As a result of this large increase, we selected a random sample of 68 cases from FY15 for detailed testing. The 68 cases were chosen from the 25,634 new EXPANDED ALL KIDS recipients in FY15 who were eligible for some other State medical benefits prior to FY15, such as Medicaid or Premium Level 1. We provided the 68 cases to DHS and worked with them to determine a cause for the increase. We also provided the sample results to HFS for its review.

We determined that the recipients were changed to Level 2 due to an increase in family income or a change in family size resulting from the implementation of the new MAGI standards. However, there was no clear reason identified by our sample testing that explained why such a large increase in the number of citizen/documented immigrants who were new to Level 2 occurred in FY15. DHS indicated that the newly implemented electronic data

clearances, specifically in regards to income, were responsible for the increase. HFS believes several factors have contributed to the increase. HFS provided the following response:

1. *We believe families that never thought to apply for All Kids are coming to us because advertising around the FFM [Federal Facilitated Marketplace] open enrollment periods continues to generate high application volumes to the ABE [Application for Benefits Eligibility] online app as well as healthcare.gov.*

2. *When FamilyCare covered adults at higher income levels, Illinois experienced an increase in children's enrollment, and it appears there is a direct connection between parents seeking coverage and the addition of children to coverage. Since parents can get financial assistance to purchase health insurance through the FFM, we believe the same phenomenon is occurring. More families are motivated to apply to the FFM for the entire family and when income is under 300% FPL, the FFM transfers the application for the children to the state. Many of these children are eligible for All Kids Premium Level 2.*

3. *More enrolled children are progressing to Premium Level 2 as a result of the renewed focus on completing redeterminations. We suspect this may be related to some improvement in the state's economic climate.*

4. *The federal requirement under the Affordable Care Act to cover all dependents or pay a fine may be encouraging moderate income families to consider All Kids coverage.*

FY15 Enrollment by ALL KIDS Plan

There was an increase of 14,183 EXPANDED ALL KIDS enrollees from June 30, 2014, to June 30, 2015. The total number of recipients increased from 52,075 on June 30, 2014, to 66,258 on June 30, 2015. Exhibit 6 breaks out enrollment by fiscal year, by plan, and by whether the child was classified as a citizen/documented immigrant or as undocumented. Appendix B shows the ALL KIDS premium and co-pay requirements by plan during FY15.

The increase in recipients in FY15 occurred unexpectedly after enrollees had steadily decreased since FY09. The number of undocumented immigrant recipients decreased from 30,441 on June 30, 2014, to 26,183 on June 30, 2015, while the citizen/documented immigrant recipients increased from 21,634 on June 30, 2014, to 40,075 on June 30, 2015.

Exhibit 6
EXPANDED ALL KIDS ENROLLMENT BY PLAN [2]
As of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY14	FY15	FY14	FY15
Assist $35,652[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		28,460	23,757
Share $38,076[1]			702	466
Premium Level 1 $50,688[1]			965	1,279
Premium Level 2 $77,112[1]	21,634[3]	40,075[3]	314	681
Totals [4]	21,634	40,075	30,441	26,183

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY15.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2014 and 2015. There were 81,440 enrollees eligible at some point during FY14 and 102,182 enrollees eligible at some point during FY15.

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

[4] Total enrollees on June 30, 2014 was 52,075, which increased by 14,183, to 66,258 on June 30, 2015.

Source: ALL KIDS enrollment data provided by HFS.

COST OF ALL KIDS SERVICES PROVIDED

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10, and to $89.3 million in FY11. During the next three years, the total cost for services dropped to $87.8 million in FY12, to $75.2 million in FY13, and to $70 million in FY14. Much of the decrease in the program in FY13 was due to the change in eligibility criteria, which eliminated Premium Level 3 through Level 8. In FY15, the cost for services increased by more than $16 million or 24 percent to almost $86.5 million.

In the past, a large portion of the cost for services for the EXPANDED ALL KIDS program was for undocumented immigrants. In FY14, undocumented immigrants accounted for 60 percent of the total costs for the EXPANDED ALL KIDS program; however, in FY15, undocumented immigrants accounted for 44 percent of the total cost for services.

The total cost for undocumented immigrants has decreased in each of the last three years. The cost for services for undocumented immigrants totaled: $54.9 million in FY09; $60.2

million in FY10; $54.9 million in FY11; $55.7 million in FY12; $48.8 million in FY13; $42.3 million in FY14; and $38.3 million in FY15.

Exhibit 7 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was classified by HFS as undocumented for both FY14 and FY15. Additionally, Exhibit 7 shows the cost of services increased by more than $16 million from $70 million in FY14 to $86.5 million in FY15.

Exhibit 7
EXPANDED ALL KIDS COST OF SERVICES PROVIDED BY ALL KIDS PLAN
Fiscal Years 2014 and 2015

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY14	FY15	FY14	FY15	FY14	FY15
Assist $35,652[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$39,546,799	$35,590,141	$39,546,799	$35,590,141
Share $38,076[1]			$971,681	$607,404	$971,681	$607,404
Premium Level 1 $50,688[1]			$1,285,740	$1,422,136	$1,285,740	$1,422,136
Premium Level 2 $77,112[1]	$27,766,776[3]	$48,197,260	$473,790	$666,187	$28,240,566	$48,863,447
Totals[2]	$27,766,776	$48,197,260	$42,278,010	$38,285,868	$70,044,785	$86,483,128

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY15.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 65 percent in FY14; therefore, the State's share for services was $9.7 million. The reimbursement rate in FY15 was 88.62%; therefore, the State's share was $5.5 million for FY15 services.

Source: ALL KIDS data provided by HFS.

COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

In FY15, the total cost of services provided for the EXPANDED ALL KIDS program totaled $86.5 million. According to data provided by HFS, 89 percent of the cost for services provided during FY15 was paid for 12 categories of services each totaling more than $1 million. Exhibit 8 shows that these 12 categories totaled $77.3 million of the $86.5 million in total EXPANDED ALL KIDS payments and were for the following services: Pharmacy; Capitation Services; Inpatient Hospital Services (General); Dental Services; Physician Services; Outpatient Services (General); General Clinic Services; Inpatient Hospital Services (Psychiatric); Healthy Kids Services; Mental Health Rehab Option Services; Speech Therapy/Pathology Services; and Physical Therapy Services. The category with the highest percentage of payments was Pharmacy at 16 percent.

Appendix C of this report shows EXPANDED ALL KIDS costs for services provided in FY15 by category of service, and Appendix D shows costs for services provided in FY15 by plan and by category of service. Appendix E shows FY15 providers that were paid more than $50,000 from the EXPANDED ALL KIDS program.

Exhibit 8
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
Totaling more than $1 million during FY15

Category of Service	Total FY15 Cost	Percent of Total FY15 Cost
Pharmacy	$13,646,550	16%
Capitation Services	12,846,623	15%
Inpatient Hospital Services (General)	11,147,044	13%
Dental Services	10,204,221	12%
Physician Services	9,223,237	11%
Outpatient Services (General)	6,415,733	7%
General Clinic Services	4,044,543	5%
Inpatient Hospital Services (Psychiatric)	2,865,156	3%
Healthy Kids Services	2,703,609	3%
Mental Health Rehab Option Services	1,638,266	2%
Speech Therapy/Pathology Services	1,502,056	2%
Physical Therapy Services	1,041,766	1%
Total for categories costing > than $1 million	**$77,278,804**	**89%**
Other categories totaling < than $1 million	9,204,324	11%
Total Cost for All Service Categories	**$86,483,128**	**100%**

Note: Totals may not add due to rounding.

Source: FY15 ALL KIDS data provided by HFS.

COST OF SERVICES AND PREMIUMS COLLECTED

HFS received $8.3 million in premiums from enrollees in FY14 and $13.4 million in FY15. As a result, the net cost of EXPANDED ALL KIDS, after premium payments, was approximately $61.7 million in FY14 and $73.1 million in FY15. Exhibit 9 shows both FY14 and FY15 payments and premiums collected from the EXPANDED ALL KIDS programs.

Exhibit 9
COST OF SERVICES FOR EXPANDED ALL KIDS AND PREMIUM AMOUNTS COLLECTED
Fiscal Years 2014 and 2015

EXPANDED ALL KIDS Plan	FY14 Services Provided	FY14 Premiums Collected	FY14 Net Cost	FY15 Services Provided	FY15 Premiums Collected	FY15 Net Cost
Assist $35,652[1]	$39,546,799	n/a	$39,546,799	$35,590,141	n/a	$35,590,141
Share $38,076[1]	$971,681	$30	$971,651	$607,404	n/a	$607,404
Premium Level 1 $50,688[1]	$1,285,740	$128,018	$1,157,722	$1,422,136	$157,255	$1,264,881
Premium Level 2[2] $77,112[1]	$28,240,566	$8,190,167	$20,050,399	$48,863,447	$13,210,695	$35,652,752
Totals[3]	$70,044,785	$8,318,215	$61,726,571	$86,483,128	$13,367,950	$73,115,178

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY15.

[2] This exhibit includes the cost of services before any federal reimbursement for Level 2 enrollees.

[3] Totals may not add due to rounding.

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

FOLLOW-UP ON FY14 RECOMMENDATIONS

The next several sections of the report discuss the five recommendations from the FY14 audit. As shown in Exhibit 10 the five recommendations were for areas related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment. All five previous recommendations are repeated as shown in Exhibit 10.

Exhibit 10
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS

Recommendation Area	Status of Recommendations as Reported in FY14 Audit	Follow-up Testing Necessary
1. Redetermination of ALL KIDS eligibility	Repeated	Yes
2. ALL KIDS data reliability	Repeated	Yes
3. Classification of Documented Immigrants	Repeated	Yes
4. Eligibility documentation	Repeated	Yes
5. Policies Covering Orthodontic Treatment [1]	Repeated	n/a

Note: [1] Our FY14 audit was released in February 2016, and our audit period for this audit ended on June 30, 2015. Therefore, this recommendation related to orthodontic policies is repeated and will be reviewed during our next audit which covers FY16.

As part of our fieldwork testing for this audit, we took three samples from the EXPANDED ALL KIDS program which consisted of the following:

1) a sample of 40 randomly selected new EXPANDED ALL KIDS cases from FY15, that were reviewed by DHS or HFS during either May or June 2015. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support birth, residency, citizenship status, and income was received or verified in order to ensure that eligibility was determined accurately.

