STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT
OF THE
COVERING ALL KIDS HEALTH INSURANCE PROGRAM

JANUARY 2020

FRANK J. MAUTINO

AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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
January 2020

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

REPORT DIGEST

PROGRAM AUDIT

For the Year Ended:
June 30, 2018

Release Date:
January 2020

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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 **tenth** annual audit (FY18) of the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings.

Integrated Eligibility System (IES) Phase II was implemented during FY18. FY18 data was obtained and reported in this audit as required but there are limitations affecting the accuracy of this data as outlined in Appendix B. HFS and DHS agreed with all five recommendations in the audit report.

1. In FY18, there were 93,944 enrollees at any point in EXPANDED ALL KIDS and the total cost of services provided was $104.3 million.
2. The total number of recipients as of June 30th was 66,353 in FY17 and 63,255 in FY18. Both citizens and undocumented immigrants slightly decreased in FY18.
3. In FY17, we found that 2,411 of the 33,531 recipients (7%) were not redetermined annually as required. In FY18, this recommendation was repeated because we could not follow up on this recommendation for FY18.
4. In FY18, 689 recipients received 3,638 services totaling $475,813 after the month of their 19th birthday. Additionally, there were 181 individuals who appeared to be enrolled with more than one identification number.
5. HFS and DHS did not identify the correct citizenship status for 4,204 recipients, and as a result, the State lost an estimated $2.6 million in federal matching Medicaid funds in FY18. The State also lost federal matching Medicaid funds in FY15 through FY17 – for an estimated total of $10.7 million lost in federal reimbursement over the last four fiscal years. This issue has been reported since the FY09 ALL KIDS audit.
6. We tested 40 initial eligibility cases, 40 redetermined cases, and 15 additional undocumented redetermined cases as part of our fieldwork testing for FY18.
   - We found 42 percent of initial cases, 15 percent of redetermined cases, and 40 percent of additional redetermined cases were coded as "undocumented" even though we found evidence supporting citizenship or documented immigrant status.
   - We also found HFS and DHS were missing at least one piece of required documentation (residency, age, and/or one month's income verification) in 35 percent of initial eligibility cases, 20 percent of redetermined cases, and 67 percent of additional redetermined cases.
7. The updated FY17 recommendation on policies covering orthodontic treatment was repeated in FY18. HFS did not have sufficient time to address these updates on more effectively monitoring orthodontic recipients under the MCO part of the program and reviewing membership requirements for the Dental Policy Review Committee.
8. Public Act 101-0272, effective August 9, 2019, amended the Covering ALL KIDS Health Insurance Act. As a result, the ALL KIDS audit will change from being performed annually to being performed every three years.

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

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

Throughout our audits, we 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 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 tenth annual audit (FY18).

This FY18 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 1-2)

ALL KIDS Program

The program included 93,944 EXPANDED ALL KIDS enrollees at any point during FY18, a decrease of 10% from the previous year (FY17) when there were 104,856 enrollees.

According to HFS, in FY18, Illinois' ALL KIDS program as a whole had a total of almost 1.7 million enrollees and HFS paid nearly $3.2 billion in claims. The program included 93,944 EXPANDED ALL KIDS enrollees at any point in FY18, which decreased (10%) from FY17 when there were 104,856 enrollees. On June 30, 2018, there were 63,255 enrollees. Thirty-five percent or 22,187 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.

EXPANDED ALL KIDS PROGRAM STATISTICS

	FY17	FY18
Enrollees at any point	104,856	93,944
Enrollees on June 30	66,353	63,255
Total Cost of Services Provided	$103,054,764	$104,320,137
Total Net Cost of Services after Premium Payments	$85,068,952	$88,066,128

Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Digest Exhibit 1
ENROLLMENT BY PLAN [2]
For EXPANDED ALL KIDS as of June 30 [3]

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY17	FY18	FY17	FY18
Assist $36,900[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		21,132	19,781
Share $39,408[1]			574	507
Premium Level 1 $52,464[1]			1,516	1,297
Premium Level 2 $79,824[1]	42,435	41,068	696	602
Totals	**42,435**	**41,068**	**23,918**	**22,187**

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 effective 4/2018. Although the monthly income standards changed during FY18, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2017 and 2018. There were 104,856 enrollees eligible at some point during FY17 and 93,944 enrollees eligible at some point during FY18.

[3] There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS enrollment data provided by HFS.

The cost of services for EXPANDED ALL KIDS has fluctuated over the years ranging from a low of $70.0 million in FY14 to a high of $104.3 million in FY18.

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS has fluctuated over the years ranging from a low of $70.0 million in FY14 to a high of $104.3 million in FY18. The total cost for undocumented immigrants has continued to decrease each year since FY12. The total cost decreased from $55.7 million in FY12 to $35.9 million in FY18.

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 FY17 and FY18. Additionally, Digest Exhibit 2 shows the cost of services increased by over $1 million from $103.1 million in FY17 to $104.3 million in FY18.

The cost of services has increased by over $1 million from $103.1 million in FY17 to $104.3 million in FY18.

In the past, a large portion of the cost for services for the EXPANDED ALL KIDS program was for undocumented immigrants; however, that has not been the case the last four years. In FY09, undocumented immigrants accounted for 70 percent of the total cost for the EXPANDED ALL KIDS program. This percentage has declined since FY09 with undocumented immigrants accounting for only 34 percent of the total cost in FY18. (pages 9-16)

Digest Exhibit 2
COST OF SERVICES PROVIDED BY PLAN
For EXPANDED ALL KIDS during Fiscal Years 2017 and 2018 [4]

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals[2]	
	FY17	FY18	FY17	FY18	FY17	FY18
Assist $36,900[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$33,034,213	$32,145,283	$33,034,213	$32,145,283
Share $39,408[1]			$767,717	$876,331	$767,717	$876,331
Premium Level 1 $52,464[1]			$2,374,695	$2,255,529	$2,374,695	$2,255,529
Premium Level 2 $79,824[1]	$66,075,439[3]	$68,396,589[3]	$802,701	$646,404	$66,878,139	$69,042,993
Totals [2]	**$66,075,439**	**$68,396,589**	**$36,979,325**	**$35,923,548**	**$103,054,764**	**$104,320,137**

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 effective 4/2018. Although the monthly income standards changed during FY18, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 88.91 percent in FY17 and 88.52 percent in FY18; therefore, the State's estimated share for services was $7.3 million in FY17 and $7.9 million in FY18.

[4] There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS data provided by HFS.

FY18 Audit Findings and Recommendations

All five issues from our previous FY17 audit were repeated or partially repeated during this FY18 audit. The five recommendations were related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment.

In FY18, we could not follow up on the first recommendation due to a missing data field needed for our review as well as redetermination dates being extended to FY19.

1. Redetermination of Eligibility

The FY17 audit found that 2,411 of the 33,531 recipients (7%) were not redetermined annually for all recipients as required by the Covering ALL KIDS Health Insurance Act. We could not follow up on this recommendation for FY18 due to a missing data field needed for our review as well as redetermination dates being extended to FY19. We will follow up on this recommendation during our next audit. (pages 1-2, 17-21)

2. ALL KIDS Eligibility Data

689 recipients received 3,638 services totaling $475,813 after the month of their 19th birthday.

During our review of the FY18 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were over the age of 18 and who were enrolled in ALL KIDS more than once. In the FY18 data, we identified 689 recipients that received 3,638 services totaling $475,813 after the month of their 19th birthday. We also identified 181 individuals who appeared to be enrolled with more than one identification number. If recipients maintain eligibility after the age of 19, or if recipients have eligibility under more than one recipient identification number, the State may provide services for non-eligible recipients. (pages 21-22)

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. An estimated total of $10.7 million in federal reimbursement was lost over the last four fiscal years (FY15 through FY18).

We determined the FY18 eligibility data contained 4,204 "undocumented" recipients who had social security numbers that were verified, of which 229 also had an alien registration number. We reviewed the services provided to the 4,204 "undocumented" recipients in FY18 and determined they had 34,697 services for a total cost of almost $5.0 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. As a result of the miscoding errors, the State is annually losing federal matching dollars. In FY18, we estimated that the State at a minimum did not collect $2.6 million in federal reimbursement for the $5.0 million in services in FY18. Additionally, we estimated that the State at a minimum did not collect $2.9 million in federal reimbursement in FY17, $2.4 million in federal reimbursement in FY16, and $2.8 million in federal reimbursement in FY15 – for a total estimated loss of **$10.7 million** in federal reimbursement over the last four fiscal years.

Initial Eligibility Testing

14 of the 33 new recipients sampled (42%) were coded as undocumented but were likely citizens or documented immigrants.

During our review of 40 new cases that were approved during May and June 2018, we found that 14 of the 33 cases (42%) 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 14 classified as undocumented. The other 7 recipients were coded as citizens. We provided these 14 cases to DHS, and DHS officials agreed they were likely documented.

Redetermination of Eligibility Testing

2 of the 13 redetermined recipients sampled (15%) were coded as undocumented but were likely citizens or documented immigrants. 6 of 15 additional redetermined recipients (40%) were coded as undocumented but were likely citizens or documented immigrants.

During our review of 40 recipients that were redetermined during May and June 2018, we found 2 of 13 recipients sampled (15%) were coded as undocumented even though we found documentation verifying the recipient's social security number and/or alien status. The other 27 recipients were coded as citizens.

Since only 13 recipients in the original redetermination sample were coded as undocumented, we performed an additional redetermination sample of 15 undocumented recipients. We found that 6 of 15 recipients sampled (40%) were coded as undocumented but likely should have been coded as citizens/documented immigrants. We provided these eight cases to DHS (two cases from the original redetermination sample and six cases from the additional redetermination sample), and DHS officials agreed they were likely documented. (pages 23-26)

4. <u>Eligibility Documentation</u>

HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and citizenship/immigration status. During our review of the new and continued eligibility process for EXPANDED ALL KIDS, we determined the data matching component used by IES (and previously the Illinois Medicaid Redetermination Project) cannot be utilized for 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 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

During initial eligibility testing, 14 of 40 cases (35%) were missing at least one piece of required documentation.

We randomly selected 40 of the 1,566 new cases approved during May and June 2018 and found significant issues. Residency was not verified in 8 of the 40 (20%) cases tested, and birth/age information was not verified in 11 of the 40 (28%) cases tested. Of the 40 cases tested, 22 reported having income. We found 30 days of income was not reviewed in 2 of the 22 cases (9%) where income was reported. Of the 40 cases reviewed, 14 cases (35%) were missing at least one piece of required documentation (verification of residency, birth/age, or income).

Eligibility Redetermination Testing

During eligibility redeterminaton testing, 8 of 40 cases (20%) were missing at least one piece of required documentation.

We also tested 40 of the medical only redeterminations that occurred during May and June 2018 and found issues regarding Illinois residency, birth/age, and income documentation. Residency was not verified in 4 of the 40 (10%) cases tested, and birth/age information was not verified in 5 of the 40 (13%) cases tested. Of the 40 cases tested, 38 reported having income. We found 30 days of income was not reviewed in 2 of the 38 cases (5%) where income was reported. Of the 40 cases reviewed, 8 cases (20%) were missing at least one piece of required documentation (verification of residency, birth/age, or income).

For the additional sample of redeterminations, 10 of 15 cases (67%) were missing at least one piece of required documentation.

Since only 13 cases in the random sample of 40 redeterminations were undocumented, we performed an additional random sample of 15 EXPANDED ALL KIDS undocumented recipients whose medical eligibility was redetermined during either May or June 2018. Residency was not verified in 8 of 15 cases tested (53%) and birth/age information was not verified in 5 of 15 cases tested (33%). We also found 30 days of income was not verified in 1 of 12 cases tested (8%). Of the 15 cases reviewed, 10 cases (67%) were missing at least one piece of required documentation (verification of residency, birth/age, or income). (pages 26-32)

5. <u>Policies Covering Orthodontic Treatment</u>

The fifth audit recommendation was not recommended until the FY14 audit. This audit recommendation was not followed up on until the FY17 audit because the Administrative Code (89 Ill. Adm. Code 140.421) related to orthodontics and the scoring tool did not become effective until January 19, 2017 (FY17). During the FY17 audit, this audit recommendation was updated and partially repeated (see text box).

For the updated FY17 orthodontics recommendation, we determined that HFS was not effectively monitoring the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program and ensuring that the State's dental administrator subcontractors were following the same requirements in the new Administrative Code and using the scoring tool for these recipients. We also found that the Dental Policy Review Committee (Committee) membership requirements were not met and there was an unbalanced representation of committee members.

FY17 Updated Audit Recommendation on Policies Covering Orthodontic Treatment

We recommended that the Department of Healthcare and Family Services should:

- more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program; and
- review the membership requirements for the Dental Policy Review Committee and update the Dental Policy Review Committee bylaws accordingly.

Since the previous FY17 audit was released in March 2019, HFS did not have sufficient time to address the FY17 updated audit recommendation for this FY18 audit. However, we did request and update data to provide updated FY18 information related to initial orthodontic placements and current orthodontic recipients. In order to update this data, we had to request FY18 encounter data from HFS. Therefore, although this FY18 encounter data was obtained and reported in this audit to provide updated FY18 information, there are limitations affecting this data as outlined in Appendix B of this audit report.

From the FY18 encounter data received, we found that the number of initial orthodontic placements continued to drop in FY18. Initial orthodontic placements were 1,138 in FY14, 1,287 in FY15, 1,557 in FY16, 1,252 in FY17, and 708 in FY18. We also found that the percentage of current MCO recipients receiving services remained about the same and continued to be significant from FY17 to FY18. The percent of MCO recipients receiving orthodontic services was 42 percent in FY17 and 41 percent in FY18.

Due to the fact that HFS did not have sufficient time to address the FY17 audit recommendation, the fifth recommendation was repeated for FY18.

We also requested and updated FY18 information related to the dental administrator contracts and Committee meetings. We found no improvements had been made yet to address the problems identified in the FY17 updated audit recommendation during FY18. Due to the fact that HFS did not have sufficient time to address the FY17 audit recommendation, this recommendation was repeated for FY18. We will follow up on both parts of this recommendation during our next audit. (pages 32-36)

Future EXPANDED ALL KIDS Audits

Public Act 101-0272, effective August 9, 2019, amended the Covering ALL KIDS Health Insurance Act. This Act requires the Auditor General to perform an audit of the Program on or before June 30, 2022 and every 3 years thereafter (rather than annually). Therefore, upon the completion of this FY18 audit, the ALL KIDS audit will change from being performed annually to being performed every three years. (pages 2-3)

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 G to the audit report contains the agency responses.