2) a sample of 40 randomly selected cases whose medical eligibility was redetermined during either May or June 2015. The total number of redeterminations in May and June 2015 was 2,518; however, not all were medical only. We determined about half of the cases were redetermined by the Supplemental Nutrition Assistance Program (SNAP). Therefore, we sampled random cases until we achieved a total population of 40 medical only cases. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support birth, residency, citizenship status, and income was received or verified in order to ensure that continued eligibility was determined accurately; and

3) a sample of 68 randomly selected recipients from the population of 25,634 recipients that were new to EXPANDED ALL KIDS in FY15, but had some other State funded medical services in FY14. We selected this sample to attempt to determine why the number of Premium Level 2 citizen/documented immigrant recipients nearly doubled from 21,634 on June 30, 2014, to 40,075 on June 30, 2015.

During the testing of our two eligibility samples, we reviewed the recipient's eligibility documentation found in the Integrated Eligibility System (IES) for the initial eligibility review and documentation found in the Max-IL system for the redetermination sample. Our review consisted mainly of locating and reviewing hard copy documents that were scanned into one of the two systems. Since our audit population, as defined by the Covering ALL KIDS Health Insurance Act, covers mainly undocumented immigrants (who do not have social security numbers needed to verify identity, citizenship, and income), the data matching criteria embedded within IES and Max-IL could not be utilized by caseworkers. Therefore, the electronic data matches were not specifically tested as part of our review. As a result, the findings in this report pertaining to eligibility determinations and redeterminations are not applicable to the Title XIX (Medicaid) population as a whole.

REDETERMINATION OF ELIGIBILITY

In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code (89 Ill. Adm. Code 123.260), were not being adequately implemented by HFS. For ALL KIDS enrollees in the Assist, Share, and Premium Level 1 categories (e.g., at or below 200 percent of the FPL), an

annual "passive" redetermination was used by HFS. Passive redetermination consisted of sending each family an annual renewal notice prior to the end of the eligibility period. The renewal notice listed the eligibility information for the family and instructed the family to return the form only if any of the information had changed. If there were no changes, the family was instructed to do nothing. In contrast, to continue coverage, enrollees in Premium Levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in our FY10 and FY11 audits. Effective October 1, 2011, Public Act 96-1501 required verification of one month's income for determining continued eligibility (instead of passive redetermination). Therefore, the recommendation was repeated and the text was changed to reflect the new one month of income requirement. According to HFS officials, the passive renewal process ended in July 2012, but corrective action did not begin until January 2013. Actions taken to implement this recommendation were included in the contract with a third party vendor, which began performing electronic eligibility verifications during our FY13 audit period.

During the FY14 audit, the process for redetermining eligibility changed again. In February 2014, a new process for redetermining eligibility began under the Illinois Medicaid Redetermination Project. A new redetermination system called Max-IL was developed to record and store redetermination information for medical-only cases. Using the new Max-IL system, medical-only cases are redetermined annually by the central redetermination unit staff. The new Max-IL system records and stores all redetermination forms mailed to the recipient, returned redetermination forms, electronic data matching results, requests for missing information, and verifications. Central redetermination staff is responsible for annually making eligibility decisions, coding the redetermination, and processing any changes on the cases. In addition, staff began using MAGI rules for redeterminations effective on April 1, 2014.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients in FY14, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for 6,625 of the 28,695 (23%) as required by the Covering ALL KIDS Health Insurance Act. HFS indicated that staffing levels were the main reason redeterminations were not completed timely. However, in FY15, HFS and DHS completed 88 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY15 audit found that 3,715 of 29,881 were not redetermined annually as required. As a result, 12 percent were not determined annually as required by the Act. If annual redeterminations of eligibility are not conducted, the State may provide services for non-eligible recipients.

ANNUAL REDETERMINATIONS

In FY15, HFS and DHS completed 88 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY15 audit found that 3,715 of 29,881 were not redetermined annually as required. As a result, 12 percent were not redetermined annually as required by the Act.

Given that redeterminations were not conducted timely for 12 percent of eligible EXPANDED ALL KIDS recipients, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2015, to June 30, 2016.

REDETERMINATION OF ELIGIBILITY	
RECOMMENDATION NUMBER **1**	***The Department of Healthcare and Family Services and the Department of Human Services should annually redetermine ALL KIDS eligibility as required by the Covering ALL KIDS Health Insurance Act.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. HFS and DHS lack the staff to complete all of the redeterminations that are due each month. The new Integrated Eligibility System (IES) Phase 2 implementation will incorporate case maintenance activities into IES. Having both new application processing, redeterminations and other case maintenance activities in one system will be more efficient and allow more flexibility to complete all of the work. After Phase 2 is implemented it will take time to catch up on delayed redeterminations.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. The redetermination process will be enhanced with the implementation of the new updated processing system, IES - Phase 2 in September 2016. IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers using a three step process. Online and classroom training venues will be available to all staff using the new system.

ALL KIDS ELIGIBILITY DATA

Due to a lack of internal controls to identify duplicate recipients or recipients that age out of the program, auditors identified issues associated with the eligibility data provided by HFS dating back to FY09. These areas included individuals who were older than 18 years of age and who are no longer eligible, and eligibility data which included duplicate enrollees with two different recipient identification numbers and/or different birth dates or addresses.

During our review of the FY15 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. According to DHS policy, caseworkers are to identify former case identification numbers. In the FY15 data, we identified 477 individuals who appeared to be enrolled with more than one identification number; therefore, the proper clearance to identify previous eligibility was not completed by the case workers. We also identified 157 recipients that received 1,276 services totaling $104,704 after the month of their 19th birthday. According to the Covering ALL KIDS Health Insurance Act, children eligible for the program must be under the age of 19.

If recipients have eligibility under more than one recipient identification number or if recipients maintain eligibility after reaching the age of 19, the State may provide services for non-eligible recipients. Therefore, the status of this part of the recommendation is also **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2015, to June 30, 2016.

ALL KIDS ELIGIBILITY DATA	
RECOMMENDATION NUMBER **2**	***The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible and ensuring that enrollees are not enrolled in ALL KIDS more than once.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. While coverage is ended systematically for most children when they turn 19, there are some situations, such as pregnancy due date coded on the case, that allow coverage as a child to continue until it is manually reviewed by a caseworker. Implementation of Phase 2 of the Integrated Eligibility System will remove the need for a manual review to end or change coverage in most situations that have resulted in covering individuals as children beyond the month they turn 19.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

The proper classification of immigration status has been an issue since the first ALL KIDS audit, which was for FY09 and was released in May 2010. Although HFS reported the miscoding of documented immigrants had been corrected in both FY12 and FY13, we found the EXPANDED ALL KIDS data continued to have recipients who are incorrectly coded as "undocumented." Although some of the inaccurate coding may have occurred due to incorrect electronic matching of social security numbers as was previously reported by HFS, we determined a lack of specific policies and procedures for caseworkers is also causing miscoding.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly coded as "undocumented."

Miscoded Citizenship Status

HFS and DHS did not identify the correct citizenship status for recipients, and as a result, the State is losing federal matching Medicaid funds. We found in past audits, and continue to find, EXPANDED ALL KIDS recipients coded as undocumented that should not be coded as undocumented. Many recipients had verified social security numbers, alien registration numbers, or a combination of both. According to DHS, "verified" means the social security number has been verified through an electronic match with the Social Security Administration. Recipients with verified social security numbers and/or alien registration numbers appear to be documented immigrants and would, therefore, be eligible for federal matching funds.

CITIZENSHIP STATUS

HFS and DHS did not identify the correct citizenship status for recipients during the process of determining new and continued eligibility, and as a result, the State is losing federal matching Medicaid funds.

For recipients categorized by HFS and DHS as "undocumented," we determined the FY15 eligibility data contained:

- 5,999 recipients coded as undocumented who had social security numbers that were verified, of which 614 also had an alien registration number; and

- 69 recipients coded as undocumented who had an alien registration number, but did not have a verified social security number.

We reviewed the services provided to these "undocumented" recipients in FY15 and determined the 5,999 recipients had 105,695 services for a total cost of almost $5.3 million. If these recipients were classified as undocumented in error, the State did not receive the eligible matching federal rate funds in FY15. Therefore, the State at a minimum did not collect $2.8 million in federal reimbursement for the $5.3 million in services. During the process of renewing cases or approving new cases, caseworkers should have either followed up with the recipients by requesting additional documentation or clarification or should have changed the citizenship status to a documented immigrant or citizen.

Initial Eligibility Testing

During our testing of 40 new cases that were approved during May and June 2015, we only found one that was not classified as undocumented. We found that 17 of the cases were coded as undocumented but likely should have been coded as citizens/documented immigrants, as we found documentation to support citizenship or documented immigrant status for each of the 17 classified as undocumented. For many of the cases, we found documentation verifying the recipient's social security number and/or alien status. Therefore, a total of 17 out of the 39 recipients sampled (44%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.

INITIAL ELIGIBILITY

17 out of the 39 recipients sampled (44%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.

Eligibility Testing for Redetermination

During our review of 40 recipients that were redetermined during May or June 2015, we found 9 of the 40 (23%) were coded as undocumented even though the enrollees had a verified social security number or other evidence supporting they were likely citizens or documented immigrants. We provided these nine to DHS, and DHS officials agreed they were likely documented.

REDETERMINATION OF ELIGIBILITY

9 of the 40 (23%) recipients were coded as undocumented even though the enrollees had a verified social security number or other evidence supporting they were likely citizens or documented immigrants.

Although HFS reported that problems related to the coding of undocumented immigrants were corrected on October 29, 2010, we continue to have multiple issues in this area. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2015, to June 30, 2016. Due to the incorrect classification

of documented and undocumented immigrants, the number of enrollees and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants. Additionally, due to the miscoding, the State is losing federal matching Medicaid funds.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS	
RECOMMENDATION NUMBER **3**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***ensure policies and procedures used to classify enrollees as a documented immigrant or undocumented immigrant contain specific instructions for caseworkers to make accurate eligibility decisions;*** • ***consider implementing an electronic edit within the Integrated Eligibility System (IES) that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;*** • ***ensure that documented immigrants are classified correctly in its database; and*** • ***ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. Additional instructions related to clearances and verifications, including those related to immigration status, have been provided to staff. In addition, edits within IES regarding immigration status will be reviewed after Phase 2 implementation.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. Conversion to an updated single processing system with the implementation of IES - Phase 2 in September 2016, will allow for improved classification of documented immigrants and electronic storage of verifications supporting the immigration status for non-citizens.

ELIGIBILITY DOCUMENTATION

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

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

The Affordable Care Act required all states apply a new budget methodology based on Modified Adjusted Gross Income (MAGI) to determine eligibility for certain households requesting or receiving medical assistance. Therefore, on October 1, 2013, HFS and DHS began using MAGI income standards for new applications received. The new eligibility process is now completed using the Integrated Eligibility System (IES). IES automatically calculates the income and other eligibility factors from a series of matches and from information entered by the caseworker. Additionally, annual redeterminations for continued eligibility are completed as part of the Illinois Medicaid Redetermination Project (IMRP), which began in February 2014. MAGI rules for redeterminations became effective on April 1, 2014. Caseworkers make eligibility decisions using electronic data matching based on verifications using social security numbers, income, residency, and citizenship. When electronic verifications are not available, hard copy documentation is requested and is scanned into IES.

HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and immigration/citizen status. During our review of the new and continued eligibility process for EXPANDED ALL KIDS, we determined the data matching component used by IES or the IMRP cannot be utilized for undocumented recipients in the EXPANDED ALL KIDS program. By definition, these children and often their parents are **undocumented**. If these recipients had the necessary social security numbers needed for the electronic matching component, these recipients would not be eligible for the EXPANDED ALL KIDS program unless they are eligible for Premium Level 2. Undocumented recipients in Assist, Share, or Premium Level 1 with verified social security numbers would be eligible for Title XIX (Medicaid) and would not be included as part of this audit. Thus, electronic data matches and searches based on social security numbers are ineffective for the undocumented portion of this population because they do not have social security numbers. Therefore, in these instances, the auditors along with DHS officials searched through IES for scanned copies of documents to determine residency, income, birth/age, and immigration/citizenship status for all recipients, including undocumented recipients.

Initial Eligibility Testing

We randomly selected 40 of the 409 new cases approved during May and June 2015 and found significant issues. As discussed in the previous section, we found that 17 of the 39 cases were coded as undocumented (44%) even though we found evidence, such as verified social security numbers, supporting the enrollee was likely a citizen or documented immigrant. As a result, these 17 recipients are likely not eligible for the EXPANDED ALL KIDS program, but would be eligible for Medicaid for which the State receives federal matching funds. Our testing results from the last audit (FY14), found there were 24 cases that were likely incorrectly coded as undocumented.

During our FY15 testing, we reviewed all 40 new cases in IES to determine whether all the required eligibility documentation was obtained or reviewed. Of the 40 cases reviewed, 24

cases (60%) were missing at least one piece of required documentation (verification of residency, birth/age, or income).

Illinois Residency Verification (Initial Eligibility)

Illinois residency verification is required for ALL KIDS by 215 ILCS 170/7(a)(3). According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was implemented to verify residency.

During our testing of new cases, we found residency was mainly verified in one of two ways. If, at a minimum, one of the recipient's parents or guardians provided a social security number, we found residency was verified using an electronic match with the Illinois Secretary of State. If there was no social security number provided, a copy of a bill (cable bill, phone bill, etc.) or other mail with the name and address was utilized to verify residency. As shown in Exhibit 11, in FY15, we found residency was not verified in 12 of the 40 cases tested (30%). In FY14, 10 of the 40 cases (25%) were missing residency documentation.

Birth/Age Information (Initial Eligibility)

In order to be eligible for ALL KIDS, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/10) defines a child as "a person under the age of 19." As part of our testing of new cases, we looked to see if documentation of birth, such as a birth certificate, was present to verify age. As shown in Exhibit 11, in both FY14 and FY15, birth/age information was not verified in 15 of the 40 (38%) cases we tested.

Income Documentation (Initial Eligibility)

Beginning on July 1, 2011, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/7(a)(2)) (Act) began requiring verification of one month's income from all sources for determining eligibility. Although HFS and DHS have implemented the required one month's worth of income requirement, caseworkers did not review 30 days of income documents as required.

In the FY15 cases from our sample of 40 where income was reported, we identified instances where 30 days of income documentation was not reviewed. Of the 40 cases tested, only 13 reported having income. For the 13 cases with income reported, 30 days of income was not reviewed in 5 of the cases (38%). During this year's testing, the number of recipients that reported having no income increased significantly. In FY14, 28 of the 40 (70%) recipients tested reported having income. However, in FY15, only 13 of 40 (33%) reported having income.

Without documentation to support the eligibility decisions, auditors are unable to determine whether eligibility decisions were completed accurately. Since we continued to identify issues during our FY15 initial eligibility testing, this part of the recommendation is **repeated** and will be followed up on in future audits.

Exhibit 11
RESULTS OF ELIGIBILITY TESTING
(Initial Eligibility)

	Residency Verified		Age Verified		30 Days Income Verified[1]	
	FY14	FY15	FY14	FY15	FY14	FY15
Number Tested	40	40	40	40	28	13
Number Missing Documentation	10	12	15	15	15	5
Percent Missing Documentation	25%	30%	38%	38%	54%	38%

[1] In FY14, 12 of 40 cases tested reported no income. In FY15, 27 of 40 cases tested reported no income.

Eligibility Redetermination Testing

We tested 40 of the medical only redeterminations that occurred during May and June 2015 and found significant issues regarding Illinois residency, birth/age, and income documentation. The total number of redeterminations in May and June 2015 was 2,518; however, not all were for medical only. We determined about one-half of the cases were redetermined by the Supplemental Nutrition Assistance Program (SNAP). Therefore, we sampled random cases until we achieved a total population of 40 medical only cases. Nine cases were coded as undocumented even though we found evidence, such as verified social security numbers, which supports that the enrollee was likely a citizen or documented immigrant. As a result, these nine recipients were likely not eligible for the EXPANDED ALL KIDS program, but would be eligible for Medicaid for which the State receives federal matching funds.

We found DHS and HFS did not obtain all required documentation to support birth, residency, and income. During our testing, we reviewed all 40 redeterminations to determine whether all required eligibility redetermination documentation was obtained or reviewed. Of the 40 cases reviewed, 31 were missing at least one piece of required documentation (verification of residency, birth/age, or income).

Illinois Residency Verification (Redetermination)

Illinois residency verification is required for ALL KIDS by 215 ILCS 170/7(a)(3). According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State (SOS) clearance was implemented to verify residency. The clearance matches the recipient's social security number with SOS records. During our testing of new cases, we found residency was mainly verified in one of two ways. If one of the recipient's parents or guardians provided a social security number, residency was verified using an electronic match with the Illinois Secretary of State. If there was no social security number provided, a copy of a bill (cable bill, phone bill, etc.) or other mail with the name and address was utilized. As shown in Exhibit 12, residency was not verified in 8 of the 40 (20%) cases we tested in FY15.

Birth/Age Information (Redetermination)

In order to be eligible for ALL KIDS, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/10) defines a child as "a person under the age of 19." As part of our testing of redetermination files, we looked to see if documentation of birth, such as a birth certificate, was present to verify age. As shown in Exhibit 12, we found birth/age information was not verified in 31 of the 40 (78%) cases we tested in FY15.

Income Documentation (Redetermination)

Beginning on October 1, 2011, the Act (215 ILCS 170/7(a)(2)) began requiring verification of one month's income from all sources for determining continued eligibility. However, caseworkers did not review 30 days of income documents as required.

In cases where income was reported, we found income eligibility documentation and calculation problems in the cases tested. Of the 40 cases tested, 35 reported having some income. As shown in Exhibit 12, 30 days of income was reviewed in all 35 of the cases where income was reported. We also identified 2 of the 35 cases (6%) where caseworkers did not calculate the income correctly.

Without documentation to support the eligibility decisions, auditors are unable to determine whether eligibility decisions were completed accurately. Due to the missing documentation identified during eligibility testing, this recommendation is **repeated** and will be followed up on in future audits.

Exhibit 12
RESULTS OF ELIGIBILITY TESTING
(Redetermination)

	Residency Verified		Age Verified		30 Days Income Verified[1]	
	FY14	FY15	FY14	FY15	FY14	FY15
Number Tested	20	40	39	40	29	35
Number Missing Documentation	12	8	29	31	4	0
Percent Missing Documentation	60%	20%	74%	78%	14%	0%

[1] In FY14, 11 of 40 cases tested reported no income. In FY15, 5 of 40 cases tested reported no income.

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***ensure all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;*** • ***ensure one month's worth of income verification is reviewed for determining eligibility; and*** • ***implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and that eligibility is determined correctly.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. While electronic means of verification implemented over the past few years have helped, they only work for those who provide an SSN. The Department will promulgate rules to require verification of date of birth for children. The Department will also provide regular reminders to caseworkers regarding income verification requirements including checking electronic sources for wage data report by employers for individuals reporting they are self-employed.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. Currently there are multiple sources that store case eligibility documents. Conversion to the new IES processing system that stores documentation electronically, for both application and ongoing eligibility determinations, will provide one source for storing supporting eligibility documentation. The Department will continue to provide ongoing policy clarification regarding income eligibility determinations.

POLICIES COVERING ORTHODONTIC TREATMENT

As part of last year's FY14 EXPANDED ALL KIDS audit, we examined the payments made to providers for orthodontic services. Our review identified two issues. The first was a lack of documentation related to orthodontic claims. The second was improvements in HFS orthodontic policies and documentation of medical necessity.

Lack of Documentation from DentaQuest

As a result of our review of policies and procedures related to the approval of orthodontia, we found that DentaQuest, the Dental Program Administrator for HFS, could not provide documents that were used to approve orthodontic claims. We requested documents used by DentaQuest for initial approval for 40 recipients that had orthodontic services during FY14. DentaQuest could not provide the documents for 9 of the 40 recipients requested (23%). According to DentaQuest officials, 3 could not be provided because "NEA" (National Electronic

Attachment) only retains records for three years, while 6 could not be provided due to a "system issue."

Orthodontic Eligibility Criteria

The Administrative Code (89 Ill. Adm. Code 140.421(a)(16)) provides the following guidance on orthodontic eligibility:

> Orthodontics. Medically necessary orthodontic treatment is approved only for patients ages 0-20 and is defined as:
>
> A) treatment necessary to correct a condition which scores 42 points or more on the Salzmann Index; or
>
> B) treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing).