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

SIGNED ORIGINAL ON FILE

Joe Butcher
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:SEC

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APPENDICES

GLOSSARY OF ACRONYMS

DHS - Illinois Department of Human Services

FFS - Fee-for-Service

FPL - Federal Poverty Level

HFS - Illinois Department of Healthcare and Family Services

HHS - Federal Department of Health and Human Services

IES - Integrated Eligibility System

MAGI - Modified Adjusted Gross Income

MCO - Managed Care Organization

OAG - Illinois Office of the Auditor General

OIG - Illinois HFS Office of the Inspector General

SNAP - Supplemental Nutrition Assistance Program

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. The Act requires that the audit include:

- payments for health services covered by the program; and
- contracts entered into by the Department of Healthcare and Family Services (HFS) in relation to the program.

This is the 10th annual audit (FY18), and follows up on HFS' and the Department of Human Services' (DHS) actions to address prior audit findings. The previous nine audits covered FY09 through FY17. These annual audits contained as many as 14 audit recommendations. The last four annual audits (FY14 through FY17) contained the same five audit recommendations. As shown in Exhibit 1, the five recommendation areas were related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment.

Nine Years of Audit Recommendations

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

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

Exhibit 1
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS

Recommendation Area	Audits Recommended	Status of the Recommendation as Reported in the FY18 Audit	Follow-up Testing
1. Redetermination of ALL KIDS Eligibility	FY09-FY17	Repeated	Yes
2. ALL KIDS Data Reliability	FY09-FY17	Repeated	Yes
3. Classification of Documented Immigrants	FY09-FY17	Repeated	Yes
4. Eligibility Documentation	FY09-FY17	Repeated	Yes
5. Policies Covering Orthodontic Treatment [1]	FY14-FY17	Repeated	Yes

[1] During the FY17 audit, the fifth audit recommendation was updated and partially repeated. Since HFS did not have sufficient time to address the FY17 updated audit recommendation, this recommendation was repeated for FY18.

Source: FY18 Program Audit of the Covering ALL KIDS Health Insurance Program.

FY18 Audit Findings and Recommendations

All five recommendations from our previous FY17 audit were repeated during this audit. Although the number of audit recommendations has decreased significantly since the first ALL KIDS audit covering Fiscal Year 2009, the first four audit recommendations have been repeated since the first ALL KIDS audit. One of these recommendations is the third audit recommendation, which includes the miscoding of documented immigrants. As a result of these miscoding errors, the State is annually losing federal matching dollars. We estimated that the total reimbursement lost was $2.8 million in FY15, $2.4 million in FY16, $2.9 million in FY17, and $2.6 in FY18 – for an estimated total of **$10.7 million** lost in federal reimbursement over the last four fiscal years.

The fifth audit recommendation was not recommended until the FY14 audit. This audit recommendation was not followed up on until the FY17 audit because the Administrative Code (89 Ill. Adm. Code 140.421) related to orthodontics and the scoring tool did not become effective until January 19, 2017 (FY17). During the FY17 audit, this recommendation was updated and partially repeated. Since HFS did not have sufficient time to address the FY17 updated audit recommendation, this recommendation was repeated for FY18. We will follow up on this recommendation during our next audit.

FY18 OAG Financial Audit Findings for HFS and DHS

Integrated Eligibility System (IES) Phase II was implemented on October 24, 2017, and revised the process for redetermination of eligibility during FY18. The FY18 Office of the Auditor General (OAG) financial audits of HFS and DHS contained significant applicable findings directed at IES and encounter data for FY18. In order to follow up on the EXPANDED ALL KIDS program annually as required by Public Act 95-985, the FY18 data was obtained and reported in this audit but there are limitations affecting the accuracy of this data as outlined in these findings. The list below includes applicable FY18 HFS and DHS financial audit findings. See Appendix B for additional information about these findings.

- Failure to perform essential project management functions over IES;
- Deletion of four months of intake eligibility files and significant problems determining eligibility for Human Service programs;
- Backlog of applications and redeterminations for Human Service programs;
- Lack of controls over changes to IES;
- Lack of security controls over IES; and
- Inadequate controls over fiscally monitoring Managed Care Organizations (MCOs) and enrollee encounter data submitted by MCOs.

Future EXPANDED ALL KIDS Audits

Public Act 101-0272, effective August 9, 2019, amended the Covering ALL KIDS Health Insurance Act. This Act requires the Auditor General to perform an audit of the Program on or before June 30, 2022 and every three years thereafter (rather than annually). Therefore, upon the completion of this FY18 audit, the ALL KIDS audit will change from being performed annually to being performed every three years. This change will allow more time for HFS and DHS to

implement audit recommendations before a subsequent audit begins. The next EXPANDED ALL KIDS audit should cover FY19 through FY22.

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

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 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 may be relevant to the program as a whole.

The Department of Healthcare and Family Services' July 2008 ALL KIDS Preliminary Report noted that "two key changes occurred" with the July 1, 2006, expansion pursuant to the Covering ALL KIDS Health Insurance Act [215 ILCS 170]. The 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, authorized 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 (signed on January 25, 2011) 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.

The original Act (July 1, 2006) expanded program benefits to cover all uninsured children in families regardless of family income. Thus, children whose family income was greater than 200 percent of the FPL and undocumented immigrant children at any income level were eligible. As discussed later, the Act was amended in January 2011 to limit some of the children originally added. Note: the Covering ALL KIDS Health Insurance Act is scheduled to be repealed on October 1, 2024.

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.

CHANGES AFFECTING THE AUDIT

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 audit of the EXPANDED ALL KIDS program. These changes to the Covering ALL KIDS Health Insurance Act included:

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

Effective August 5, 2019, Public Act 101-209 reduced the income requirement listed above. More specifically, the requirement for verifying income for one month was reduced to one pay stub beginning in FY20. This updated requirement was the same requirement in place prior to July 1, 2011. Additionally, information required for annual redeterminations may be obtained from a recipient's application for non-health care benefits if it is sufficient to make a determination for continued eligibility for medical assistance.

Changes Affecting the Covering ALL KIDS Health Program Audit

Five events have had a significant impact on the EXPANDED ALL KIDS program and our audits. These events are outlined 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.** Effective July 1, 2011, children whose families' household income was above 300 percent of the FPL were no longer eligible for the program. 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.** On June 4, 2013, HFS received a notification from the federal Department of Health and Human Services (HHS) that Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300 percent of the FPL under Title XXI of the Social Security Act, as reauthorized under the Children's Health Insurance Program Reauthorization Act of 2008 (CHIPRA). 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). In FY18, the reimbursement rate was 88.52 percent. According to HFS officials, as of June 30, 2018, HFS had recouped a total of **$117.55 million** from the federal HHS.

   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. HFS officials estimate **$41.77 million** was recouped from the federal HHS as of June 30, 2018. Exhibit 2 provides a summary of the federal reimbursement recoupments for the ALL KIDS program for fiscal years 2014 through 2018. This information was provided by HFS as of June 30th of the fiscal year being reported.

Exhibit 2
ALL KIDS FEDERAL REIMBURSEMENT RECOUPMENTS (IN MILLIONS)
Fiscal Years 2014 – 2018

		Children 200-300% of FPL		Documented Immigrants	
Fiscal Year [1]	Reimbursement % [2]	FY Total	Cumulative Total	FY Total	Cumulative Total
FY14	65.00%	$10.44	$25.72	$6.57	$14.85
FY15	65.53%	$15.83	$41.55	$5.15	$20.00
FY16	88.62%	$23.69	$65.24	$5.65	$25.65
FY17	88.91%	$25.42	$90.66	$5.70	$31.35
FY18	88.52%	$26.89	$117.55	$10.42	$41.77

Notes:

[1] This information was provided by HFS as of June 30th of the fiscal year being reported.

[2] The federal fiscal year runs from October 1 until September 30 so the reimbursement percentage listed is the percentage that covered most of the State fiscal year being reported.

Source: ALL KIDS federal reimbursement recoupment data provided by HFS.

FY18 Total Increase for Documented Immigrants

According to HFS, the total amount recouped for documented immigrants increased from $5.70 million in FY17 to $10.42 million in FY18 because the State borrowed money from bond proceeds to pay for outstanding FY17 bills. More specifically, the FY18 budget included spending authority for unpaid FY17 bills using revenue from a general obligation bond sale. As a result, there was a total of 15 or 16 months' worth of bills paid in FY18 (for both unpaid FY17 bills and FY18 bills) versus a typical 12 months of bills paid in a fiscal year. In addition, HFS noted that the overall population was slightly larger in FY18.

3) **Changes to HFS' payment cycle changed the audit methodology for reporting payments by fiscal year.** 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. 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 Patient Protection and Affordable Care Act required that all states apply a new budget methodology based on MAGI to determine eligibility for certain households requesting or receiving medical assistance. 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.

The Patient Protection and Affordable Care Act required states to convert income standards and take into account that certain types of income (child support, workers' compensation, educational scholarships and grants, veterans' benefits, supplemental security income, etc.) will no longer apply under the MAGI budgeting methodology. Additionally, standards must be based on FPLs that were in effect in March 2010. MAGI budgeting determines how to count income and who to include in the income standard or Eligibility Determination Group.

As shown in Exhibit 3, in FY13, a family of four qualified for ALL KIDS Assist at 133 percent of the FPL ($31,321 annually); however, the same family of four qualified at 147 percent of the FPL in subsequent years ($35,064 in FY14, $35,652 in FY15, $35,724 in FY16, $36,168 in FY17, and $36,900 in FY18). Therefore, the way DHS processed both new ALL KIDS applications and annual redeterminations changed during our FY14 audit period. Exhibit 3 shows the annual applicable FPL income guidelines for a family of four by plan for each of the last six fiscal years.

Exhibit 3
ANNUAL FEDERAL POVERTY LEVEL (FPL) FOR FAMILY OF FOUR
Fiscal Years 2013 – 2018

EXPANDED ALL KIDS Plan	FY13 Percent of FPL	Annual FY13 Maximum Income	FY14 -FY18 Percent of FPL[1]	Annual Maximum Income [1]				
				FY14	FY15	FY16	FY17	FY18
Assist	133%	$31,321	147%	$35,064	$35,652	$35,724	$36,168	$36,900
Share	150%	$35,325	157%	$37,440	$38,076	$38,148	$38,628	$39,408
Premium Level 1	200%	$47,100	209%	$49,848	$50,688	$50,784	$51,420	$52,464
Premium Level 2	300%	$70,650	318%	$75,840	$77,112	$77,280	$78,228	$79,824

[1] Does not include certain types of excluded income (child support, workers' compensation, veterans' benefits, etc.).
Source: DHS eligibility documentation.

5) **Integrated Eligibility System (IES) Phase II was implemented on October 24, 2017, and revised the process for redetermination of eligibility.** According to DHS, IES is the web-based eligibility system that caseworkers have been using since October 2013 to determine initial eligibility at intake for programs offered through DHS including the ALL KIDS program. Phase II of IES was implemented in October 24, 2017, and all HFS and DHS eligibility caseworkers transitioned to using IES exclusively to process initial and ongoing eligibility determinations, as well as all tasks associated with the maintenance of approved cases. The legacy systems were retired and IES Phase II moved HFS/DHS to a fully-integrated business model where all staff work in one system to process applications and cases. All eligibility information and documentation began being contained within IES, and paper case files were no longer needed or created.

The FY18 OAG financial audits of HFS and DHS contained significant findings directed at IES. Although we reviewed the traditional data sets needed for this audit, there were many changes and challenges not previously encountered during prior EXPANDED ALL KIDS audits due to the implementation of IES Phase II during FY18. It was time-consuming to

work through these issues with the agencies. As stated previously, in order to follow up on the EXPANDED ALL KIDS program annually as required by Public Act 95-985, the FY18 data was obtained and reported for this audit but there are limitations affecting the accuracy of this data as outlined in the findings. See Appendix B for additional information about these findings.

Revised Initial Eligibility Determination

On October 1, 2013, HFS and DHS replaced the Automated Intake System (AIS) 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. Supporting documentation can be uploaded into the system by recipients or state staff. IES also uses electronic data matches or clearances (listed below) to verify eligibility. Client social security numbers are used to extract information. The following sources are examples where information can be extracted.

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

Revised Redetermination of Eligibility

Annual redeterminations for ALL KIDS were completed as part of the Illinois Medicaid Redetermination Project for the first part of FY18. This project began in February 2014. Under this project, the MAX-IL system was used 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 collected electronic data from various sources about the case and made an automated recommendation about ongoing eligibility.

Under MAX-IL, the recipients received a pre-populated redetermination form two months before it was due. Recipients were 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 made eligibility decisions based on verifications using social security numbers to determine income, residence, and citizenship. The last mailing of redetermination forms by MAX-IL was in October 2017. When the contract with the vendor ended, the stored documents were uploaded into Content Manager Software, which assigns and stores documents electronically.

IES Phase II went live on October 24, 2017. The process of redetermining eligibility changed when IES Phase II was implemented. According to HFS, IES Phase II incorporated all case maintenance activities, including redeterminations, into one system. Therefore, the State was now using one system to process both new applications and maintain active cases for all medical coverage, Supplemental Nutrition Assistance Program (SNAP), and cash assistance.

Under IES Phase II, IES gathers electronic clearance data and known case information approximately two months before the medical benefit period ends. Cases qualify for an automatic redetermination when income and other nonfinancial criteria can be verified electronically. When eligible for automated redetermination, IES generates a pre-populated form with electronic income information and other case information. A response is not needed if there are no changes to report and the information on the form is correct. If there are changes, the recipient has 30 days to report them. The new information is applied to the case to determine the outcome of the medical redetermination. According to DHS officials, only documented immigrants/citizens qualify for the automatic redetermination process. Undocumented immigrants/noncitizens have to complete the manual redetermination process.

Recipients that do not qualify for an automatic redetermination are sent a redetermination form with a due date. The form is pre-populated with known income and case information. The recipient has 30 days to respond. If the recipient does not respond, the medical benefit ends automatically. If the recipient does respond, medical coverage continues until a review is completed. A notice is sent informing the recipient about the outcome. In April 2018, a one month grace period was added before running the auto-cancellations for non-receipt of the redetermination form to allow sufficient time for all documents to be received. As a result, a 90 day reinstatement period may be utilized if medical coverage is canceled due to the non-receipt of the form. If the form is returned within 90 days of the date coverage ends and applicants are eligible for any medical programs, coverage is reinstated without a break in coverage.

ALL KIDS PROGRAM

According to HFS, in FY18, Illinois' ALL KIDS program as a whole had a total of almost 1.7 million enrollees and HFS paid nearly $3.2 billion in claims. The program included 93,944 EXPANDED ALL KIDS enrollees **at any point in** FY18, which decreased (10%) from FY17 when there were 104,856 enrollees (see text box).

The number of EXPANDED ALL KIDS enrollees at the end of the fiscal year decreased from FY17 to FY18. On June 30, 2018, there were 63,255 enrollees compared to 66,353 on June 30, 2017, a decrease of 3,098. We followed up with HFS and asked why the cost of services increased when the number of enrollees decreased. According to HFS, the increase in cost per enrollee can be attributed primarily to increases in pharmacy costs and other new costs associated with

EXPANDED ALL KIDS PROGRAM STATISTICS

	FY17	FY18
Enrollees at any point	104,856	93,944
Enrollees on June 30	66,353	63,255
Total Cost of Services Provided	$103,054,764	$104,320,137
Total Net Cost of Services after Premium Payments	$85,068,952	$88,066,128

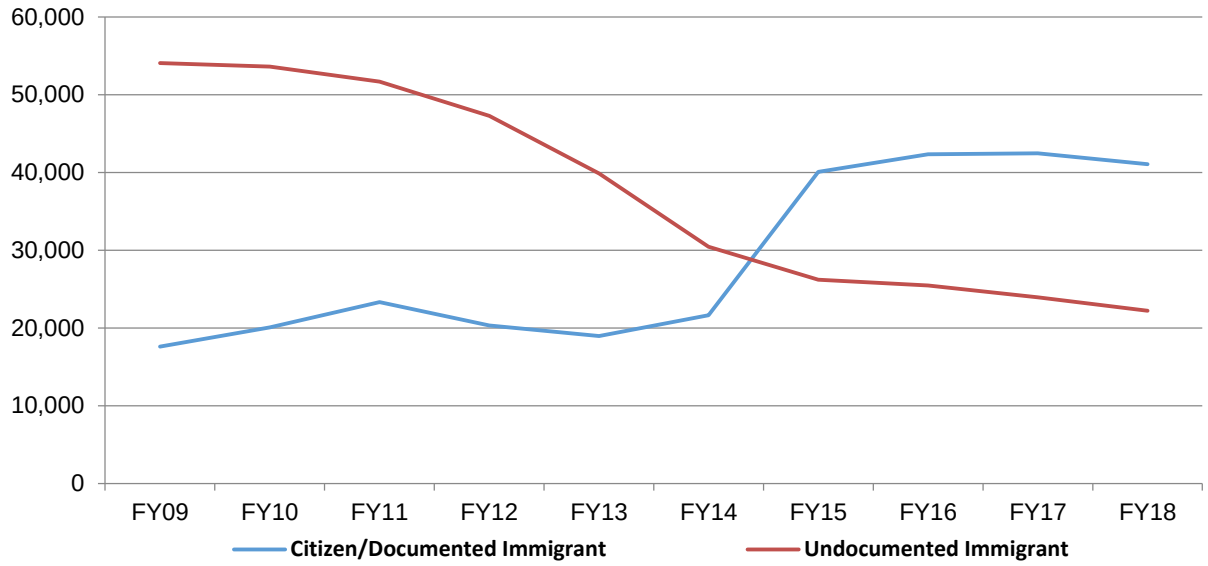
Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

healthy child services including immunizations.

ALL KIDS Enrollment

As shown in Exhibits 4 and 5, the number of undocumented immigrants enrolled as of June 30 has declined each year since 2009. Conversely, the number of citizen/documented immigrant EXPANDED ALL KIDS recipients (Premium Level 2) increased each year since 2013 until this year. In 2018, the number of citizen/documented immigrants slightly decreased from 42,435 in FY17 to 41,068 in FY18. Since both types of enrollees decreased, the total enrollment also decreased from 66,353 in FY17 to 63,255 in FY18.

Exhibit 4
EXPANDED ALL KIDS ENROLLMENT
As of June 30 for Fiscal Years 2009 – 2018



Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS enrollment data provided by HFS.

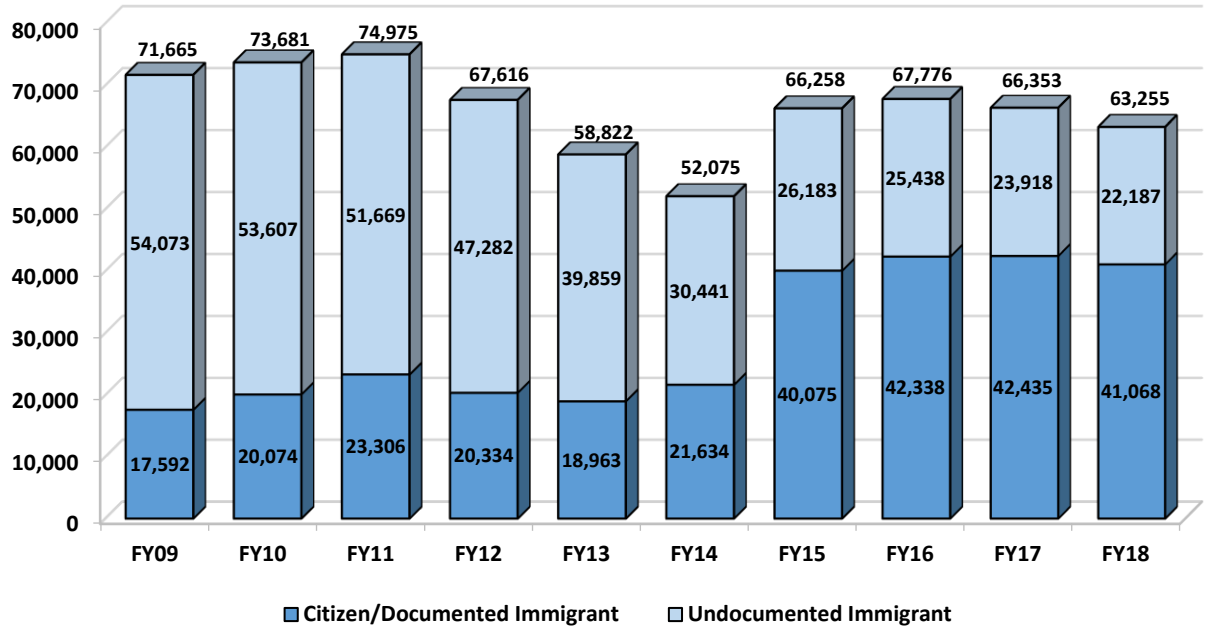
Until the number of citizen/documented immigrant recipients increased in FY15, total enrollment had decreased from FY11 until FY15. There was a 22,900 enrollee decrease from FY11 to FY14, some of which was due to the elimination of Premium Levels 3 through 8 after June 30, 2012, as required by Public Act 96-1501. Premium Levels 1 and 2 were not eliminated by Public Act 96-1501.

In total, as seen in Exhibit 5, the number of citizen/documented immigrant recipients increased while the total number of undocumented recipients decreased from FY09 to FY18.

- The number of citizen/documented immigrant recipients **increased** from 17,592 in FY09 to 41,068 in FY18 (133%).

- The number of undocumented recipients **decreased** from 54,073 in FY09 to 22,187 in FY18 (59%).

Exhibit 5
ENROLLEES AS OF JUNE 30
For EXPANDED ALL KIDS during Fiscal Years 2009 – 2018



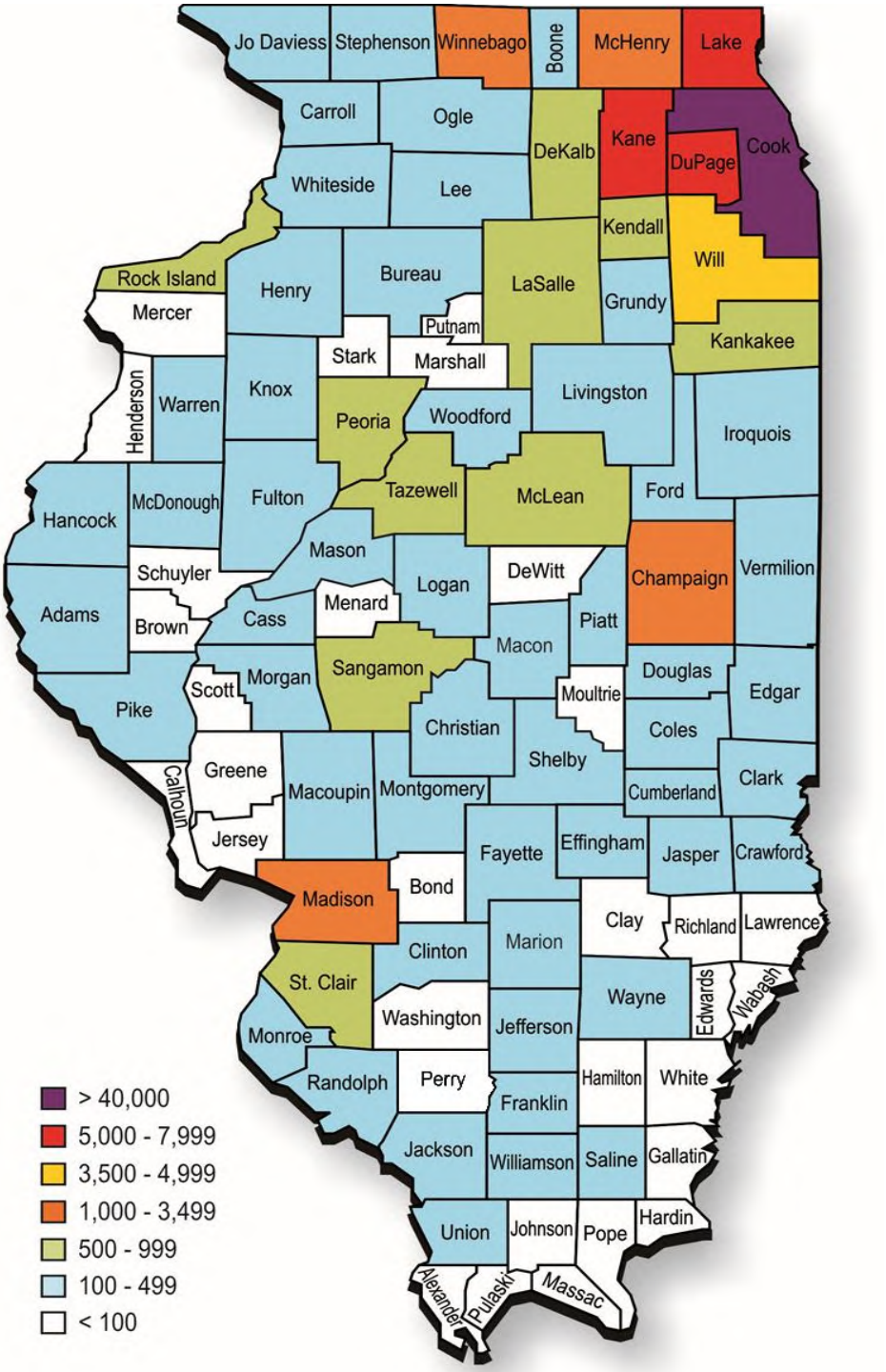
Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS data provided by HFS.

ALL KIDS Enrollees by County

Exhibit 6 shows the number of EXPANDED ALL KIDS enrollees by county. As seen in this exhibit, the majority of enrollees in FY18 lived in Cook County (43,545). The other counties with large populations of EXPANDED ALL KIDS enrollees included: DuPage (7,324), Lake (6,924), Kane (5,294), and Will (4,513). All five of these counties experienced a decrease in the number of enrollees from FY17 to FY18, ranging from a decrease of 5 percent (Will) to 29 percent (Kane) in populations.

Exhibit 6
EXPANDED ALL KIDS ENROLLMENT BY COUNTY
Fiscal Year 2018



Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: FY18 eligibility data provided by HFS.

Enrollment by ALL KIDS Plan

Exhibit 7 breaks out enrollment by plan, fiscal year, and by whether the child was classified as a citizen/documented immigrant or as undocumented for FY17 and FY18. As noted previously, the total number of EXPANDED ALL KIDS enrollees decreased from 66,353 in FY17 to 63,255 in FY18. There was also a decrease in the number of undocumented immigrants from FY17 to FY18. The HFS data classified 23,918 (36%) as undocumented immigrants in FY17 and 22,187 (35%) as undocumented immigrants in FY18. Appendix C shows the ALL KIDS premium and co-pay requirements by plan during FY18.

Exhibit 7
ENROLLMENT BY PLAN [2]
For EXPANDED ALL KIDS as of June 30 for Fiscal Years 2017 and 2018 [3]

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants		Totals	
	FY17	FY18	FY17	FY18	FY17	FY18
Assist $36,900[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		21,132	19,781	21,132	19,781
Share $39,408[1]			574	507	574	507
Premium Level 1 $52,464[1]			1,516	1,297	1,516	1,297
Premium Level 2 $79,824[1]	42,435	41,068	696	602	43,131	41,670
Totals	**42,435**	**41,068**	**23,918**	**22,187**	**66,353**	**63,255**

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 effective 4/2018. Although the monthly income standards changed during FY18, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2017 and 2018. There were 104,856 enrollees eligible at some point during FY17 and 93,944 enrollees eligible at some point during FY18.

[3] There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS enrollment data provided by HFS.

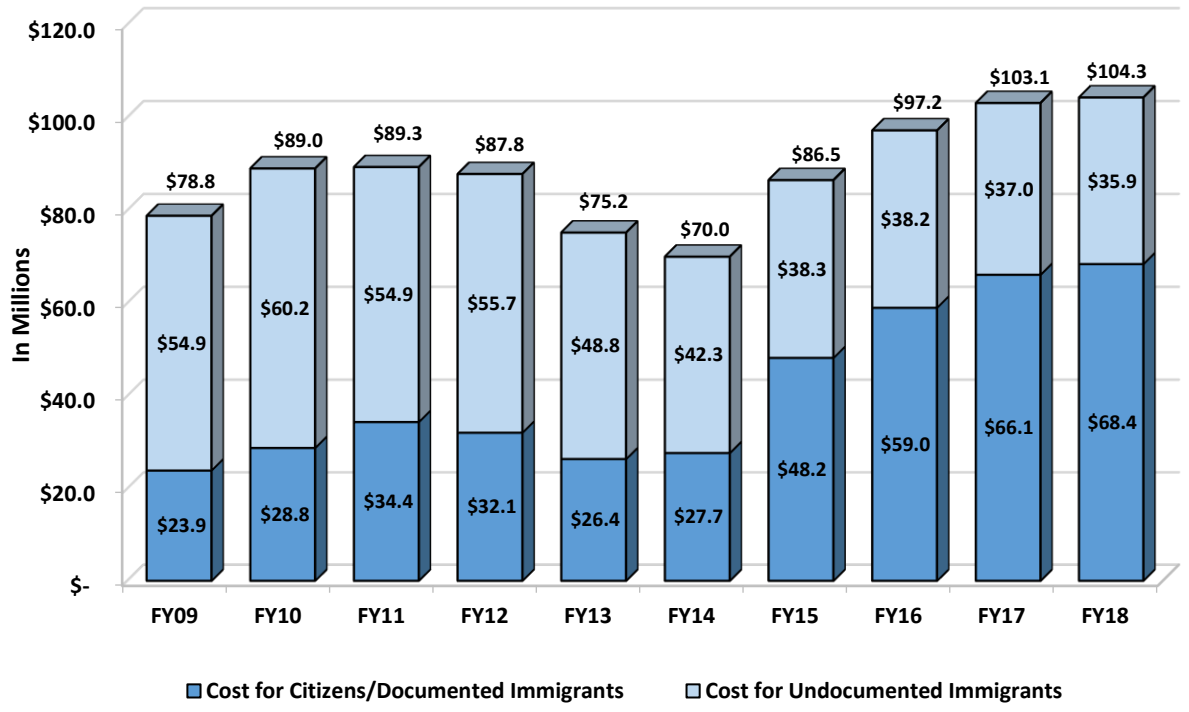
COST OF SERVICES PROVIDED BY FISCAL YEAR

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS has fluctuated over the years ranging from a low of $70.0 million in FY14 to a high of $104.3 million in FY18. Exhibit 8 shows the total cost of services for each year as well as the cost broken down between two categories: 1) citizens and documented immigrants; and 2) undocumented immigrants.