We also reviewed HFS' Dental Office Reference Manual in effect for FY14, and found similar requirements, which stated:

> *Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. Participants must have a severe, dysfunctional, handicapping malocclusion as determined by a score of 42 points or greater on the modified salzmann index, or objective documentation that the malocclusion is an impairment of, or a hazard to the ability to eat, chew, speak, or breathe. [emphasis added]*
>
> *Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. Interceptive orthodontics is not a covered benefit. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered. [emphasis added]*

Furthermore, HFS' State Plan under Title XIX of the Social Security Act (Medicaid), submitted to, and approved by, the federal Centers for Medicare & Medicaid Services, notes that covered procedures are specified in the HFS' Dental Office Reference Manual or Provider Notices. The State Plan also states: "*Coverage of orthodontia is limited to case[s] which present a severe handicapping malocclusion or a handicapping dentofacial deformity" and "Dental services performed only for cosmetic reasons are not covered."*

We found almost none of the recipients were approved for orthodontics in FY14 using the Salzmann Index score (89 Ill. Adm. Code 140.421(a)(16)(A)). Only 8 of 13,576 orthodontic cases approved by DentaQuest were approved using the Salzmann Index. We discussed the severity of these requirements with DentaQuest officials. A DentaQuest official noted that a 42 on the Salzmann Index was a very high score (i.e., is a severe condition). The official noted a score of 42 is a higher requirement compared to what other states use.

The majority of the recipients were approved using the medical necessity standard (89 Ill. Adm. Code 140.421(a)(16)(B)). According to DentaQuest, once an orthodontist submits pictures, and x-rays (if necessary) to DentaQuest, DentaQuest completes the scoring tool to determine whether to approve the service, deny the service, or request additional information.

Based on the HFS Dental Office Reference Manual, completion of the Salzmann Index is only necessary if the recipient does not qualify due to the medical necessity requirement found in the Administrative Code (89 Ill. Adm. Code 140.421(a)(16)(B)).

The official noted that the scoring tool used by DentaQuest for orthodontic cases was changed in 2010. We reviewed documents provided by HFS that addressed the change in the scoring tool. A change to the scoring tool was discussed at several meetings of the DentaQuest Peer Review Committee in 2008, 2009, and 2010. These meetings were attended by officials from DentaQuest, member dentists, and HFS officials. The Committee recommended keeping the Salzmann Index score requirement, but recommended adopting a new Medical Necessity Scoring Tool to capture medical necessity without requiring a written order from a physician.

According to DentaQuest, another reason for changing the scoring tool was recipients were appealing DentaQuest denials in order to get necessary orthodontia. At the December 19, 2009 Committee meeting, a DentaQuest official stated that it is difficult to uphold a denial at a fair hearing if the appellant produces a doctor's order stating that the patient's malocclusion causes a disability impacting eating, speaking, chewing or breathing. We requested, but HFS was unable to provide, information on how many orthodontia cases were being overturned during the fair hearing process.

The change in the scoring tool corresponded with a significant increase in orthodontia claims being paid by HFS. In FY10, the EXPANDED ALL KIDS program paid for only $322,892 in orthodontic services. By FY14, 4,020 EXPANDED ALL KIDS recipients had orthodontic services totaling $3.6 million. Similarly, orthodontic services increased dramatically for HFS' medical program as a whole. In FY10, payments for orthodontic services totaled $2.9 million. In FY 2012, the amount paid increased to $16.6 million, and by FY14, payments totaled $36.6 million.

Review of Orthodontic Cases

While the scoring tool was approved in FY11, the Administrative Code delineating eligibility criteria for orthodontic services was not changed. As noted above, few cases are approved using the Salzmann Index in the first section of the Administrative Code (89 Ill. Adm. Code 140.421(a)(16)(A)). Rather, most cases are approved pursuant to the second part of the Administrative Code which states: *treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing).*

It is HFS' position that the revised scoring tool continues to comply with the requirements of the Administrative Code. In December 2009, a DentaQuest dentist recommended Illinois adopt the Medical Necessity Scoring Tool, and if the recipient does not qualify, use the modified Salzmann. The Peer Review Committee minutes stated *"the state regulations require that orthodontia should be approved if the Modified Salzmann is 42 points or higher or if the service is medically necessary. Using both tools will meet the state regulations and will not necessitate a rules change."* All committee members approved the recommendation.

According to HFS, the change to the scoring tool received approval from two other HFS committees. HFS provided limited documentation showing that the change was approved by the Dental Program Policy Committee or the Policy Review System.

We noted there were a large number of dentists providing orthodontic services that were among the highest paid providers in the EXPANDED ALL KIDS program, and we approached the HFS Office of the Inspector General (OIG) for assistance reviewing eligibility documentation for a sample of the providers. We also noted that based on our review of 15 case files, we had questions regarding whether some recipients approved for orthodontic services met the need standards established in HFS' administrative rule or Dental Office Reference Manual (DORM).

The OIG agreed to have an OIG dental consultant review cases selected by us. We worked with the OIG and jointly visited four orthodontist offices. We obtained and reviewed the documentation for 10 recipients at each location for a total of 40 cases. As of October 27, 2014, there were 453 orthodontic claims paid for these 40 cases totaling $124,000. Auditors judgmentally selected 10 cases for each provider where it appeared from the electronic data the treatment was completed during FY14 or in early FY15. Auditors found 1 of the 4 providers could not provide evidence to support all services provided. In all 10 cases reviewed for this provider, auditors could not find evidence for all of the services billed.

Auditors also determined that the scoring tool was completed by DentaQuest, and not by the recipient's dentist, as HFS had previously indicated to the auditors. Auditors asked HFS what monitoring is conducted by HFS related to the approval of orthodontics. HFS indicated it does not review eligibility decisions made by DentaQuest.

During our testing, we had discussions with the orthodontists related to the approval process. We were able to ask 3 of the 4 orthodontists specifically about the approval process. All three orthodontists indicated they could not follow the reasoning behind why some cases were approved by DentaQuest.

Results from OIG Dental Consultant's Review

During our last audit, the OIG provided a report which noted that due to the modifications made in 2011 to the medical necessity prior approval procedures, *"the threshold for medically necessary services was made less stringent increasing the number of prior approvals of orthodontic services."* During the review of the 40 sample cases, the OIG's dental consultant found that each of the 40 cases met the Department's medical necessity criteria using the new, less stringent scoring tool; however, the consultant found *"limited or no corroborating evidence of conditions of a handicapping malocclusion, including documentation establishing a condition that impairs or creates a hazard in eating, chewing, speaking or breathing, other than that which was documented in Attachment G."* Attachment G of the DORM is the Medical Necessity Scoring Tool. The OIG recommended increasing the documentation required to establish medical necessity, such as a narrative report from the dentist, as well as a certification from a medical professional certifying that the client meets the conditions of a medical need for orthodontic services.

The OIG found guidelines for providers of orthodontic services were unclear and inconsistent. The OIG recommended the definition of medical necessity be revised and more clearly defined. The OIG also recommended changes to either the Administrative Code, Department Handbooks, or policies to include more specific examples of medical necessity.

Conclusion

Expenditures by the State for orthodontic services for children in EXPANDED ALL KIDS specifically, and HFS' medical program generally, increased dramatically from FY10 to FY14. This increase corresponds to the time when the scoring tool used to determine medical necessity for orthodontic services was revised. A review conducted by the HFS OIG concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity.

HFS agreed with this recommendation and indicated it would review the issues raised and take appropriate action. Since our FY14 audit was released in February 2016, and the audit period for this audit ended earlier on June 30, 2015, this part of the recommendation is **repeated** and we will follow up during our next audit which covers FY16.

POLICIES COVERING ORTHODONTIC TREATMENT	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services should:*** • ***ensure DentaQuest is receiving and maintaining documentation needed to support orthodontia approvals;*** • ***examine and address the issues raised by the OIG in its review of orthodontic claims; and*** • ***more effectively monitor the actions taken by DentaQuest (the State's contractual Dental Program Administrator).***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts this recommendation. The Department conducts various monitoring activities as part of the ongoing management of the DentaQuest contract and also receives and reviews the annual Service Organization Control report outlining any control issues noted by independent auditors; however, there have been significant changes in staff in the Bureau that oversees the Dental program. The Department will remind DentaQuest that they must maintain documentation according to our records retention policies. The Department will also review the issues raised by the OIG and take appropriate action.

SCOPE AND METHODOLOGY

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

Audit Objectives

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

Since this is the seventh audit of the EXPANDED ALL KIDS program in the last seven years and there have been significant changes to the Covering ALL KIDS Health Insurance Act that were effective prior to the FY15 audit period, this audit followed up on previous recommendations, determined if new laws and policies were properly implemented, and reviewed the eligibility determination and redetermination process that was implemented during FY15. During our audit, HFS officials reported that there were no new contracts related to the ALL KIDS Expansion for FY15.

During this audit, we met with both HFS and DHS officials and determined that initial and redetermination of eligibility procedures had not changed since the FY14 audit. Therefore, initial ALL KIDS eligibility was processed through the Integrated Eligibility System (IES). Additionally, annual redeterminations for ALL KIDS were completed as part of the Illinois Medicaid Redetermination Project. As a result, we conducted testing in these areas to ensure compliance with applicable laws, rules, and policies. Since these samples were of a narrowly defined group of recipients, neither sample should be projected to the population. Additionally, many of these recipients were classified as undocumented immigrants, and therefore, did not qualify for Medicaid.

Fieldwork

As discussed earlier in this report, sample testing was conducted in several areas. The methodologies for each are outlined in the section titled "Follow-up of FY14 Recommendations." The areas in which detailed testing was conducted include: initial eligibility, redetermination of eligibility, and testing to determine the causes for the increase in Premium Level 2 citizen/documented population in FY15.

Since the data system was reviewed during FY13 by the Auditor General's Information Systems Division, we did not review the data system during FY15. However, we did review the data for completeness by conducting limit tests and range tests. Any weaknesses in internal

controls that have not been addressed from the previous audits are included as findings in this report.

Exit Conferences Attendees

Exit conferences were held with both the Department of Healthcare and Family Services and with the Department of Human Services. The meeting with HFS was held on July 13, 2016, and included the following representatives from the department: Ray Marchiori, Chief of Staff; Jacqui Ellinger, Deputy Administrator Medical Programs; Mollie Zito, General Counsel; Teresa Hursey, Acting Administrator of Medical Programs; Lynne Thomas, Chief - Bureau of All Kids; Christina McCutchan, Dental Manager; Jamie Nardulli, Chief Internal Auditor; and Amy Lyons, Audit Liaison.

The meeting with DHS was held on July 14, 2016, and included the following representatives from the department: Fred Flather, Chief of Staff; Paul Thelen, Acting Bureau Chief –Bureau of Performance Management; Brenda Flowers, Public Service Administrator; Jane Hewitt, Chief Internal Auditor; Albert Okwuegbunam, Acting Audit Liaison; and Sunday Odele, Audit Liaison.