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. The total cost for undocumented

immigrants has continued to decrease each year since FY12 – from $55.7 million in FY12 to $35.9 million in FY18.

Exhibit 8
COST OF SERVICES
For EXPANDED ALL KIDS during Fiscal Years 2009 – 2018

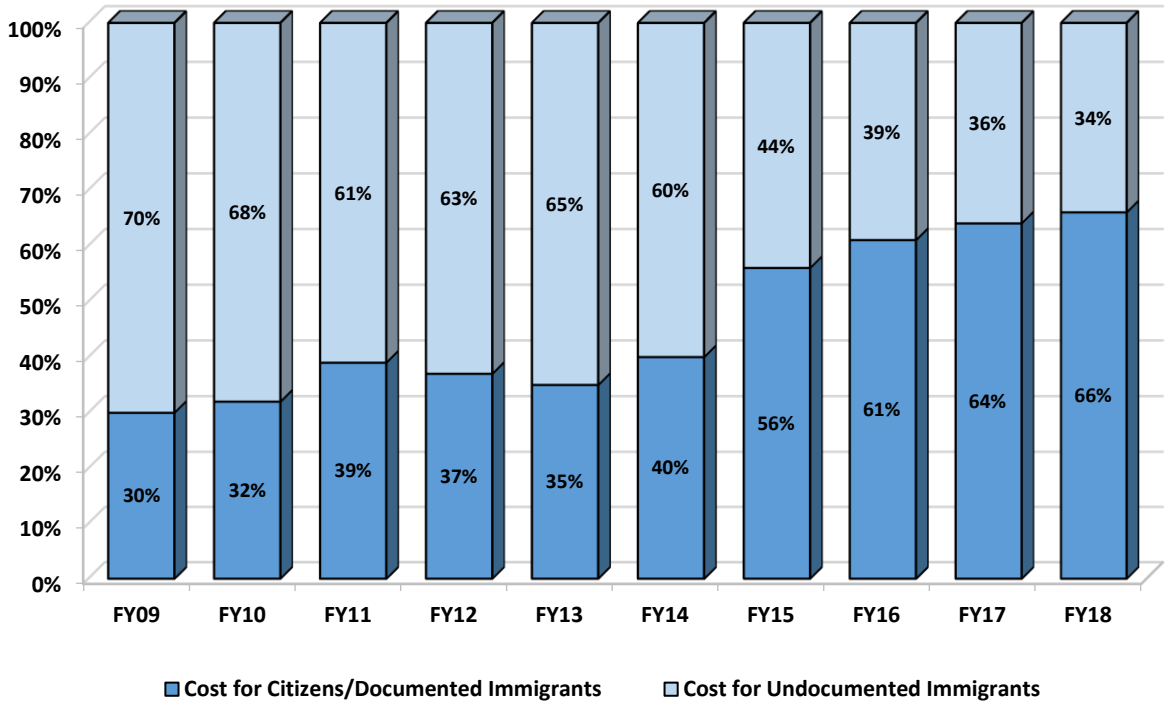


Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS data provided by HFS.

In the past, a large portion of the cost for services for the EXPANDED ALL KIDS Program was for undocumented immigrants; however, that has not been the case the last several years. Exhibit 9 shows the percentage of total cost for the two categories mentioned above: 1) citizens and documented immigrants; and 2) undocumented immigrants. In FY09, undocumented immigrants accounted for 70 percent of the total costs for the EXPANDED ALL KIDS program. This percentage has declined each year since FY13 with undocumented immigrants accounting for only 34 percent of the total cost in FY18.

Exhibit 9
PERCENTAGE OF COST OF SERVICES
For EXPANDED ALL KIDS during Fiscal Years 2009 – 2018



Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS data provided by HFS.

Exhibit 10 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 FY17 and FY18. Additionally, Exhibit 10 shows the cost of services increased by more than $1 million from $103.1 million in FY17 to $104.3 million in FY18.

Exhibit 10
COST OF SERVICES PROVIDED BY PLAN
For EXPANDED ALL KIDS during Fiscal Years 2017 and 2018 [4]

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY17	FY18	FY17	FY18	FY17	FY18
Assist $36,900[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$33,034,213	$32,145,283	$33,034,213	$32,145,283
Share $39,408[1]			$767,717	$876,331	$767,717	$876,331
Premium Level 1 $52,464[1]			$2,374,695	$2,255,529	$2,374,695	$2,255,529
Premium Level 2 $79,824[1]	66,075,439[3]	$68,396,589[3]	$802,701	$646,404	$66,878,139	$69,042,993
Totals [2]	**$66,075,439**	**$68,396,589**	**$36,979,325**	**$35,923,548**	**$103,054,764**	**$104,320,137**

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 effective 4/2018. Although the monthly income standards changed during FY18, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 88.91 percent in FY17 and 88.52 percent in FY18; therefore, the State's share for services was $7.3 million in FY17 and $7.9 million in FY18.

[4] There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: ALL KIDS data provided by HFS.

COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

According to data provided by HFS, 92 percent of the cost for services provided during FY18 for EXPANDED ALL KIDS was paid for 13 categories of services each totaling more than $1 million. Exhibit 11 shows the 13 categories of services which totaled $95.8 million of the $104.3 million in total EXPANDED ALL KIDS payments.

The category with the highest percentage of payments was Capitation Services at 29 percent (see Exhibit 11). Although this category decreased slightly from 30 percent in FY17 to 29 percent in FY18, it has increased since FY15 when it only accounted for 15 percent of payments. During the FY16 audit, HFS officials explained that this increase was due to FY16 being the first full year of mandatory managed care enrollment for all regions after beginning implementation in FY15 as a result of Public Act 96-1501. Public Act 96-1501 mandated a transition from paying for services on a fee-for-service basis to paying a per member per month capitation rate to managed care organizations for care coordination. This resulted in the increase in payments in capitation services from FY15 to FY18.

We followed up with HFS to find out why the previous increase in capitation services had not continued. HFS officials stated that the FY16 increase was from when the majority of managed care regions were implemented. Therefore, HFS did not expect to see a significant

increase in the percentage of Capitation Services for FY17 or FY18. However, since more managed care counties were implemented in April 2018, officials stated that there may be an increase in the percentage of capitation services during FY19.

We requested the encounter data to review where the 29 percent in Capitation Services were being distributed during FY18. Although only 95% of the encounter data was reported in FY18, our review found that the top four services provided were Dental Services (15%), Inpatient Hospital Services – General (14%), Pharmacy Services (12%), and Physician Services (10%). Therefore, the top four services provided under capitation payments were the same as the top four services provided on a fee-for-service basis (just in a different order). Exhibit 11 shows the top services provided on a fee-for-service basis. If the percentage of capitation services increases during future audits, we may need to review the encounter data for capitation services in more detail at that time. Appendix B outlines the FY18 OAG financial audit finding regarding the monitoring of FY18 encounter data and resulting limitations of this data.

Exhibit 11
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE [1]
Totaling more than $1 million during FY18 for the EXPANDED ALL KIDS Program [2]

Category of Service	Total FY18 Cost	Percent of Total FY18 Cost
1. Capitation Services	$30,733,531	29%
2. Pharmacy Services	18,877,291	18%
3. Inpatient Hospital Services (General)	8,194,894	8%
4. Dental Services	8,074,753	8%
5. Physician Services	6,819,482	7%
6. Outpatient Services (General)	5,996,933	6%
7. Healthy Kids Services	4,893,951	5%
8. General Clinic Services	3,700,819	3%
9. Speech Therapy/Pathology Services	2,311,194	2%
10. Inpatient Hospital Services (Psychiatric)	2,188,559	2%
11. Mental Health Rehab Option Services	1,621,997	2%
12. Nursing Service	1,396,689	1%
13. Medical Supplies	1,003,388	1%
Total for categories costing > than $1 million	**$95,813,481**	**92%**
Other categories totaling < than $1 million	8,506,656	8%
Total Cost for All Service Categories	**$104,320,137**	**100%**

Notes:

[1] Totals may not add due to rounding.

[2] There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: FY18 ALL KIDS data provided by HFS.

The appendices show additional information on the cost of services provided as follows:

- Appendix D shows EXPANDED ALL KIDS total cost of services provided by category of service during FY18.
- Appendix E shows EXPANDED ALL KIDS total cost of services provided by plan and by category of service during FY18.
- Appendix F shows total services provided by providers that were paid more than $50,000 from EXPANDED ALL KIDS in FY18.

COST OF SERVICES AND PREMIUMS COLLECTED

HFS received $18.0 million in premiums from enrollees in FY17, and $16.3 million in FY18. As a result, the net cost of EXPANDED ALL KIDS after premium payments was approximately $85.1 million in FY17 and $88.1 million in FY18. Exhibit 12 shows payments and premiums collected from the EXPANDED ALL KIDS program.

Exhibit 12
COST OF SERVICES AND PREMIUM AMOUNTS COLLECTED [2]
For the EXPANDED ALL KIDS Program during Fiscal Years 2017 and 2018 [4]

EXPANDED ALL KIDS Plan	FY17 Services Provided	FY17 Premiums Collected	FY17 Net Cost	FY18 Services Provided	FY18 Premiums Collected	FY18 Net Cost
Assist $36,900[1]	$33,034,213	n/a	$33,034,213	$32,145,283	n/a	$32,145,283
Share $39,408[1]	$767,717	$110	$767,607	$876,331	$38,679	$837,652
Premium Level 1 $52,464[1]	$2,374,695	$208,021	$2,166,674	$2,255,529	$178,204	$2,077,325
Premium Level 2 $79,824[1]	$66,878,139	$17,777,681	$49,100,458	$69,042,993	$16,037,125	$53,005,868
Totals [3]	**$103,054,764**	**$17,985,812**	**$85,068,952**	**$104,320,137**	**$16,254,008**	**$88,066,129**

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 effective 4/2018. Although the monthly income standards changed during FY18, these were the most recent effective amounts and were utilized during the months tested for the audit.

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

[3] Totals may not add due to rounding.

[4] There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

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

FOLLOW-UP ON PRIOR AUDIT RECOMMENDATIONS

This FY18 audit of the EXPANDED ALL KIDS program followed up on HFS and DHS actions to address prior audit findings. All five issues from our previous FY17 audit were

repeated during the FY18 audit. The next several sections of the report discuss these recommendations.

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 FY18, which were approved by DHS or HFS during either May or June 2018. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support residency, birth/age, income, and citizenship/immigration status was received or verified in order to ensure that eligibility was determined accurately.

2) A sample of 40 randomly selected EXPANDED ALL KIDS cases from FY18, whose medical eligibility was redetermined during either May or June 2018. According to data provided by DHS, the total number of redeterminations in May and June 2018 was 2,940. Since SNAP cases are redetermined differently than those that are medical only, we requested DHS exclude SNAP cases from our sample and then randomly selected 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 residency, birth/age, income, and citizenship/immigration status was received or verified in order to ensure that continued eligibility was determined accurately.

3) An additional sample of 15 randomly selected EXPANDED ALL KIDS cases from FY18 who were undocumented recipients and whose medical eligibility was redetermined during either May or June 2018. Since only 13 cases in the random sample of 40 redetermination cases were undocumented, we performed an additional sample since 13 was a much lower number of undocumented cases reviewed compared to previous audits. In addition, these undocumented recipients are at a higher risk for missing eligibility documentation since they do not qualify for the automatic redetermination process. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support residency, birth/age, income, and citizenship/immigration status was received or verified in order to ensure that continued eligibility was determined accurately.

During the testing of these eligibility samples, we reviewed the recipient's eligibility documentation found in IES for the initial eligibility review and the redetermination samples. Since our samples were selected from May or June 2018, these recipients were approved after the implementation of IES Phase II. We also reviewed the FY18 data provided by HFS for completeness. See Appendix B for the FY18 OAG financial audit findings directed at IES outlining the limitations of the data presented in this audit including the fieldwork samples.

Since our audit population, as defined by the Covering ALL KIDS Health Insurance Act, contains 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

The FY09, FY10, and FY11 audits 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. Effective October 1, 2011, Public Act 96-1501 required verification of one month's income for determining continued eligibility. Therefore, in FY13, the recommendation was repeated and the text was changed to reflect the new one month of income requirement.

During the FY14 audit, the process for redetermining eligibility changed again and this process was used from FY15 through the first part of FY18. Under this process, the new redetermination system called MAX-IL was developed and medical-only cases were redetermined annually by the central redetermination unit staff. Staff also began using MAGI rules for redeterminations on April 1, 2014. During this time (FY14 through FY17), the EXPANDED ALL KIDS audits continued to contain this recommendation about ALL KIDS recipients not being redetermined annually as required. The FY17 audit found that 2,411 of the 33,531 recipients (7%) were not redetermined annually as required.

ANNUAL REDETERMINATIONS

In FY17, we found that 2,411 of the 33,531 recipients (7%) were not redetermined annually as required for the EXPANDED ALL KIDS program. We could not follow up on this recommendation for FY18 due to a missing data field needed for our review as well as redetermination dates being extended to FY19. We will follow up on this recommendation during our next audit.

On October 24, 2017, the process of redetermining eligibility changed with the implementation of IES Phase II. According to HFS officials, IES determines and generates the appropriate form, systematically cancels, redetermines, or maintains eligibility until a case worker reviews the form, if necessary.

We requested the data needed to follow up on this recommendation in a useable format from HFS. HFS reported that some of the FY18 data was stored in the legacy systems (prior to the implementation of IES Phase II) and the rest of the data was stored in IES (after the implementation of IES Phase II). While requesting the data to follow up on the status of this recommendation, we determined there were issues with the FY18 data needed for this review.

- We found that a field was missing from the data that was previously provided during prior EXPANDED ALL KIDS audits and required for the completion of our follow-up analysis. During prior audits, this data field provided the status of the case and was used to determine if cases were being redetermined annually as required. According to HFS officials, this data field could not be provided in the FY18 data.

- In addition, in September 2017, the HFS Director approved the decision to extend some FY18 redetermination dates by one year. For example, if a case was to be redetermined for eligibility in November 2017 (FY18), the redetermination date was changed to November 2018 (FY19). For the FY18 audit period, HFS officials explained that the FY18 redetermination data for July 2017 through December 2017 was affected by the one year extension of redetermination dates.

Since the field needed to review the redetermination data could not be provided for the FY18 data and the data provided did not include all FY18 redeterminations because some dates were extended by one year to FY19, we were unable to follow up on the status of this recommendation for FY18. In June and July 2019, we communicated with HFS that we could not follow up on this recommendation as a result of these issues and requested to be informed about any updates related to these issues or if additional data could be provided. No additional information was provided so we were unable to follow up on the status of this recommendation for FY18. Since the FY17 audit found that 2,411 of the 33,531 recipients (7%) were not redetermined annually as required, the status of this recommendation was **repeated**. We will follow up on this recommendation during our next audit.

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. The Department has incorporated case maintenance activities into IES including new application processing and redeterminations to be more efficient; however, the Department needs to catch up on delayed redeterminations and update case information converted from the legacy system. The Department believes this will be completed by December 2020.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services accepts the recommendation that All Kids cases should be redetermined annually.

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 FY18 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were over the age of 18 and who were enrolled in ALL KIDS more than once.

- We identified 689 recipients that received 3,638 services totaling $475,813 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. This was a significant increase from 134 recipients in FY17 to 689 recipients in FY18 (414%). According to HFS, the reason for this increase was due to the changes that were taking place during the conversion from the legacy system to IES Phase II during FY18.

- We also identified 181 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. According to DHS policy, caseworkers are to identify former case identification numbers. This was a significant decrease from 428 individuals in FY17 to 181 individuals in FY18 (58%). HFS officials said this decrease was anticipated due to the implementation of IES Phase II during FY18. According to HFS, IES Phase II "allows for Case Maintenance and Application Processing to be in one system, which makes it easier for the caseworkers to identify RINs/avoid duplicates. There are also safeguards in IES to assist the caseworkers in identifying duplicates."

If recipients maintain eligibility after reaching the age of 19, or if recipients have eligibility under more than one recipient identification number, the State may provide services for non-eligible recipients. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit.

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. The Department has implemented case maintenance functions in IES including more automated case actions; however, clean up of issues existing prior to implementation of IES Phase 2 have not been completed. An enhancement request has been submitted to allow for systematic authorization of cases in which there has been a past eligibility override. This portion is approximately 60% complete and is estimated to be completed by December 2020.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

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

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 was also causing miscoding.

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.

Social Security Numbers

For recipients categorized by HFS and DHS as "undocumented," we determined the FY18 eligibility data contained 4,204 recipients coded as undocumented who had social security numbers that were verified. Of these 4,204 "undocumented" recipients, 229 of them also had alien registration numbers.

LOSS OF FEDERAL MATCHING FUNDS

HFS and DHS did not identify the correct citizenship status for recipients during the process of determining new and continued eligibility. As a result, the State is losing federal matching Medicaid funds - a total estimated loss of **$10.7 million** in federal reimbursement over the last four fiscal years.

We reviewed the services provided to these 4,204 "undocumented" recipients in FY18 and determined these recipients had 34,697 services for a total cost of almost $5.0 million. If these recipients were classified as undocumented in error, the State did not receive the eligible matching federal rate funds in FY18. Therefore, we used the federal reimbursement rates (50.74% for Title XIX in FY18 and 88.52% for Title XXI in FY18) and estimated the total amount lost in federal reimbursement. We estimated that the State at a minimum did not collect **$2.6 million** in federal reimbursement for the $5.0 million in services in FY18. Additionally, we estimated that the State at a minimum did not collect $2.9 million in federal reimbursement in FY17, $2.4 million in federal reimbursement in FY16, and $2.8 million in federal reimbursement in FY15 – for a total estimated loss of **$10.7 million** in federal reimbursement over the last four fiscal years. 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.

Alien Registration Numbers

For recipients categorized by HFS and DHS as "undocumented," we determined the FY18 eligibility data contained 22 recipients coded as undocumented who had an alien registration number, but did not have a verified social security number.

The number of recipients coded as undocumented who had an alien registration number had increased significantly from 11 in FY16 to 118 in FY17. We followed up with HFS to determine why this number had significantly increased and HFS explained that IES was experiencing alien status errors during that time frame but the errors had since been resolved. As a result, we followed up and reviewed the number of recipients coded as undocumented who had an alien registration number during this audit and found that this number had again decreased significantly from 118 in FY17 to 22 in FY18.

Testing Results

During our testing of new and redetermined cases that were approved during May and June of 2018, we reviewed the citizenship status for these recipients. We found documentation to support citizenship and/or documented immigrant status for recipients classified as undocumented in both the new and redetermined samples. These testing results are below.

Initial Eligibility Testing

During our review of 40 new cases, we found that 14 of the 33 cases (42%) were coded as undocumented but likely should have been coded as citizens/documented immigrants. Each of the 14 recipients classified as undocumented had documentation verifying they were likely citizens or documented immigrants. Therefore, a total of 14 out of the 33 recipients sampled (42%) who were coded as undocumented were likely citizens or documented immigrants. The other 7 recipients were coded as citizens. We provided these 14 cases to DHS, and DHS officials agreed they were likely documented.

INITIAL ELIGIBILITY

14 out of the 33 recipients sampled (42%) who were coded as undocumented were likely citizens or documented immigrants.

Redetermination of Eligibility Testing

During our review of 40 recipients that were redetermined during May or June 2018, we found 2 of 13 recipients sampled (15%) were coded as undocumented even though we found documentation verifying the recipient's social security number and/or alien status. The other 27 recipients were coded as citizens. Since only 13 recipients in the original redetermination sample were coded as undocumented, we performed an additional redetermination sample of 15 undocumented

REDETERMINATION OF ELIGIBILITY

2 of the 13 redetermined recipients sampled (15%) were coded as undocumented even though they were likely citizens or documented immigrants. Since only 13 recipients were coded as undocumented in this sample, we performed an additional sample of 15 undocumented recipients for redetermination cases. We found that 6 of 15 recipients sampled (40%) were coded as undocumented even though they were likely citizens or documented immigrants.

recipients. We found that 6 of 15 recipients sampled (40%) were coded as undocumented but likely should have been coded as citizens/documented immigrants. Each of the six recipients classified as undocumented had a verified social security number supporting they were likely citizens or documented immigrants. We provided these eight cases to DHS (two cases from the original redetermination sample and six cases from the additional redetermination sample), and DHS officials agreed they were all likely documented.

Additional Review of the Misclassification of Undocumented Recipients

Since the State is losing a significant amount of federal reimbursements annually due to the misclassification of undocumented recipients, we decided to take a closer look at the cases in our sample with a number in the field labeled "SSN" but still classified as undocumented in the HFS data. For all 14 cases with numbers in this column (7 new cases, 1 redetermination case, and 6 additional undocumented redetermination cases), we determined that all recipients sampled (100%) had verified social security numbers. These verified social security numbers support that these recipients were likely citizens or documented immigrants. We discussed this issue with DHS and DHS officials agreed that a majority of cases with social security numbers would be documented immigrants. As a result, we performed an additional review of the FY18 EXPANDED ALL KIDS data to determine the total number of undocumented recipients containing a number in this field.

Of the 93,944 EXPANDED ALL KIDS enrollees **at any point** in FY18, we found that 29,544 were classified as undocumented during our review. Of those 29,544 recipients, 5,482 (19%) contained a number in the field labeled "SSN." Since this is a significant number of undocumented recipients containing a number in this field, we followed up with DHS. DHS officials noted that DHS is in the process of submitting an enhancement request that would assist with this issue, if implemented. According to DHS, this pending request was logged in August 2018 and would prompt caseworkers for additional review if IES identifies a social security number for an undocumented recipient in the data. As of December 2019, DHS officials stated that the process was still being formulated. DHS officials added that additional meetings were held in August 2019 and December 2019 regarding design approval and implementation was estimated for March 2020.

Conclusion

We continue to have multiple issues related to the coding of undocumented immigrants. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit. 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. A Medical Morsel titled, "When is a Noncitizen Child Considered Undocumented?", was sent to staff on July 11, 2018. The Medical Morsel lists the steps to take in IES to ensure noncitizen children are coded correctly. The Department has not implemented electronic edits but estimates remaining corrective action to be implemented by March 2020.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services accepts the recommendation. Due to the complexity of proper classification of documented and undocumented immigrants, additional communication and/or training to staff is needed. Given the population of documented and undocumented immigrants is small relative to the remainder of the population, the related policy is not as widely and confidently understood as policy related to the programs administered to the US Citizen population. For this reason, IES should be modified to assist with the proper classification of immigrants as much as possible. An IES enhancement request is pending with the system developer that will assist in ensuring proper classification of immigration status.

ELIGIBILITY DOCUMENTATION

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

On January 25, 2011, Public Act 96-1501 was adopted, which addressed some of this recommendation. The Public Act mandated 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. These changes were effective on July 1, 2011.

The Patient Protection and Affordable Care Act required all states apply a new budget methodology based on Modified Adjusted Gross Income (MAGI). Therefore, on October 1, 2013, HFS and DHS began using MAGI income standards for new applications received. The 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 were completed as part of the Illinois Medicaid Redetermination Project for the first part of FY18. This project began in February 2014 and ended when IES Phase II was implemented on October 24, 2017. The process of redetermining eligibility changed with the implementation of IES Phase II. Under IES Phase II, IES determines and generates the appropriate form, systematically cancels, redetermines, or maintains eligibility until a caseworker reviews the form, if necessary.

HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and citizenship/immigration status. During our review of the new and continued eligibility process for EXPANDED ALL KIDS, we determined the data matching component used by IES (and previously the Illinois Medicaid Redetermination Project) 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, birth/age, income, and citizenship/immigration status for all recipients, including undocumented recipients.

Initial Eligibility Testing

We randomly selected 40 of the 1,566 new cases approved during May and June 2018 and found significant issues. As discussed previously, 14 of the 33 cases (42%) were coded as undocumented even though evidence, such as verified social security numbers, supported the enrollee was likely a citizen or documented immigrant (the other 7 recipients were coded as citizens, for a total of 40 sampled). As a result, these 14 recipients were likely not eligible for the EXPANDED ALL KIDS program, but would have been eligible for Medicaid for which the State receives federal matching funds. Our testing results from the last audit (FY17) found 17 of 40 cases (43%) were likely incorrectly coded as undocumented.

During our FY18 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, **14 cases (35%)** 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 13, in FY18, we found residency was not verified in 8 of the 40 cases tested (20%).

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 13, in FY18, auditors determined that birth/age information was not verified in 11 of the 40 (28%) cases we tested.

Income Documentation (Initial Eligibility)

Beginning on July 1, 2011, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/7(a)(1)) 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 always review 30 days of income documents as required.

In the FY18 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, 22 reported having income. For the 22 cases with income reported, 30 days of income was not reviewed in 2 of the cases (9%). Five additional FY18 cases contained income calculation errors. See Exhibit 13 for a summary of the FY17 and FY18 testing results.

Conclusion

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 FY18 initial eligibility testing, this part of the recommendation is **repeated** and will be followed up on during our next audit.

Exhibit 13
RESULTS OF ELIGIBILITY TESTING
(Initial Eligibility)

	Residency Verified		Age Verified		30 Days Income Verified [1]	
	FY17	**FY18**	**FY17**	**FY18**	**FY17**	**FY18**
Number Tested	40	40	40	40	24	22
Number Missing Documentation	7	8	14	11	2	2[2]
Percent Missing Documentation	18%	20%	35%	28%	8%	9%

Notes:

[1] In FY17, 16 of 40 cases tested reported no income. In FY18, 18 of 40 cases tested reported no income.

[2] Five additional cases had income calculation errors.

Source: FY17 OAG Audit and FY18 Eligibility Testing Results for Initial Eligibility.

Eligibility Redetermination Testing

We tested 40 of the medical only redeterminations that occurred during May and June 2018 and found issues regarding Illinois residency, birth/age, and income documentation. According to data provided by DHS, the total number of redeterminations in May and June 2018 was 2,940. Since SNAP cases are redetermined differently than those that are medical only, we requested DHS exclude SNAP cases from our sample and then randomly selected 40 medical only cases.

As discussed previously, 2 of 13 recipients sampled (15%) were coded as undocumented even though we found documentation, such as verified social security numbers, supporting that the enrollee was likely a citizen or documented immigrant (the other 27 recipients were coded as citizens, for a total of 40 sampled). As a result, these two recipients were likely not eligible for the EXPANDED ALL KIDS program, but would have been eligible for Medicaid for which the State receives federal matching funds.

During our FY18 testing, we reviewed all 40 redetermined cases to determine whether all required eligibility redetermination documentation was obtained or reviewed. Of the 40 cases reviewed, **8 cases (20%)** 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 clearance was implemented to verify residency. The clearance matches the recipient's social security number with Secretary of State records. 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 14, residency was not verified in 4 of the 40 (10%) cases we tested in FY18.

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." We looked to see if documentation of birth, such as a birth certificate, was present to verify age. As shown in Exhibit 14, birth/age information was not verified in 5 of the 40 (13%) cases we tested in FY18.

Income Documentation (Redetermination)

Beginning on October 1, 2011, the Covering ALL KIDS Health Insurance 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 always 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, 38 reported having income. For the 38 cases with income reported, 30 days of income was not reviewed in 2 of the cases with income reported (5%). Additionally, we identified six other cases where the income was not calculated correctly. See Exhibit 14 for a summary of the FY17 and FY18 testing results.

Exhibit 14
RESULTS OF ELIGIBILITY TESTING
(Redetermination)

	Residency Verified		Age Verified		30 Days Income Verified [1]	
	FY17	**FY18**	**FY17**	**FY18**	**FY17**	**FY18**
Number Tested	40	40	40	40	35	38
Number Missing Documentation	13	4	25	5	7	2[2]
Percent Missing Documentation	33%	10%	63%	13%	20%	5%

Notes:

[1] In FY17, 5 of 40 cases tested reported no income. In FY18, 2 of 40 cases tested reported no income.

[2] Six additional cases had income calculation errors.

Source: FY17 OAG Audit and FY18 Eligibility Testing Results for Redeterminations.