The Office of the Auditor General was represented at both meetings by: Scott Wahlbrink, Senior Audit Manager; Teresa DeStasio, Audit Supervisor; Angela Coleman and Geoffrey Piehl, Staff Auditors.

APPENDIX A

Covering ALL KIDS Health Insurance Act [215 ILCS 170]

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

Appendix A

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

INSURANCE

(215 ILCS 170/) Covering ALL KIDS Health Insurance Act.

(215 ILCS 170/1)

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

Sec. 1. Short title. This Act may be cited as the Covering ALL KIDS Health Insurance Act. (Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/5)

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

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

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

(215 ILCS 170/7)

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

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

(a) The Department of Healthcare and Family Services or its designees shall:
(1) By July 1, 2011, require verification of, at a
minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.
(2) By October 1, 2011, require verification of, at a
minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.
(3) By July 1, 2011, require verification of
Illinois residency.
(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.
(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.
(Source: P.A. 98-651, eff. 6-16-14.)

(215 ILCS 170/10)
(Section scheduled to be repealed on July 1, 2016)
Sec. 10. Definitions. In this Act:
"Application agent" means an organization or individual, such as a licensed health care provider, school, youth service agency, employer, labor union, local chamber of commerce, community-based organization, or other organization, approved by the Department to assist in enrolling children in the Program.
"Child" means a person under the age of 19.
"Department" means the Department of Healthcare and Family Services.
"Medical assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.
"Program" means the Covering ALL KIDS Health Insurance Program.
"Resident" means an individual (i) who is in the State for other than a temporary or transitory purpose during the taxable year or (ii) who is domiciled in this State but is absent from the State for a temporary or transitory purpose during the taxable year.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/15)
(Section scheduled to be repealed on July 1, 2016)
Sec. 15. Operation of Program. The Covering ALL KIDS Health Insurance Program is created. The Program shall be administered by the Department of Healthcare and Family Services. The Department shall have the same powers and authority to administer the Program as are provided to the Department in connection with the Department's administration of the Illinois Public Aid Code, including, but not limited to, the provisions under Section 11-5.1 of the Code, and the Children's Health Insurance Program Act. The Department shall coordinate the Program with the existing children's health programs operated by the Department and other State agencies. Effective October 1, 2013, the determination of eligibility under this Act shall comply with the requirements of 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations. If changes made to this Section require federal approval, they shall not take effect until such approval has been received.
(Source: P.A. 98-104, eff. 7-22-13.)

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

(3) who (i) effective July 1, 2014, in accordance
with 42 CFR 457.805 (78 FR 42313, July 15, 2013) or any other federal requirement necessary to obtain federal financial participation for expenditures made under this Act, has been without health insurance coverage for 90 days; (ii) is a newborn whose responsible relative does not have available affordable private or employer-sponsored health insurance; or (iii) within one year of applying for coverage under this Act, lost medical benefits under the Illinois Public Aid Code or the Children's Health Insurance Program Act; and
(3.5) whose household income, as determined,
effective October 1, 2013, by the Department, is at or below 300% of the federal poverty level as determined in compliance with 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations.
An entity that provides health insurance coverage (as defined in Section 2 of the Comprehensive Health Insurance Plan Act) to Illinois residents shall provide health insurance data match to the Department of Healthcare and Family Services as provided by and subject to Section 5.5 of the Illinois Insurance Code. The Department of Healthcare and Family Services may impose an administrative penalty as provided under Section 12-4.45 of the Illinois Public Aid Code on entities that have established a pattern of failure to provide the information required under this Section.
The Department of Healthcare and Family Services, in collaboration with the Department of Insurance, shall adopt rules governing the exchange of information under this Section. The rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records, including provisions under the Federal Health Insurance Portability and Accountability Act (HIPAA).
(b) The Department shall monitor the availability and retention of employer-sponsored dependent health insurance coverage and shall modify the period described in subdivision (a)(3) if necessary to promote retention of private or employer-sponsored health insurance and timely access to healthcare services, but at no time shall the period described in subdivision (a)(3) be less than 6 months.
(c) The Department, at its discretion, may take into account the affordability of dependent health insurance when determining whether employer-sponsored dependent health insurance coverage is available upon reemployment of a child's parent as provided in subdivision (a)(3).
(d) A child who is determined to be eligible for the Program shall remain eligible for 12 months, provided that the child maintains his or her residence in this State, has not yet attained 19 years of age, and is not excluded under subsection (e).
(e) A child is not eligible for coverage under the Program if:
(1) the premium required under Section 40 has not
been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid; re-enrollment shall be completed

before the next covered medical visit, and the first month's required premium shall be paid in advance of the next covered medical visit; or
(2) the child is an inmate of a public institution or an institution for mental diseases.
(f) The Department may adopt rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program in conformance with Section 7 of this Act; rules providing for re-enrollment, grace periods, notice requirements, and hearing procedures under subdivision (e)(1) of this Section; and rules regarding what constitutes availability and affordability of private or employer-sponsored health insurance, with consideration of such factors as the percentage of income needed to purchase children or family health insurance, the availability of employer subsidies, and other relevant factors.
(g) Each child enrolled in the Program as of July 1, 2011 whose family income, as established by the Department, exceeds 300% of the federal poverty level may remain enrolled in the Program for 12 additional months commencing July 1, 2011. Continued enrollment pursuant to this subsection shall be available only if the child continues to meet all eligibility criteria established under the Program as of the effective date of this amendatory Act of the 96th General Assembly without a break in coverage. Nothing contained in this subsection shall prevent a child from qualifying for any other health benefits program operated by the Department.
(Source: P.A. 98-130, eff. 8-2-13; 98-651, eff. 6-16-14.)

(215 ILCS 170/21)
(Section scheduled to be repealed on July 1, 2016)
Sec. 21. Presumptive eligibility. Beginning on the effective date of this amendatory Act of the 96th General Assembly and except where federal law or regulation requires presumptive eligibility, no adult may be presumed eligible for health care coverage under the Program and the Department may not cover any service rendered to an adult unless the adult has completed an application for benefits, all required verifications have been received, and the Department or its designee has found the adult eligible for the date on which that service was provided. Nothing in this Section shall apply to pregnant women.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/25)
(Section scheduled to be repealed on July 1, 2016)
Sec. 25. Enrollment in Program. The Department shall develop procedures to allow application agents to assist in enrolling children in the Program or other children's health programs operated by the Department. At the Department's discretion, technical assistance payments may be made available for approved applications facilitated by an application agent. The Department shall permit

day and temporary labor service agencies, as defined in the Day and Temporary Labor Services Act and doing business in Illinois, to enroll as unpaid application agents. As established in the Free Healthcare Benefits Application Assistance Act, it shall be unlawful for any person to charge another person or family for assisting in completing and submitting an application for enrollment in this Program.
(Source: P.A. 96-326, eff. 8-11-09.)

(215 ILCS 170/30)
(Section scheduled to be repealed on July 1, 2016)
Sec. 30. Program outreach and marketing. The Department may provide grants to application agents and other community-based organizations to educate the public about the availability of the Program. The Department shall adopt rules regarding performance standards and outcomes measures expected of organizations that are awarded grants under this Section, including penalties for nonperformance of contract standards.
The Department shall annually publish electronically on a State website the premiums or other cost sharing requirements of the Program.
(Source: P.A. 97-689, eff. 6-14-12.)

(215 ILCS 170/35)
(Section scheduled to be repealed on July 1, 2016)
Sec. 35. Health care benefits for children.
(a) The Department shall purchase or provide health care benefits for eligible children that are identical to the benefits provided for children under the Illinois Children's Health Insurance Program Act, except for non-emergency transportation.
(b) As an alternative to the benefits set forth in subsection (a), and when cost-effective, the Department may offer families subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance.
(c) Notwithstanding clause (i) of subdivision (a)(3) of Section 20, the Department may consider offering, as an alternative to the benefits set forth in subsection (a), partial coverage to children who are enrolled in a high-deductible private health insurance plan.
(d) Notwithstanding clause (i) of subdivision (a)(3) of Section 20, the Department may consider offering, as an alternative to the benefits set forth in subsection (a), a limited package of benefits to children in families who have private or employer-sponsored health insurance that does not cover certain benefits such as dental or vision benefits.
(e) The content and availability of benefits described in subsections (b), (c), and (d), and the terms of eligibility for those benefits, shall be at the Department's discretion and the Department's determination of efficacy and cost-effectiveness as a means of promoting retention of private or employer-

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

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

(215 ILCS 170/40)
(Section scheduled to be repealed on July 1, 2016)
Sec. 40. Cost-sharing.
(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:
(1) The Department, by rule, shall set forth requirements concerning co-payments and coinsurance for health care services and monthly premiums. This cost-sharing shall be on a sliding scale based on family income. The Department may periodically modify such cost-sharing.
(2) Notwithstanding paragraph (1), there shall be no co-payment required for well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law.
(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.
(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in a certain geographic area.
(Source: P.A. 94-693, eff. 7-1-06.)

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

(215 ILCS 170/45)
(Section scheduled to be repealed on July 1, 2016)
Sec. 45. Study; contracts.
(a) The Department shall conduct a study that includes, but is not limited to, the following:
(1) Establishing estimates, broken down by regions of the State, of the number of children with and without health insurance coverage; the number of children who are eligible for Medicaid or the Children's Health Insurance Program, and, of that number, the number who are enrolled in Medicaid or the Children's Health Insurance Program; and the number of children with access to dependent coverage through an employer, and, of that number, the number who are enrolled in dependent coverage through an employer.
(2) Surveying those families whose children have access to employer-sponsored dependent coverage but who decline such coverage as to the reasons for declining coverage.
(3) Ascertaining, for the population of children accessing employer-sponsored dependent coverage or who have access to such coverage, the comprehensiveness of dependent coverage available, the amount of cost-sharing currently paid by the employees, and the cost-sharing associated with such coverage.
(4) Measuring the health outcomes or other benefits for children utilizing the Covering ALL KIDS Health Insurance Program and analyzing the effects on utilization of healthcare services for children after enrollment in the Program compared to the preceding period of uninsured status.
(b) The studies described in subsection (a) shall be conducted in a manner that compares a time period preceding or at the initiation of the program with a later period.
(c) The Department shall submit the preliminary results of the study to the Governor and the General Assembly no later than July 1, 2008 and shall

submit the final results to the Governor and the General Assembly no later than July 1, 2010.
(d) The Department shall submit copies of all contracts awarded for the administration of the Program to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.
(Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

(215 ILCS 170/47)
(Section scheduled to be repealed on July 1, 2016)
Sec. 47. Program Information. The Department shall report to the General Assembly no later than September 1 of each year beginning in 2007, all of the following information:
(a) The number of professionals serving in the primary care case management program, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.
(b) The number of non-primary care providers accepting referrals, by specialty designation, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.
(c) The number of individuals enrolled in the Covering ALL KIDS Health Insurance Program by income or premium level and by county, and, for counties with a population of 100,000 or greater, by geo zip code.
(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/50)
(Section scheduled to be repealed on July 1, 2016)
Sec. 50. Consultation with stakeholders. The Department shall present details regarding implementation of the Program to the Medicaid Advisory Committee, and the Committee shall serve as the forum for healthcare providers, advocates, consumers, and other interested parties to advise the Department with respect to the Program. The Department shall consult with stakeholders on the rules for healthcare professional participation in the Program pursuant to Sections 52 and 53 of this Act.
(Source: P.A. 94-693, eff. 7-1-06; 95-650, eff. 6-1-08.)