Additional Undocumented Testing (Redetermination)

Since only 13 cases in the random sample of 40 redeterminations were undocumented, we performed an additional random sample of 15 EXPANDED ALL KIDS undocumented recipients whose medical eligibility was redetermined during either May or June 2018. We performed this additional sample because: 1) 13 was a much lower number of undocumented recipients reviewed compared to prior EXPANDED ALL KIDS audits, and 2) undocumented

recipients pose a higher audit risk of missing eligibility documentation since these recipients do not qualify for the automatic redetermination process.

As discussed previously, we found that 6 of 15 recipients sampled (40%) were coded as undocumented but likely should have been coded as citizens/documented immigrants. In addition, we reviewed the 15 cases electronically with assistance from DHS officials. During this review, we determined whether all necessary eligibility documentation to support residency, birth/age, and income was received or verified in order to ensure that continued eligibility was determined accurately. Of the 15 cases reviewed, **10 (67%)** were missing at least one piece of required documentation (verification of residency, birth/age, or income).

More specifically, the results determined that HFS and DHS were missing documentation needed to verify residency in 8 of 15 cases tested (53%) and birth/age in 5 of 15 cases tested (33%). We also found one month's income was not verified in 1 of 12 cases tested (8%) and income was not calculated correctly for four additional cases. See Exhibit 15 for the FY18 testing results of the additional sample of undocumented redeterminations.

Exhibit 15
RESULTS OF ADDITIONAL UNDOCUMENTED TESTING
(Redeterminations)

	Residency Verified	Age Verified	30 Days Income Verified [1]
	FY18	FY18	FY18
Number Tested	15	15	12
Number Missing Documentation	8	5	1[2]
Percent Missing Documentation	53%	33%	8%

Notes:

[1] In FY18, 3 of 15 cases tested reported no income.

[2] Four additional cases had income calculation errors.

Source: FY18 Eligibility Testing Results for Additional Sample of Undocumented Redeterminations.

Conclusion

Without documentation to support the eligibility decisions, auditors are unable to determine whether eligibility decisions were completed accurately. Although the redetermination testing results appear to have improved since FY17, we cannot confirm if this is accurate as HFS officials explained that some redetermination dates were pushed out a year during this FY18 audit period. As noted in the FY18 OAG financial audits, HFS and DHS made the decision to extend redetermination dates for medical cases by one year. See Appendix B for additional information about these audits. Due to insufficient redetermination data and missing documentation identified during our FY18 eligibility testing of redeterminations, this part of the recommendation is **repeated** and will be followed up on during our next audit.

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 residency and birth/age is received in order to ensure that eligibility is determined accurately; and*** • ***ensure one month's worth of income verification is reviewed for determining eligibility.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department implemented IES Phase 2 and changed laws to allow monthly income to be determined using one paystub. However, the Department has not proposed rules to require verification of date of birth for children yet.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services accepts the recommendation. The Department will continue to communicate with staff regarding the uploading of supporting documentation for eligibility determinations. The Department will also continue to communicate to staff the necessity of ensuring one month's worth of income verification is reviewed for determining eligibility. The Department of Human Services will consult with the Department of Healthcare and Family Services regarding the incorporation of rules requiring the verification of birth for children. Although in most cases other than the Expanded ALL KIDS Program which covers undocumented immigrant children, the child's birth certificate or other document proves the date of birth, for medical programs, we are not required to verify age for children unless questionable due to conflicting information.

POLICIES COVERING ORTHODONTIC TREATMENT

In FY17, HFS updated the Administrative Code and scoring tool in response to the FY14 audit recommendation on policies covering orthodontic treatment. HFS officials noted that the new Administrative Code and scoring tool addressed problems identified in this previous audit recommendation. More specifically, 89 Ill. Adm. Code 140.421 updated the Administrative Code related to orthodontics. Effective January 19, 2017, medically necessary orthodontic treatment became approved only for patients under the age of 21 and defined as:

- treatment necessary to correct a condition that scores 28 points or more on the Handicapping Labio-Lingual Deviation Index (HLD); or

- treatment necessary to correct the following conditions: (i) cleft palate, (ii) deep impinging bite with signs of tissue damage (not just touching palate), (iii) anterior crossbite with gingival recession; and (iv) severe traumatic deviation (i.e. accidents,

tumors, etc.). (Note: In FY19, (v) impacted maxillary central incisor was added to this definition, effective January 1, 2019.)

We followed up with the HFS Office of the Inspector General (OIG) during the FY17 audit and discussed HFS's actions to update the Code and scoring tool. According to the OIG, the actions taken by HFS were sufficient to meet the problems identified in the FY14 EXPANDED ALL KIDS audit recommendation, which stated that HFS should "examine and address the issues raised by the OIG in its review of orthodontic claims." However, the OIG further stated that although the actions taken by HFS were sufficient for the EXPANDED ALL KIDS recipients receiving orthodontic care under the fee-for-service (FFS) part of the program, the OIG could not comment on the status of the EXPANDED ALL KIDS recipients receiving care under the Managed Care Organization (MCO) part of the program.

Monitoring of EXPANDED ALL KIDS Orthodontic Recipients under MCOs

For the updated FY17 orthodontics recommendation, we determined that HFS was not effectively monitoring the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program and ensuring that the State's dental administrator subcontractors were following the same requirements in the new Administrative Code and using the scoring tool for these recipients. As a result, we recommended that HFS needs to more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program.

Since the previous audit was released in March 2019, HFS did not have sufficient time to address the FY17 updated audit recommendation for this FY18 audit. Therefore, we were unable to review the status of this part of the updated audit recommendation and determine if HFS was more effectively monitoring the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program in FY18. However, we did request and update data to provide updated FY18 information related to initial orthodontic placements, current orthodontic recipients, and dental administrator contracts.

In order to update the data for initial orthodontic placements and current orthodontic recipients, we had to request FY18 encounter data from HFS. The FY18 OAG financial audit of HFS included a finding related to HFS's inadequate controls over monitoring encounter data submitted by MCOs. Therefore, although this FY18 encounter data was obtained and reported in this audit to provide updated FY18 information, there are limitations affecting this data as outlined in the FY18 HFS financial audit finding. See Appendix B for more information about this finding regarding encounter data.

Initial Orthodontic Placements

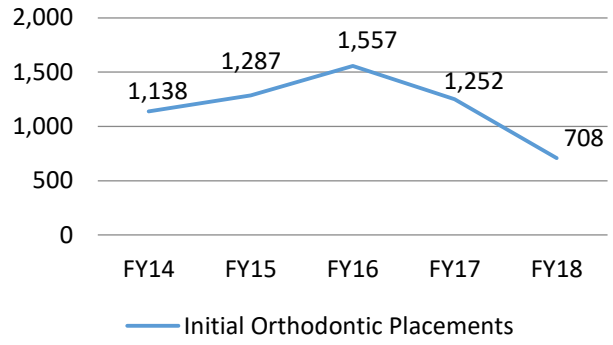
We followed up during the FY17 audit and requested the FFS and MCO initial orthodontic placement data for FY14 through FY17. We wanted to review the total number of newly approved EXPANDED ALL KIDS orthodontic recipients during these fiscal years. During that follow up, we found that the number of initial orthodontic placements grew steadily from FY14 to FY16 before dropping in FY17. We concluded that the decrease in the number of initial orthodontic placements in FY17 may have been due to the new Administrative Code and scoring tool, which were updated in FY17 in response to the FY14 audit recommendation.

During this FY18 audit, we followed up and requested this same FFS and MCO initial orthodontic placement data for FY18. As seen in Exhibit 16, we found the number of initial placements continued to drop in FY18. More specifically, initial orthodontic placements were 1,138 in FY14, 1,287 in FY15, 1,557 in FY16, 1,252 in FY17, and 708 in FY18. Therefore, we concluded that the number of initial orthodontic placements continued to decrease in FY18 after the new policy and scoring tool were implemented in FY17.

Current Orthodontic Recipients

During the FY17 audit, we determined that the number of recipients receiving care under the MCOs increased from FY15 to FY17. However, when we followed up during this FY18 audit, we found that this number decreased in FY18. As seen in

Exhibit 16
TOTAL NUMBER OF EXPANDED ALL KIDS INITIAL ORTHODONTIC PLACEMENTS
Fiscal Years 2014 – 2018



Note: This includes the total number of EXPANDED ALL KIDS initial orthodontic placements for FFS and MCO programs. For the MCO data, only between 85% and 95% of the encounter data was reported for FY15 through FY18.

Source: ALL KIDS orthodontic data provided by HFS.

Exhibit 17
RECIPIENTS RECEIVING ORTHODONTIC SERVICES
By Fee-For-Service and Managed Care Organizations
Fiscal Years 2015 – 2018

		Initial Placements	%	Current Recipients	%
FY15	FFS	1,069	83%	4,514	79%
	MCO	218	17%	1,188	21%
FY16	FFS	934	60%	3,906	60%
	MCO	623	40%	2,657	40%
FY17	FFS	705	56%	3,836	58%
	MCO	547	44%	2,834	42%
FY18	FFS	466	66%	3,043	59%
	MCO	242	34%	2,137	41%

Note: For the MCO data, only between 85% and 95% of the encounter data was reported for FY15 through FY18.

Source: ALL KIDS orthodontic data provided by HFS.

Exhibit 17, the number of current MCO recipients decreased from 2,834 in FY17 (with 93% of the encounter data reported) to 2,137 in FY18 (with 95% of the encounter data reported.)

Although the number of current MCO recipients decreased from FY17 to FY18, the percentage of MCO recipients receiving services remained about the same and continued to be significant for both fiscal years. The percent of current MCO recipients receiving orthodontic services was 42 percent in FY17 and 41 percent in FY18. Therefore, the percentage of MCO recipients remained significant in FY18 and HFS needs to continue to more effectively monitor the recipients receiving care under the MCO part of the program.

Dental Administrator Contracts

During the FY17 audit, HFS stated that the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program were covered by 13 MCO health plan providers and their 13 dental subcontractors in FY17. We reviewed these 13 subcontracts and found these subcontracts did not contain specific contract requirements such as monthly prior authorization reporting requirements or meeting requirements that were also included in HFS's FFS contract. During the FY17 audit, HFS also confirmed that HFS was not receiving monthly prior authorization reports or any other monitoring information about the recipients receiving care under the MCO part of the program.

As a result, we followed up on these same 13 dental administrator subcontracts during this FY18 audit. According to HFS, in FY18, these health plan providers and their dental subcontractors remained the same until January 2018. On January 1, 2018, Illinois expanded managed care statewide and implemented a new program with only 9 of these 13 MCOs. According to HFS, the associated FY17 dental subcontracts for these 9 MCOs had not been updated as of May 31, 2019. Therefore, since the dental subcontracts had not been updated, we found no improvements had been made yet to address the problems related to the dental administrator subcontracts identified in the FY17 updated audit recommendation during this FY18 audit.

Dental Policy Review Committee Requirements

For the updated FY17 orthodontics recommendation, we also found that the Dental Policy Review Committee (Committee) membership requirements were not met and there was an unbalanced representation of committee members. According to the Committee bylaws, about half of the members should be represented by dentists/hygienists and about half of the members should be represented by appointments from HFS. Since four of the seven appointed members were missing, we determined there was an imbalance of representation for those being appointed by HFS. Therefore, we recommended that HFS review the membership requirements for the Committee and update the bylaws accordingly.

We followed up on the status of this recommendation during this FY18 audit. In FY18, the Committee met on December 2017, February 2018, and May 2018. According to HFS, HFS has been working on updating membership requirements for the Committee. HFS stated that a new amendment was approved to update the bylaws at the August 2018 Committee meeting.

Since these bylaws were not approved until FY19, we will follow up on this part of the updated audit recommendation during the next audit.

Conclusion

Since the previous audit was released in March 2019 and HFS did not have sufficient time to address the FY17 updated audit recommendation for this FY18 audit, this recommendation is **repeated** and will be followed up on during the next audit. We will follow up on both parts of the updated FY17 orthodontics recommendation during the next audit: the monitoring of the orthodontic recipients receiving care under the MCO part of the program and the reviewing of the Dental Policy Review Committee requirements.

POLICIES COVERING ORTHODONTIC TREATMENT	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services should:*** • ***more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program; and*** • ***review the membership requirements for the Dental Policy Review Committee and update the Dental Policy Review Committee bylaws accordingly.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts and has implemented the recommendation. The requirements in the committee bylaws for FY19 were updated and recipients receiving orthodontic care under the MCO's are now monitored similarly to fee for service recipients.

APPENDICES

APPENDIX A

Covering ALL KIDS Health Insurance Act [215 ILCS 170]

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

Appendix A

COVERING ALL KIDS HEALTH INSURANCE ACT [215 ILCS 170]

INSURANCE

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

(215 ILCS 170/1)

(Section scheduled to be repealed on October 1, 2019)

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 October 1, 2019)

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 October 1, 2019)

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 October 1, 2019) 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 October 1, 2019)
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 October 1, 2019) 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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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)
(Section scheduled to be repealed on October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)
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 October 1, 2019)

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 October 1, 2019)

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)
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 October 1, 2019)
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 October 1, 2019)
Sec. 98. Repealer. This Act is repealed on October 1, 2019.
(Source: P.A. 99-518, eff. 6-30-16.)

(215 ILCS 170/99)
(Section scheduled to be repealed on October 1, 2019)
Sec. 99. Effective date. This Act takes effect July 1, 2006.
(Source: P.A. 94-693, eff. 7-1-06.)

Note: This version of the Covering ALL KIDS Health Insurance Act was effective during the FY18 audit period. Public Act 101-0272 amended this Act on August 9, 2019 and changed the audit from being performed annually to every 3 years.

APPENDIX B

AUDIT SCOPE AND METHODOLOGY

Appendix B

AUDIT SCOPE AND METHODOLOGY

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

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

Since this is the 10th audit of the EXPANDED ALL KIDS program in the last 10 years and there have been significant changes to the Covering ALL KIDS Health Insurance Act that were effective prior to the FY18 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 utilized during FY18. During our audit, HFS officials reported that there were no new contracts related to the ALL KIDS expansion for FY18.

As discussed earlier in this report, sample testing was conducted. The methodologies for each are outlined in the section titled "Follow-up on Prior Audit Recommendations." The areas in which detailed testing were conducted included: initial eligibility, redetermination of eligibility, and additional undocumented redeterminations. We conducted testing 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 Title XIX (Medicaid). Although these recipients may be eligible for medical assistance, they would not be eligible under Title XIX (Medicaid).

We met with both HFS and DHS officials and determined that initial eligibility procedures had not significantly changed since the FY14 audit for this FY18 audit. Initial ALL KIDS eligibility continued to be processed through the Integrated Eligibility System (IES). However, we determined that the procedures for the redetermination of eligibility had changed during FY18. For the beginning part of FY18, annual redeterminations for ALL KIDS were completed as part of the Illinois Medicaid Redetermination Project. On October 24, 2017, the process of redetermining eligibility changed with the implementation of IES Phase II. Therefore,

some of the FY18 redetermination data was stored in the legacy systems (prior to the implementation of IES Phase II) and the remaining FY18 redetermination data was stored in IES (after the implementation of IES Phase II). All eligibility caseworkers in DHS and HFS transitioned to using IES exclusively to process ongoing eligibility determinations during FY18.

FY18 Data Issues

Although we reviewed the data sets needed to follow up on the EXPANDED ALL KIDS program for FY18, there were many changes and challenges not previously encountered during prior EXPANDED ALL KIDS audits due to the implementation of IES Phase II during FY18. It was time-consuming to work through these issues with the agencies. We requested and received multiple data updates and additional explanations needed to complete the data analysis required for this FY18 audit.

The updated FY18 data results are reported in this audit as required by Public Act 95-985; however, there are limitations affecting the accuracy of this data as outlined in the FY18 OAG financial audits of HFS and DHS. We reviewed these financial audits of HFS and DHS. The audits contained significant applicable findings directed at IES and encounter data for FY18. The list below includes applicable FY18 HFS and DHS audit findings as well as some supporting details.

- **Failure to perform essential project management functions over IES (HFS 2018-004, DHS 2018-007)** - HFS and DHS did not adequately execute internal controls over the implementation and operation of IES Phase II. Specifically, HFS and DHS did not perform adequate project management functions over the implementation of IES Phase II.

  HFS and DHS did not have current, formal written agreements, policies, or procedures defining the roles and responsibilities regarding the operation of IES. In addition, in September 2017, the HFS Director approved the decision to extend some redetermination dates for medical cases by one year. For example, if a case was to be redetermined for eligibility in November 2017 (FY18), the redetermination date was changed to November 2018 (FY19). Existing benefits continued to be paid until the redetermination was performed.

- **Deletion of four months of intake eligibility files and significant problems determining eligibility for human service programs (HFS 2018-005, DHS 2018-008) -** HFS and DHS lacked controls over eligibility determinations and retention of intake documentation for the State's human service programs. The development vendor did not ensure the appropriate backups of the databases were completed and retained by not saving a backup of the IES Phase I database prior to the transition to IES Phase II.

- **Backlog of applications and redeterminations for human service programs (HFS 2018-006, DHS 2018-009)** - HFS and DHS did not maintain adequate controls to ensure applications for human service programs were reviewed and approved or denied within the mandated 45 or 30 day timeframes. Additionally, HFS and DHS did not conduct timely redeterminations of eligibility.

- **Lack of controls over changes to IES (HFS 2018-007, DHS 2018-010)** - HFS and DHS lacked controls over changes to IES. In April 2018, HFS and DHS developed an IES change process document but the document contained substantial deficiencies. Failure to establish and document robust change controls over the IES hampers the ability to secure the IES system as well as data which should be adequately protected against unauthorized changes and accidental or intentional destruction or alteration.

- **Lack of security controls over IES (HFS 2018-008), DHS 2018-011) -** HFS and DHS failed to implement adequate security controls over IES. During testing of IES security controls, HFS and DHS provided the populations requested but were unable to provide sufficient evidence to ensure the populations were complete and accurate. Due to failure to maintain internal controls over the security of IES, HFS and DHS have left the IES environment, application, and data exposed to malicious attacks, security breaches, and the possibility of unauthorized changes to the IES application and data**.**

- **Inadequate controls over fiscally monitoring managed care organizations (MCOs) and enrollee encounter data submitted by MCOs (HFS 2018-010) -** HFS failed to implement adequate monitoring controls over MCO and MCO contracts. In addition, HFS did not have or perform procedures to ensure that enrollee encounter data submitted by the MCOs was accurate and complete. HFS should have enforced monitoring and accountability provisions established in MCO contracts and developed procedures over encounter data to exercise fiduciary responsibility.

Since the data system was reviewed as part of the FY18 OAG financial audits of HFS and DHS, we did not review the data system for this audit in FY18. However, we did review the data for completeness by conducting limit and range tests. Any weaknesses in internal controls that have not been addressed from the previous audits are included in this report.

Exit Conferences

Draft reports were sent to HFS and DHS and exit conferences were held with them as well. The dates of the exit conferences, along with the principal attendees, are noted as follows:

Date: December 2, 2019

Agency	Name and Title
Department of Healthcare and Family Services	• Amy Lyons, Audit Liaison • Lynn Thomas, Deputy Administrator for Eligibility Policy • George Jacaway, ALL KIDS Bureau Chief • Jeremy Thomas, Bureau of Eligibility Integrity • Edna Canas, Bureau of Professional and Ancillary Services, Interim Chief • Christina McCutchan, Bureau of Professional and Ancillary Services, Dental Unit
Office of the Auditor General	• Sarah Cors, Senior Audit Manager • Patrick Rynders, Audit Supervisor

Date: December 5, 2019

Agency	Name and Title
Department of Human Services	• Amy DeWeese, Chief Internal Auditor • Albert Okwuegbunam, Audit Liaison • Paul Thelen, Family & Community Services Audit Liaison • Mary Spriggs Ploessl, DFCS Interim Associate Director
Office of the Auditor General	• Sarah Cors, Senior Audit Manager • Patrick Rynders, Audit Supervisor

APPENDIX C

COVERING ALL KIDS HEALTH INSURANCE ACT PLANS

Appendix C
COVERING ALL KIDS HEALTH INSURANCE ACT PLANS
Fiscal Year 2018

	Assist	Share	Premium Level 1	Premium Level 2
Premium	None	None	1 child $15 2 children $25 Each add'l child: $5	$40 per child
Max Monthly Premium	n/a	n/a	$40 for 5 or more children	$80 for 2 or more children
Physician Visit	$0	$3.90	$5.00	$10.00
Emergency Room Visit (Emergency)	$0	$3.90	$5.00	$30.00
Emergency Room Visit (Non-Emergency)	$0	$10.00	$25.00	$30.00
Generic Drug	$0	$2.00	$3.00	$3.00
Brand Name Drug	$0	$3.90	$5.00	$7.00
Inpatient Admission	$0	$3.90/Day	$5.00/Day	$100/Admission
Outpatient Service	No Co-Pay	No Co-Pay	No Co-Pay	5%
Annual Out-of-Pocket Max.	No co-payments	$100 per family for all services	$100 per family for all services	$500 per child for hospital services

Source: Illinois Department of Healthcare and Family Services.

APPENDIX D

TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

Appendix D
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
Fiscal Year 2018

Category of Service	FY18 Payment Amount	Percent of Total Payments
Capitation Services	$30,733,531	29%
Pharmacy Services (Drug and OTC)	$18,877,291	18%
Inpatient Hospital Services (General)	$8,194,894	8%
Dental Services	$8,074,753	8%
Physician Services	$6,819,482	7%
Outpatient Services (General)	$5,996,933	6%
Healthy Kids Services	$4,893,951	5%
General Clinic Services	$3,700,819	3%
Speech Therapy/Pathology Services	$2,311,194	2%
Inpatient Hospital Services (Psychiatric)	$2,188,559	2%
Mental Health Rehab Option Services	$1,621,997	2%
Nursing service	$1,396,689	1%
Medical Supplies	$1,003,388	1%
Physical Therapy Services	$926,388	1%
Other Transportation	$768,885	1%
Waiver service (depends on HCPCS code)	$767,102	1%
Medical equipment/prosthetic devices	$748,449	1%
Occupational Therapy Services	$604,208	1%
Clinical Laboratory Services	$535,776	1%
Social work service	$511,208	<1%
Targeted case management service (early intervention)	$392,903	<1%
Nurse Practitioners Services	$383,674	<1%
Anesthesia Services	$329,694	<1%
Optical Supplies	$307,514	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	$306,696	<1%
Psychiatric Clinic Services (Type 'B')	$271,077	<1%
Alcohol and Substance Abuse Rehab Services	$254,652	<1%
Psychologist service	$238,737	<1%
Psychiatric Clinic Services (Type 'A')	$221,867	<1%
Emergency Ambulance Transportation	$170,262	<1%
Optometric Services	$165,164	<1%
Targeted case management service (mental health)	$157,914	<1%
Early Intervention Services	$96,299	<1%
Inpatient Hospital Services (Physical Rehabilitation)	$95,549	<1%
Audiology Services	$50,875	<1%
Podiatric Services	$44,962	<1%

Appendix D
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
Fiscal Year 2018

Category of Service	FY18 Payment Amount	Percent of Total Payments
Non-Emergency Ambulance Transportation	$36,762	<1%
LTC--ICF/MR	$29,544	<1%
Licensed Clinical Professional Counselor	$22,773	<1%
Fluoride varnish	$12,558	<1%
Midwife Services	$11,763	<1%
Outpatient Services (ESRD)	$10,204	<1%
Home Health Services	$8,352	<1%
Family Planning Counseling	$5,130	<1%
Taxicab Services	$3,999	<1%
Independent Diagnostic Testing.	$3,946	<1%
Physicians Psychiatric Services	$3,188	<1%
FFS procedure to implement contraceptive devices for PT 040, 048.	$3,101	<1%
Clinic Services (Physical Rehabilitation)	$2,419	<1%
Service Car	$1,784	<1%
LTC--Developmental training (level I)	$811	<1%
Chiropractic Services	$383	<1%
Medicar Transportation	$63	<1%
Portable X-Ray Services	$22	<1%
Total FY18 Cost of Services	**$104,320,137**	**100%**

Notes: May not add due to rounding.

There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: Summary of FY18 ALL KIDS data provided by HFS.

APPENDIX E

TOTAL COST OF SERVICES PROVIDED BY PLAN AND CATEGORY OF SERVICE

Appendix E
TOTAL COST OF SERVICES PROVIDED BY PLAN AND BY CATEGORY OF SERVICE
Fiscal Year 2018

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Capitation Services	$30,733,531	$27,743,414	$818,137	$2,091,493	$812	$79,675
Pharmacy Services (Drug and OTC)	18,877,291	456,704	3,341	13,892	87,897	18,315,457
Inpatient Hospital Services (General)	8,194,894	775,542	15,708	3,084	24,077	7,376,483
Dental Services	8,074,753	522,801	13,559	43,422	152,836	7,342,135
Physician Services	6,819,482	309,845	6,165	19,194	80,592	6,403,687
Outpatient Services (General)	5,996,933	385,368	6,244	20,267	64,260	5,520,794
Healthy Kids Services	4,893,951	333,162	4,568	11,964	60,930	4,483,328
General Clinic Services	3,700,819	504,363	4,046	18,023	66,359	3,108,029
Speech Therapy/Pathology Services	2,311,194	87,734	784	7,023	5,032	2,210,621
Inpatient Hospital Services (Psychiatric)	2,188,559	262,370	0	0	6,775	1,919,414
Mental Health Rehab Option Services	1,621,997	38,910	811	4,414	14,561	1,563,301
Nursing service	1,396,689	215,522	0	0	0	1,181,167
Medical Supplies	1,003,388	57,004	85	392	13,310	932,597
Physical Therapy Services	926,388	41,808	0	4,573	9,582	870,426
Other Transportation	768,885	0	0	0	0	768,885
Waiver service (depends on HCPCS code)	767,102	0	0	0	0	767,102
Medical equipment/prosthetic devices	748,449	98,307	94	94	10,525	639,430
Occupational Therapy Services	604,208	23,068	13	1,088	1,598	578,441
Clinical Laboratory Services	535,776	50,330	302	3,509	14,418	467,217
Social work service	511,208	2,609	49	0	905	507,644
Targeted case management service (early intervention)	392,903	41,576	358	2,841	1,358	346,771
Nurse Practitioners Services	383,674	14,084	201	1,140	3,120	365,129
Anesthesia Services	329,694	18,267	461	783	3,623	306,562
Optical Supplies	307,514	17,387	501	1,384	4,914	283,328
Development Therapy, Orientation and Mobility Services (Waivers)	306,696	44,827	0	3,644	1,057	257,167
Psychiatric Clinic Services (Type 'B')	271,077	5,321	0	0	5,040	260,716
Alcohol and Substance Abuse Rehab Services	254,652	10,832	0	0	3,470	240,350
Psychologist service	238,737	1,770	0	0	0	236,967
Psychiatric Clinic Services (Type 'A')	221,867	2,168	0	239	2,797	216,662
Emergency Ambulance Transportation	170,262	12,125	0	889	638	156,610
Optometric Services	165,164	8,790	158	593	2,654	152,969

Appendix E
TOTAL COST OF SERVICES PROVIDED BY PLAN AND BY CATEGORY OF SERVICE
Fiscal Year 2018

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Targeted case management service (mental health)	$157,914	$3,357	$20	$85	$1,715	$152,738
Early Intervention Services	96,299	22,992	0	1,017	260	72,030
Inpatient Hospital Services (Physical Rehabilitation)	95,549	0	0	0	0	95,549
Audiology Services	50,875	2,136	51	69	150	48,469
Podiatric Services	44,962	2,155	650	60	782	41,315
Non-Emergency Ambulance Transportation	36,762	12,119	0	219	134	24,291
LTC--ICF/MR	29,544	0	0	0	0	29,544
Licensed Clinical Professional Counselor	22,773	1,713	0	0	53	21,007
Fluoride varnish	12,558	312	26	0	104	12,116
Midwife Services	11,763	2,155	0	0	0	9,608
Outpatient Services (ESRD)	10,204	10,204	0	0	0	0
Home Health Services	8,352	0	0	0	0	8,352
Family Planning Counseling	5,130	240	0	60	30	4,800
Taxicab Services	3,999	489	0	0	0	3,511
Independent Diagnostic Testing.	3,946	0	0	0	38	3,908
Physicians Psychiatric Services	3,188	209	0	0	0	2,979
FFS procedure to implement contraceptive devices for PT 040, 048.	3,101	737	0	0	0	2,364
Clinic Services (Physical Rehabilitation)	2,419	0	0	0	0	2,419
Service Car	1,784	343	0	76	0	1,366
LTC--Developmental training (level I)	811	0	0	0	0	811
Chiropractic Services	383	52	0	0	0	331
Medicar Transportation	63	63	0	0	0	0
Portable X-Ray Services	22	0	0	0	0	22
Total Cost of Services	**$104,320,137**	**$32,145,283**	**$876,331**	**$2,255,529**	**$646,404**	**$68,396,589**

Notes: May not add due to rounding.

There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: Summary of FY18 ALL KIDS data provided by HFS.