(215 ILCS 170/52)
(Section scheduled to be repealed on July 1, 2016)
Sec. 52. Adequate access to specialty care.
(a) The Department shall ensure adequate access to specialty physician care for Program participants by allowing referrals to be accomplished without undue delay.
(b) The Department shall allow a primary care provider to make appropriate referrals to specialist physicians or other healthcare providers for an enrollee

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

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

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

(215 ILCS 170/53)

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

Sec. 53. Program standards.

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

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

(c) The Department shall adopt variance procedures for the application of any disease management program or any performance measures to an individual enrollee.

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

(215 ILCS 170/54)

Sec. 54. Dental home initiative. The Department, in cooperation with the dental community and other affected organizations such as Head Start, shall work to develop and promote the concept of a dental home for children covered under this Act. Included in this dental home outreach should be an

effort to ensure an ongoing relationship between the patient and the dentist with an effort to provide comprehensive, coordinated, oral health care so that all children covered under this Act have access to preventative and restorative oral health care.
(Source: P.A. 97-283, eff. 8-9-11.)

(215 ILCS 170/55)
(Section scheduled to be repealed on July 1, 2016)
Sec. 55. Charge upon claims and causes of action; right of subrogation; recoveries. Sections 11-22, 11-22a, 11-22b, and 11-22c of the Illinois Public Aid Code apply to health care benefits provided to children under this Act, as provided in those Sections.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/56)
(Section scheduled to be repealed on July 1, 2016)
Sec. 56. Care coordination.
(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.
(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.
(c) To qualify for compliance with this Section, the 50% goal shall be

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

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

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

(215 ILCS 170/60)

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

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

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

(215 ILCS 170/63)

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

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

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

(215 ILCS 170/65)

Sec. 65. (Repealed).

(Source: P.A. 94-693, eff. 7-1-06. Repealed internally, eff. 7-1-08.)

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

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

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

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

APPENDIX B

Covering ALL KIDS Health Insurance Program Plans

Appendix B
COVERING ALL KIDS HEALTH INSURANCE PROGRAM PLANS
Fiscal Year 2015

	Assist	Share	Premium Level 1	Premium Level 2
Premium	None	None	$15 (1) $25 (2) $30 (3) $35 (4) $40 (5+)	$40 (1) $80 (2+)
Max Monthly Premium	n/a	n/a	$40	$80
Physician Visit	None	$3.90	$5	$10
Emergency Room Visit (Emergency)	None	None	$5	$30
Emergency Room Visit (Non-Emergency)	None	None	$25	$30
Generic Drug	None	$2	$3	$3
Brand Name Drug	None	$3.90	$5	$7
Inpatient Admission	None	$3.90/day	$5/day	$100
Outpatient Service	None	$3.90/visit	$5/visit	5% of ALL KIDS payment rate
Annual Out-of-Pocket Max.	n/a	$100 per family	$100 per family	$500 per child

Source: Illinois Department of Healthcare and Family Services.

APPENDIX C

FY15 Total Cost of Services Provided by Category of Service

Appendix C
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
During FY15

Category of Service	FY15 Payment Amount	Percent of Total Payments
Pharmacy Services	$13,646,550.17	16%
Capitation Services	12,846,623.29	15%
Inpatient Hospital Services (General)	11,147,044.36	13%
Dental Services	10,204,221.34	12%
Physician Services	9,223,237.00	11%
Outpatient Services (General)	6,415,732.81	7%
General Clinic Services	4,044,542.68	5%
Inpatient Hospital Services (Psychiatric)	2,865,155.64	3%
Healthy Kids Services	2,703,609.10	3%
Mental Health Rehab Option Services	1,638,265.84	2%
Speech Therapy/Pathology Services	1,502,055.80	2%
Physical Therapy Services	1,041,766.32	1%
Medical Equipment/Prosthetic Devices	699,858.50	<1%
Medical Supplies	669,873.72	<1%
Alcohol and Substance Abuse Rehab. Services	650,947.73	<1%
Home Health Services	647,588.58	<1%
Clinical Laboratory Services	625,598.78	<1%
Optical Supplies	489,478.50	<1%
Occupational Therapy Services	466,326.52	<1%
Nursing Service	456,637.90	<1%
Anesthesia Services	386,384.87	<1%
Other Transportation	385,689.22	<1%
Case Management	379,559.51	<1%
Targeted Case Management Service (Mental Health)	358,490.51	<1%
Waiver Service (depends on HCPCS code)	335,623.09	<1%
Psychiatric Clinic Services (Type 'A')	308,993.06	<1%
Targeted Case Management Service (Early Intervention)	265,800.36	<1%
Psychiatric Clinic Services (Type 'B')	260,062.42	<1%
Social Work Service	244,126.67	<1%
Nurse Practitioners Services	222,133.64	<1%
Emergency Ambulance Transportation	212,163.09	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	199,217.92	<1%
Optometric Services	180,119.95	<1%
Inpatient Hospital Services (Physical Rehabilitation)	142,348.82	<1%
Psychologist Service	137,552.97	<1%

Appendix C
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
During FY15

Category of Service	FY15 Payment Amount	Percent of Total Payments
Outpatient Services (ESRD)	$93,380.93	<1%
LTC--ICF/MR	73,211.70	<1%
Podiatric Services	64,107.89	<1%
Non-Emergency Ambulance Transportation	48,952.03	<1%
Audiology Services	40,345.94	<1%
Early Intervention Services	38,381.18	<1%
Midwife Services	31,464.24	<1%
Service Car	30,881.52	<1%
Fluoride varnish	12,402.00	<1%
Taxicab Services	8,425.43	<1%
Licensed Clinical Professional Counselor	7,378.84	<1%
Independent Diagnostic Testing.	5,435.10	<1%
Family Planning Counseling	5,409.44	<1%
FFS procedure to implement contraceptive devices for PT 040, 048	5,236.86	<1%
Home Care	4,853.94	<1%
Chiropractic Services	4,203.26	<1%
Clinic Services (Physical Rehabilitation)	3,253.40	<1%
Physicians Psychiatric Services	1,524.67	<1%
Medicar Transportation	778.02	<1%
Portable X-Ray Services	121.41	<1%
Total FY15 Cost of Services	**$86,483,128.48**	**100%**

Source: Summary of FY15 ALL KIDS data provided by HFS.

APPENDIX D

FY15 Total Cost of Services Provided by Plan and Category of Service

Appendix D

TOTAL COST OF SERVICES PROVIDED BY PLAN AND CATEGORY OF SERVICE

During FY15

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Pharmacy Services	$13,646,550	$2,268,497	$54,311	$113,022	$172,236	$11,038,485
Capitation Services	12,846,623	11,897,957	167,704	509,063	4,870	267,029
Inpatient Hospital Services (General)	11,147,044	3,925,991	41,767	56,319	19,935	7,103,032
Dental Services	10,204,221	4,451,247	99,715	248,768	140,424	5,264,068
Physician Services	9,223,237	3,066,897	64,014	128,347	92,847	5,871,131
Outpatient Services (General)	6,415,733	2,266,335	43,367	94,495	62,231	3,949,305
General Clinic Services	4,044,543	2,088,584	32,053	55,941	39,892	1,828,072
Inpatient Hospital Services (Psychiatric)	2,865,156	1,302,039	14,493	35,696	17,459	1,495,468
Healthy Kids Services	2,703,609	808,498	19,762	43,076	31,392	1,800,882
Mental Health Rehab Option Services	1,638,266	574,499	15,535	29,017	10,690	1,008,524
Speech Therapy/Pathology Services	1,502,056	44,068	971	4,304	721	1,451,992
Physical Therapy Services	1,041,766	241,932	7,993	14,286	12,006	765,550
Medical Equipment/Prosthetic Devices	699,859	171,962	8,909	13,504	20,416	485,069
Medical Supplies	669,874	165,158	5,642	4,171	4,612	490,291
Alcohol and Substance Abuse Rehab. Services	650,948	260,644	668	5,114	0	384,521
Home Health Services	647,589	8,315	0	216	0	639,057
Clinical Laboratory Services	625,599	336,937	5,999	10,348	9,183	263,132
Optical Supplies	489,479	236,096	3,617	10,537	6,325	232,903
Occupational Therapy Services	466,327	38,261	13	1,654	1,390	425,008
Nursing Service	456,638	0	0	0	0	456,638
Anesthesia Services	386,385	142,862	3,275	4,699	3,046	232,501
Other Transportation	385,689	0	0	0	0	385,689
Case Management	379,560	331,035	8,410	16,197	312	23,606
Targeted Case Management Service (Mental Health)	358,491	80,076	520	2,238	1,160	274,497
Waiver Service (Depends on HCPCS code)	335,623	0	0	0	0	335,623
Psychiatric Clinic Services (Type 'A')	308,993	96,903	1,494	2,965	6,143	201,488
Targeted Case Management Service (Early Intervention)	265,800	18,845	586	2,317	422	243,630
Psychiatric Clinic Services (Type 'B')	260,062	137,051	1,982	0	0	121,030
Social Work Service	244,127	13,155	48	231	130	230,563

Appendix D

TOTAL COST OF SERVICES PROVIDED BY PLAN AND CATEGORY OF SERVICE

During FY15

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Nurse Practitioners Services	$222,134	$55,594	$889	$1,677	$1,272	$162,701
Emergency Ambulance Transportation	212,163	78,240	933	3,201	1,503	128,287
Development Therapy, Orientation and Mobility Services (Waivers)	199,218	17,024	167	1,762	250	180,015
Optometric Services	180,120	73,202	1,372	3,562	2,409	99,574
Inpatient Hospital Services (Physical Rehabilitation)	142,349	93,652	0	0	0	48,697
Psychologist Service	137,553	3,566	0	46	464	133,476
Outpatient Services (ESRD)	93,381	79,880	0	0	0	13,501
LTC--ICF/MR	73,212	73,212	0	0	0	0
Podiatric Services	64,108	23,039	180	1,242	915	38,731
Non-Emergency Ambulance Transportation	48,952	26,730	179	809	463	20,770
Audiology Services	40,346	6,609	132	903	542	32,160
Early Intervention Services	38,381	5,551	0	0	0	32,830
Midwife Services	31,464	28,400	0	1,734	0	1,330
Service Car	30,882	26,990	17	435	0	3,439
Fluoride Varnish	12,402	1,378	26	130	52	10,816
Taxicab Services	8,425	2,936	0	0	0	5,490
Licensed Clinical Professional Counselor	7,379	3,176	0	0	0	4,203
Independent Diagnostic Testing	5,435	2,178	35	68	472	2,682
Family Planning Counseling	5,409	1,345	0	0	0	4,064
FFS Procedure to Implement Contraceptive Devices for PT 040, 048	5,237	4,898	0	0	0	338
Home Care	4,854	3,461	0	0	0	1,393
Chiropractic Services	4,203	3,837	39	43	1	284
Clinic Services (Physical Rehabilitation)	3,253	854	0	0	0	2,400
Physicians Psychiatric Services	1,525	291	0	0	0	1,233
Medicar Transportation	778	191	587	0	0	0
Portable X-Ray Services	121	60	0	0	0	61
Total Cost of Services	**$86,483,128**	**$35,590,141**	**$607,404**	**$1,422,136**	**$666,187**	**$48,197,260**

Note: May not add due to rounding.
Source: Summary of FY15 ALL KIDS data provided by HFS.

APPENDIX E

Total ALL KIDS Services Provided by Provider Greater Than $50,000 Fiscal Year 2015

Note:

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

Appendix E

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

Fiscal Year 2015

Provider Name	City	State	Total Amount Paid
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	$4,424,299.88
FAMILY HEALTH NETWORK	CHICAGO	IL	2,527,922.75
MERIDIAN HEALTH PLAN INC VMC	CHICAGO	IL	2,262,389.99
HARMONY HEALTH PLAN	CHICAGO	IL	2,087,275.13
BLUE CROSS BLUE SHIELD IL FHP	CHICAGO	IL	1,563,106.92
ILLINICARE HEALTH PLAN INC FHP	WESTMONT	IL	1,322,013.54
COUNTYCARE FHP	CHICAGO	IL	1,282,350.00
THE BLEEDING AND CLOTTING	PEORIA	IL	991,944.59
RUSH CHILDRENS SERVICES	CHICAGO	IL	943,343.32
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	865,866.84
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	845,771.07
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	840,756.96
AETNA BETTER HEALTH INC FHP	CHICAGO	IL	781,387.49
LUTHERAN GENERAL CHILDRENS HOS	PARK RIDGE	IL	714,430.77
CAREMARK INC	MT PROSPECT	IL	703,397.41
HOPE CHILDRENS HOSPITAL	OAK LAWN	IL	693,556.02
COMER CHILDRENS HOSPITAL	DARIEN	IL	647,522.12
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	634,592.96
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	526,018.02
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	504,875.47
CHICAGO SCHOOL DIST 299	CHICAGO	IL	492,978.88
HARTGROVE HOSPITAL	CHICAGO	IL	473,499.55
WALGREENS SPECIALTY PHRM 15438	CANTON	MI	404,385.86
RIVEREDGE HOSPITAL	FOREST PARK	IL	361,703.66
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	341,121.89
CARDINAL GLENNON CHILDRENS HSP	SAINT LOUIS	MO	334,922.84
PROFESSIONAL BUILDING PHARMACY	CHICAGO	IL	312,496.46
PRESENCE SAINT MARY NAZARETH	CHICAGO	IL	306,110.51
MOLINA HEALTHCARE OF ILL FHP	OAK BROOK	IL	268,175.62
ALEXIAN BROS CHILDRENS HOSP	HOFFMAN ESTATES	IL	254,547.97
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	243,917.11
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	243,081.87
DSCC	SPRINGFIELD	IL	237,332.31
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	IL	228,341.14
CARLE FOUNDATION HOSPITAL	URBANA	IL	222,175.29
COMMUNITY HEALTHCARE SERVICES	LOMA LINDA	CA	212,779.52
CHILDRENS HOSP OF WISCONSIN	MILWAUKEE	WI	210,899.51
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	209,908.25
ST ANTHONY HOSPITAL	CHICAGO	IL	209,828.83
ROSECRANCE CENTER	ROCKFORD	IL	204,224.18
MAXIM HEALTHCARE SERVICES INC	ROSEMONT	IL	199,173.56
EVANSTON HOSPITAL	EVANSTON	IL	196,142.62
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HGTS	IL	184,001.88
ADVOCATE NORTHSIDE	CHICAGO	IL	183,372.14
HEALTH ALLIANCE CONNECT FHP	URBANA	IL	182,933.59
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	180,679.67
MT SINAI HOSP MED CTR CHICAGO	CHICAGO	IL	180,613.45
BENJAMIN DALE	CHICAGO	IL	179,225.50
AQEL FADI	CHICAGO	IL	175,363.31

Appendix E

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

Fiscal Year 2015

Provider Name	City	State	Total Amount Paid
FANTUS HEALTH CENTER	CHICAGO	IL	$168,664.32
COPLEY MEMORIAL HOSPITAL	AURORA	IL	165,946.98
WALGREENS 13974	CHICAGO	IL	163,701.89
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	163,565.52
GARFIELD PARK HOSPITAL	CHICAGO	IL	158,280.55
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	154,312.93
LABORATORY CORPORATION AMERICA	DUBLIN	OH	152,763.24
YARMOLYUK YAROSLAV	ARLINGTON HTS	IL	151,568.14
NASREEN TAIBA	ADDISON	IL	149,671.93
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	140,080.41
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	137,064.52
CONTINUUM PEDIATRIC NURSING	ROLLING MEADOWS	IL	134,236.36
OPTION CARE ENTERPRISES INC	COLUMBIA	MO	129,231.38
KEMMERER VILLAGE	ASSUMPTION	IL	129,103.99
OPTION CARE ENTERPRISES INC	WOOD DALE	IL	128,355.74
GREATER ELGIN FAMILY CARE CTR	ELGIN	IL	127,228.41
AURORA CHICAGO LAKESHORE CHILD	CHICAGO	IL	124,276.78
C AND M PHARMACY LLC	GLENVIEW	IL	121,832.76
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	121,094.06
ROWAN SUSAN	CHICAGO	IL	118,465.49
AMBER ENTERPRISES INC	CHICAGO	IL	118,452.84
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	117,231.03
THE GENESIS CENTER	DES PLAINES	IL	116,641.05
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	115,582.39
PRESENCE MERCY MEDICAL CENTER	AURORA	IL	115,408.02
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	114,865.84
THE KENNETH W YOUNG CENTERS	ELK GROVE VLGE	IL	114,332.17
UNITED SEATING AND MOBILITY	LOMBARD	IL	113,696.16
EDWARD HOSPITAL	NAPERVILLE	IL	113,605.77
PRESENCE SAINT JOSEPH CHICAGO	CHICAGO	IL	113,333.04
EDGEWATER UPTOWN COMM MHC	CHICAGO	IL	110,505.10
ACCREDO HEALTH GROUP INC	ORLANDO	FL	109,467.41
ADVOCATE SHERMAN HOSPITAL	ELGIN	IL	109,000.87
VNA HEALTH CARE	AURORA	IL	108,543.24
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	108,354.25
ALEXIAN BROTHERS MED CTR	ELK GROVE VLGE	IL	103,146.53
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	102,000.07
MACNEAL HOSPITAL	BERWYN	IL	100,825.66
CHACON JOSE	AURORA	IL	95,934.09
JOSHI ASHWINI	CHICAGO	IL	94,444.96
COMM UNIT SCH DIST 300	CARPENTERSVILLE	IL	94,030.44
RIVERSIDE MED CTR	KANKAKEE	IL	93,682.85
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	92,686.70
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	92,645.41
SHRINERS HOSPITAL FOR CHILDREN	CHICAGO	IL	89,604.19
WHITESMAN LOUIS	CHICAGO	IL	87,000.07
REHABILITATION INSTITUTE	CHICAGO	IL	85,077.04
ADVOCATE ACCOUNTABLE CARE	ROLLING MEADOWS	IL	84,22200
PRESENCE SAINT JOSEPH MED CTR	JOLIET	IL	82,985.35

Appendix E

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

Fiscal Year 2015

Provider Name	City	State	Total Amount Paid
BOND DRUG COMPANY OF IL 03729	HANOVER PARK	IL	$82,906.32
VISTA CLINIC OF COOK COUNTY	PALATINE	IL	82,221.52
HINSDALE HOSPITAL	HINSDALE	IL	81,817.83
GARCIA ELOISA	CHICAGO	IL	81,261.47
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	81,042.47
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	80,288.55
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	79,301.37
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	78,995.89
FAMILY SERVICE ASSOCIATION	ELGIN	IL	78,343.80
WEBER ROBERT	WHEELING	IL	77,082.07
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	IL	76,842.80
TRC CHILDRENS DIALYSIS CENTER	CHICAGO	IL	75,993.26
DUAIBIS RAMZI	AURORA	IL	75,910.98
DOUBEK PHARMACY INC	ALSIP	IL	75,379.37
SAGUN MATTHEW	OAK LAWN	IL	74,310.00
THE PAVILION FOUNDATION	CHAMPAIGN	IL	73,409.84
ALDEN VILLAGE HEALTH FACILITY	BLOOMINGDALE	IL	73,211.70
KINGSWAY HOME HEALTH SERVICES	CHICAGO	IL	71,662.21
NORWEGIAN AMERICAN HOSP GROUP	CHICAGO	IL	70,746.91
PIONEER CENTER FOR HUMAN SRVCS	WOODSTOCK	IL	69,484.07
ALIVIO MEDICAL CENTER	CHICAGO	IL	68,952.91
RANKEN JORDAN A PED REHAB CTR	MARYLAND HTS	MO	67,834.83
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	IL	67,714.46
A2CL SERVICES LLC	WEST ALLIS	WI	67,380.31
WALGREEN CO	DES PLAINES	IL	67,103.02
SMARTPLAN CHOICE	DES PLAINES	IL	66,906.00
NORTHWESTERN LAKE FOREST HSPTL	LAKE FOREST	IL	66,194.32
CHRIST HOSPITAL	OAK LAWN	IL	65,515.21
WALGREENS SPECIALTY 10997	CARNEGIE	PA	64,365.60
LEYDEN FAMILY SERVICE AND MHC	FRANKLIN PARK	IL	64,351.40
MCC HEALTHCARE SERVICES INC	EVERGREEN PARK	IL	64,186.86
SHIELD DENVER HLT CARE CTR INC	ELMHURST	IL	64,127.26
CHICAGO BEHAVIORAL HOSPITAL	DES PLAINES	IL	64,045.38
KELLOGG ELIZABETH	ELGIN	IL	63,644.05
MAHAIRI AMJAD	ELGIN	IL	63,170.42
GLENOAKS HOSPITAL	GLENDALE HGTS	IL	63,091.44
WALGREEN CO STORE 5724	CHICAGO	IL	62,989.99
LAMBERGHINI FLAVIA	CHICAGO	IL	61,565.88
CORNELL INTERVENTION WOODRIDGE	WOODRIDGE	IL	61,006.11
BOND DRUG COMPANY OF IL 05103	CICERO	IL	60,718.58
MEDSTAR LABORATORY INC	HILLSIDE	IL	60,631.98
NORWEGIAN AMERICAN HOSP	CHICAGO	IL	60,413.83
BOND DRUG COMPANY OF IL 03078	WAUKEGAN	IL	59,493.66
METHODIST MEDICAL CNTR	PEORIA	IL	58,931.61
WILLIAMS JILADA	MAYWOOD	IL	58,847.71
ACTIVSTYLE INC	MINNEAPOLIS	MN	58,546.60
ANCHOR HOME HEALTH CARE	GLEN CARBON	IL	58,326.38
WINE PAUL	CHICAGO	IL	58,139.30
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	57,127.93

Appendix E

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

Fiscal Year 2015

Provider Name	City	State	Total Amount Paid
MENEGAS WILLIAM	CHICAGO	IL	$57,056.42
GATEWAY FOUNDATION	SPRINGFIELD	IL	56,937.42
CICERO HEALTH CENTER	CICERO	IL	56,409.25
CYSTIC FIBROSIS PHARMACY INC	ORLANDO	FL	56,378.58
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	56,330.21
TARGET PHARMACY T 837	MELROSE PARK	IL	55,866.66
SCHWAB REHAB HOSP	CHICAGO	IL	55,420.37
SCHOOL DISTRICT U 46	ELGIN	IL	55,328.55
MIDLAKES CLINIC	ROUND LK BEACH	IL	55,101.90
ECHO JOINT AGREEMENT	SOUTH HOLLAND	IL	55,042.13
CORNELL INTERVENTIONS DUPAGE	WILLOWBROOK	IL	54,729.87
ARBOLEDA CLEIDY	CHICAGO	IL	54,573.76
MILORO MICHAEL	BURR RIDGE	IL	54,449.97
ESPERANZA LITTLE VILLAGE	CHICAGO	IL	54,125.14
OWEIS TAMARA	CHICAGO	IL	53,713.77
OBAISI NOOR	YORKVILLE	IL	53,221.32
TSALIAGOS CHRISTOS	CHICAGO	IL	53,105.50
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	51,966.90
ROSECRANCE INC	ROCKFORD	IL	51,959.13
REHABILITATION INSTITUTE	CHICAGO	IL	51,950.13
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	51,481.52
MERCY HOSPITAL MEDICAL CENTER	CHICAGO	IL	51,277.89
SILVER CROSS HOSPITAL	NEW LENOX	IL	51,242.92
BOND DRUG COMPANY OF ILLINOIS	CHICAGO	IL	51,240.75
BLESSING HOSPITAL	QUINCY	IL	50,967.11
WALGREENS SPECIALTY PHRM 15443	FRISCO	TX	50,650.16

Source: FY15 data provided by HFS.

APPENDIX F
Agency Responses

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

July 21, 2016

Honorable Frank J. Mautino
Auditor General
State of Illinois

Dear Auditor General Mautino:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit of the "Covering ALL KIDS Health Insurance Program".

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

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

Sincerely,

SIGNED ORIGINAL ON FILE

Felicia F. Norwood
Director

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

Attachment Response
Report: Covering ALL KIDS Health Insurance Program

Recommendation Number 1: Redetermination of Eligibility

The Department of Healthcare and Family Services and the Department of Human Services should annually redetermine ALL KIDS eligibility as required by the Covering ALL KIDS Health Insurance Act.

Response:
The Department accepts the recommendation. HFS and DHS lack the staff to complete all of the redeterminations that are due each month. The new Integrated Eligibility System (IES) Phase 2 implementation will incorporate case maintenance activities into IES. Having both new application processing, redeterminations and other case maintenance activities in one system will be more efficient and allow more flexibility to complete all of the work. After Phase 2 is implemented it will take time to catch up on delayed redeterminations.

Recommendation Number 2: All Kids Data Reliability

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

Response:
The Department accepts the recommendation. While coverage is ended systematically for most children when they turn 19, there are some situations, such as pregnancy due date coded on the case, that allow coverage as a child to continue until it is manually reviewed by a caseworker. Implementation of Phase 2 of the Integrated Eligibility System will remove the need for a manual review to end or change coverage in most situations that have resulted in covering individuals as children beyond the month they turn 19.

Recommendation Number 3: Classification of Documented Immigrants

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

- ensure policies and procedures used to classify enrollees as a documented immigrant or undocumented immigrant, contain specific instructions for caseworkers to make accurate eligibility decisions;

- consider implementing an electronic edit within the lntegrated Eligibility System (IES) that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;

- ensure that documented immigrants are classified correctly in its database; and,

- ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.

Response:
The Department accepts the recommendation. Additional instructions related to clearances and verifications, including those related to immigration status, have been provided to staff. In addition, edits within IES regarding immigration status will be reviewed after Phase 2 implementation.

Recommendation Number 4: Eligibility Documentation

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

- ensure all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;

- require one month's worth of income verification for determining eligibility; and

- implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and that eligibility is determined correctly.

Response:
The Department accepts the recommendation. While electronic means of verification implemented over the past few years have helped, they only work for those who provide an SSN. The Department will promulgate rules to require verification of date of birth for children. The Department will also provide regular reminders to caseworkers regarding income verification requirements including checking electronic sources for wage data report by employers for individuals reporting they are self-employed.

Recommendation Number 5: Policies over Orthodontic Treatment

The Department of Healthcare and Family Services should:

- ensure DentaQuest is receiving and maintaining documentation needed to support orthodontia approvals;

- examine and address the issues raised by the OIG in its review of orthodontic claims; and,

- more effectively monitor the actions taken by DentaQuest (the State's contractual Dental Program Administrator).

Response:
The Department accepts this recommendation. The Department conducts various monitoring activities as part of the ongoing management of the DentaQuest contract and also receives and reviews the annual Service Organization Control report outlining any control issues noted by independent auditors; however, there have been significant changes in staff in the Bureau

that oversees the Dental program. The Department will remind DentaQuest that they must maintain documentation according to out records retention policies. The Department will also review the issues raised by the OIG and take appropriate action.

July 21, 2016

Frank J. Mautino, Auditor General
Office of the Auditor General
740 East Ash
Springfield, Illinois 62703-3154

Dear Auditor General Mautino:

Attached is the Department of Human Services' (DHS) response to the recommendations included in the draft report of the seventh annual audit of the Covering ALL KIDS Health Insurance program:

Finding Statement - 1: ANNUAL REDETERMINATIONS
In FY15, HFS and DHS completed 88 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY 15 audit found that 3,715 of 29,881 were not redetermined annually as required. As a result, 12 percent were not redetermined annually as required by the Act.

Recommendation Number - 1: REDETERMINATION OF ELIGIBILITY
The Department of Healthcare and Family Services and the Department of Human Services should annually redetermine ALL KIDS eligibility as required by the ALL KIDS Health Insurance Act.

Department Response:
The Department of Human Services agrees with the recommendation. The redetermination process will be enhanced with the implementation of the new updated processing system, IES - Phase 2 in September 2016. IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers using a three step process. Online and classroom training venues will be available to all staff using the new system.

Finding Statement-3: CLASSIFICATION OF DOCUMENTED IMMIGRANTS
EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly coded as "undocumented". HFS and DHS did not identify the correct citizenship status for recipients during the process of determining new and continued eligibility, and as a result, the State is losing federal matching Medicaid funds.

- 17 out of the 39 recipients sample (44%) who were coded as undocumented during initial eligibility were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.
- 9 of the 40 (23%) were coded as undocumented during the redetermination of eligibility even though the enrollees had a verified social security number or other evidence supporting they were likely citizens or documented immigrants.

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

- ensure policies and procedures used to classify enrollees as a documented immigrant or undocumented immigrant contain specific instructions for caseworkers to make accurate eligibility decisions;

- consider implementing an electronic edit within the Integrated Eligibility System (IES) that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;
- ensure that documented immigrants are classified correctly in its database; and
- ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.

Department Response:
The Department of Human Services agrees with the recommendation. Conversion to an updated single processing system with the implementation of IES – Phase 2 in September 2016, will allow for improved classification of documented immigrants and electronic storage of verifications supporting the immigration status for non-citizens.

Finding Statement -4: ELIGIBILITY DOCUMENTATION
All six of the previous ALL KIDS audits found that, due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS did not obtain documentation to support eligibility in some instances. This included required documentation for residency, birth, and income. As a result, auditors could not determine whether eligibility was determined correctly by HFS and DHS.

During our FY15 testing, we reviewed all 40 new cases in IES to determine whether all the required eligibility documentation was obtained or reviewed. Of the 40 cases reviewed, 24 cases (60%) were missing at least one piece of required documentation (verification of residency, birth/age, income).

Recommendation Number - 4:
The Department of Healthcare and Family Services and the Department of Human Services should:
- ensure all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;
- ensure one month's worth of income verification is reviewed for determining eligibility; and
- implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and that eligibility is determined correctly.

Department Response:
The Department of Human Services agrees with the recommendation. Currently there are multiple sources that store case eligibility documents. Conversion to the new IES processing system that stores documentation electronically, for both application and ongoing eligibility determinations, will provide one source for storing supporting eligibility documentation. The Department will continue to provide ongoing policy clarification regarding income eligibility determinations.

If you have any questions, please contact me at 217/558-6931 or jane.hewitt@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE

Jane Hewitt, CIA, CGAP
Chief Internal Auditor

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