APPENDIX F

TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER GREATER THAN $50,000

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 F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2018

Provider Name	City	State	Total Amount Paid
BLUE CROSS BLUE SHIELD IL MMCP	CHICAGO	IL	$4,493,978
BLUE CROSS BLUE SHIELD IL FHP	CHICAGO	IL	$3,982,177
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	$3,882,001
MERIDIAN HEALTH PLAN INC MMCP	CHICAGO	IL	$3,417,414
MERIDIAN HEALTH PLAN INC VMC	CHICAGO	IL	$3,170,767
COUNTYCARE MMCP	CHICAGO	IL	$2,631,824
FAMILY HEALTH NETWORK	CHICAGO	IL	$1,941,796
ILLINICARE HEALTH PLAN MMCP	WESTMONT	IL	$1,922,917
ILLINICARE HEALTH PLAN INC FHP	WESTMONT	IL	$1,599,838
COUNTYCARE FHP	CHICAGO	IL	$1,482,019
AETNA BETTER HEALTH INC FHP	CHICAGO	IL	$1,464,863
ALLIANCERX WALGREENS PRIME #15	CANTON	MI	$1,268,735
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	$1,149,557
CAREMARK INC	MT PROSPECT	IL	$1,093,933
HARMONY HEALTH PLAN MMCP	CHICAGO	IL	$967,888
MOLINA HEALTHCARE OF ILL MMCP	OAK BROOK	IL	$964,171
MOLINA HEALTHCARE OF ILL FHP	OAK BROOK	IL	$861,154
HARMONY HEALTH PLAN	CHICAGO	IL	$806,605
DSCC	SPRINGFIELD	IL	$752,939
ADVOCATE ILLINOIS MASONIC MEDI	CHICAGO	IL	$704,881
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	$648,335
PROFESSIONAL BUILDING PHARMACY	CHICAGO	IL	$589,541
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	$588,674
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	$563,443
CHICAGO PUBLIC SCHOOLS DIST299	CHICAGO	IL	$559,303
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	$489,093
ADVOCATE CHILDRENS HOSPITAL	OAK LAWN	IL	$478,997
NEXTLEVEL HEALTH PARTNERS MMCP	CHICAGO	IL	$474,818
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	$464,109
CARLE FOUNDATION HOSPITAL	URBANA	IL	$427,886
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	$426,169
ACCREDO HEALTH GROUP	WARRENDALE	PA	$385,421
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	$372,069
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	$351,709
FOUNDATION CARE LLC	EARTH CITY	MO	$338,040
NEXTLEVEL HEALTH PARTNERS FHP	CHICAGO	IL	$322,154
ALLIANCERX WALGREENS PRIME #16	FRISCO	TX	$314,134
SSM HEALTH CARDINAL GLENNON CH	SAINT LOUIS	MO	$291,885
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	$290,887
SPECIALTYTHERAPEUTIC CARE, LP	HOUSTON	TX	$290,165
RIVEREDGE HOSPITAL	FOREST PARK	IL	$290,003
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	$289,135
COMER CHILDRENS HOSPITAL	CHICAGO	IL	$283,201
CVS/SPECIALTY	MONROEVILLE	PA	$267,563
CVS SPECIALTY	MT PROSPECT	IL	$257,305
LEGACY MEDICAL CARE INC	ARLINGTON HEIGH	IL	$238,277
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	$237,449
WALGREENS #13974	CHICAGO	IL	$233,331
CAREMARK L.L.C.,DBA CVS/SPECIA	REDLANDS	CA	$219,438
RUSH CHILDRENS SERVICES	CHICAGO	IL	$199,745

Appendix F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2018

Provider Name	City	State	Total Amount Paid
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	$190,907
WAL MART STORES EAST LP 105315	ORLANDO	FL	$181,264
BOND DRUG COMPANY OF ILLINOIS	CHICAGO	IL	$180,944
GARFIELD PARK HOSPITAL	CHICAGO	IL	$162,104
THE PAVILION FOUNDATION	CHAMPAIGN	IL	$155,058
BOND DRUG COMPANY OF IL 4494	CHICAGO	IL	$142,241
PRESENCE SAINTS MARY & ELIZABE	CHICAGO	IL	$136,559
VNA HEALTH CARE	AURORA	IL	$135,070
ALEXIAN BROTHERS CHILDRENS HOS	HOFFMAN ESTATES	IL	$132,220
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	$128,656
WALGREENS #05711	DES PLAINES	IL	$127,949
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	$121,112
SENECA HEALTH CENTER	ELGIN	IL	$119,705
NUMOTION	LOMBARD	IL	$115,797
EDWARD HOSPITAL	NAPERVILLE	IL	$113,327
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	$113,235
HARTGROVE HOSPITAL	CHICAGO	IL	$112,571
BRIOVARX INFUSION SERVICES 305	LENEXA	KS	$112,348
EVANSTON HOSPITAL	EVANSTON	IL	$111,067
RIVERSIDE MED CTR	KANKAKEE	IL	$107,554
HEARTLAND INTERNATIONAL HEALTH	CHICAGO	IL	$107,536
FRANCES NELSON HEALTH CENTER	CHAMPAIGN	IL	$105,512
FANTUS HEALTH CENTER	CHICAGO	IL	$105,343
CENTEGRA HOSPITAL - MCHENRY	MCHENRY	IL	$104,296
LABORATORY CORPORATION AMERICA	DUBLIN	OH	$103,428
INFANT WELFARE SOCIETY OF CHIC	CHICAGO	IL	$101,775
THE BLEEDING AND CLOTTING	PEORIA	IL	$101,736
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	$99,736
DOHMEN LIFE SCIENCE SRVCS LLC	CHESTERFIELD	MO	$99,706
JAVON BEA HOSPITAL	ROCKFORD	IL	$95,999
COPLEY MEMORIAL HOSPITAL	AURORA	IL	$94,900
WALGREENS #05603	SYCAMORE	IL	$94,488
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	$94,352
BOND DRUG COMPANY OF IL 03749	WAUKEGAN	IL	$93,538
EDWARDS HEALTH CARE SERVICES	HUDSON	OH	$92,967
REHABTECH SUPPLY CORPORATION	ELMHURST	IL	$92,274
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	$91,957
SHIRLEY RYAN ABILITY LAB	CHICAGO	IL	$91,897
PRESENCE SAINT JOSEPH CHICAGO	CHICAGO	IL	$91,568
WALGREENS #04504	GALESBURG	IL	$90,484
BOND DRUG COMPANY OF IL 04464	LAKE ZURICH	IL	$90,299
LAKE COUNTY HEALTH DEPARTMENT	WAUKEGAN	IL	$89,769
MCKESSON PATIENT CARE SOLUTION	MOON TWP	PA	$89,260
ADVOCATE SHERMAN HOSPITAL	ELGIN	IL	$87,148
ALLIANCERX WALGREENS PRIME #15	FRISCO	TX	$86,992
HUNTLEY COMMUNITY SCHOOL DISTR	ALGONQUIN	IL	$86,964
CRUSADER CLINIC	ROCKFORD	IL	$85,889
COMM UNIT SCH DIST 300	ALGONQUIN	IL	$85,870
PCC COMMUNITY WELLNESS CENTER	OAK PARK	IL	$85,780
OPTION CARE	WOOD DALE	IL	$82,356

Appendix F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2018

Provider Name	City	State	Total Amount Paid
UNIVERSITY OF WISCONSIN HOSP	MADISON	WI	$82,056
THE KENNETH W YOUNG CENTERS	ELK GROVE VLG	IL	$81,986
CHICAGO BEHAVIORAL HOSPITAL	DES PLAINES	IL	$81,849
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	$80,287
WALGREENS #01249	CICERO	IL	$79,483
NAPERVILLE PSYCHIATRIC VENTURE	NAPERVILLE	IL	$79,271
SARAH BUSH LINCOLN H C	MATTOON	IL	$78,271
NORTHWESTERN MED SPCLTY PHARM	CHICAGO	IL	$76,376
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HEIGH	IL	$76,184
WALGREENS #00089	BRIDGEVIEW	IL	$76,139
A2CL SERVICES LLC	WEST ALLIS	WI	$75,484
BOND DRUG COMPANY OF IL 4150	BELVIDERE	IL	$73,510
THE GENESIS CENTER	DES PLAINES	IL	$73,167
NW SUBURBAN SPEC EDUC ORG	MT PROSPECT	IL	$72,973
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	$72,082
WALMART PHARMACY 10-0460	PANA	IL	$71,813
KUSNOTO BUDI	CHICAGO	IL	$71,726
ALLIANCERX WALGREENS PRIME #16	PITTSBURGH	PA	$71,675
BOND DRUG COMPANY OF IL 3994	VILLA PARK	IL	$70,643
NORTHWESTERN LAKE FOREST HSPTL	LAKE FOREST	IL	$67,872
ZHANG TAORAN	BOLINGBROOK	IL	$67,406
PROFESSIONAL OFFICE BUILDING I	CHICAGO	IL	$67,242
GLENBROOK HOSPITAL OUTPATIENT	GLENVIEW	IL	$66,597
WALL TIMOTHY R	NAPERVILLE	IL	$65,283
MICHELLES PHARMACY INC	GILLESPIE	IL	$64,932
SILVER CROSS HOSPITAL	NEW LENOX	IL	$63,537
ST ANTHONY HOSPITAL	CHICAGO	IL	$63,388
DUPAGE COUNTY HEALTH DEPARTMEN	WHEATON	IL	$62,635
DOWNERS GROVE GDE SCH DIST 58	DOWNERS GROVE	IL	$62,568
ALEXIAN BROTHERS MEDICAL CENTE	ELK GROVE VLG	IL	$62,463
WILL COUNTY HEALTH DEPT	JOLIET	IL	$61,003
STREAMWOOD COMMUNITY HEALTH	STREAMWOOD	IL	$60,951
SULLIVAN DRUGS	MOUNT OLIVE	IL	$60,912
WALGREENS #07754	PALATINE	IL	$60,766
VALLEY VIEW CUSD 365U	ROMEOVILLE	IL	$59,944
STEVENS KATHARINE	MELROSE PARK	IL	$59,901
CHESTNUT HEALTH SYSTEMS INC	MARYVILLE	IL	$59,736
SYDORAK INNA	HARWOOD HEIGHTS	IL	$59,090
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	$58,948
THE PHARMACIE SHOPPE	CASEY	IL	$58,873
MACNEAL HOSPITAL	BERWYN	IL	$57,239
PERLMAN ELIZABETH	CHICAGO	IL	$56,690
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	$56,674
CVS PHARMACY 08752	MORTON GROVE	IL	$56,440
SHIELD DENVER HEATH CARE CENTE	ELMHURST	IL	$56,435
BOND DRUG COMPANY OF ILLINOIS	CAROL STREAM	IL	$55,836
MIDLAKES CLINIC	ROUND LAKE BEAC	IL	$55,434
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	$55,212
SUNNYBROOK SD 171	LANSING	IL	$54,697
PRESENCE RESURRECTION MED CTR	CHICAGO	IL	$54,680

Appendix F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2018

Provider Name	City	State	Total Amount Paid
ROSECRANCE INC	CRYSTAL LAKE	IL	$54,625
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	IL	$54,393
ROSELAND PHARMACY ONE	CHICAGO	IL	$54,057
PLAINFIELD SCHOOL DIST 202	PLAINFIELD	IL	$54,029
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	$53,945
SCHAUMBURG CCSD 54	SCHAUMBURG	IL	$53,898
WALMART PHARMACY 10-0481	MATTOON	IL	$53,361
VNA HEALTH CARE	ELGIN	IL	$53,250
PRESENCE MERCY MEDICAL CENTER	AURORA	IL	$52,904
GREATER ELGIN FAMILY CARE CENT	ELGIN	IL	$52,804
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	$51,931
WALGREENS #07100	ELGIN	IL	$51,474
BELLUCCI JACKSON JENNIFER	WAUCONDA	IL	$51,373
ARBOLEDA CLEIDY	NILES	IL	$50,553

Note: There are limitations affecting the accuracy of the FY18 data due to the implementation of IES Phase II (see Appendix B for more information).

Source: FY18 data provided by HFS.

APPENDIX G

AGENCY RESPONSES

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

December 6, 2019

Honorable Frank J. Mautino
Auditor General
740 East Ash
Springfield, IL 62703

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

Theresa Eagleson
Director

Enclosure

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

Attachment Responses
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. The Department has incorporated case maintenance activities into IES including new application processing and redeterminations to be more efficient; however, the Department needs to catch up on delayed redeterminations and update case information converted from the legacy system. The Department believes this will be completed by December 2020.

Recommendation Number 2: All Kids Data Reliability
The Department of Halthcare 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 eligibile and ensuring that enrollees are not enrolled in ALL KIDS more than once.

Response:
The Department accepts the recommendation. The Department has implemented case maintenance functions in IES inlcuding more automated case actions; however, clean up of issues existing prior to implementation of IES Phase 2 have not been completed. An enhancement request has been submitted to allow for systematic authorization of cases in which there has been a past eligibility override. This portion is approximately 60% complete and is estimated to be completed by December 2020.

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 IES that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;
- ensure that documented immigrants are classified correcting in its database; and
- ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching fund are not received for ineligible recipients.

Response:
The Department accepts the recommendation. A Medical Morsel titled, "When is a Noncitizen Child Considered Undocumented?", was sent to staff on July 11, 2018. The Medical Morsel lists the steps to take in IES to ensure noncitizen children are coded correctly. The Department has not implemented electronic edits but estimates remaining corrective action to be implemented by March 2020.

Recommendation Number 4: Eligibility Documentation
The Department of Healthcare and Family Services and the Department of Human Services should:

- ensure all necessary eligibility documentation to support residency and birth/age is received in order to ensure that eligibility is determined accurately; and
- ensure one month's worth of income verification is reviewed for determining eligibility.

Response:
The Department accepts the recommendation. The Department implemented IES Phase 2 and changed laws to allow monthly income to be determined using one paystub. However, the Department has not proposed rules to require verification of date of birth for children yet.

Recommendation Number 5: Policies over Orthodontic Treatment
The Department of Healthcare and Family Services should:

- more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program; and
- review the membership requirements for the Dental Policy Review Committee and update the Dental Policy Review Committee bylaws accordingl.

Response:
The Department accepts and has implemented the recommendation. The requirements in the committee bylaws for FY19 were updated and recipients receiving orthodontic care under the MCO's are now monitored similarly to fee for service recipients.

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

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

December 16, 2019

Sarah Cors
Senior Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash Street
Springfield, IL62703-3254

Dear Ms. Cors:

Attached, please find the Department's official responses to the findings identified in the Illinois Department of Human Services 2018 tenth annual audit of the Covering ALL KIDS Health Insurance program Audit Draft Findings.

Please review the attached Departmental responses and let me know if you have any questions or concerns.

You can reach me at Amy.DeWeese@Illinois.gov or (217) 558-6931.

Sincerely,

SIGNED ORIGINAL ON FILE

Amy De Weese, CPA
Chief Internal Auditor

cc: Grace Hou, Secretary
Kia Coleman, Assistant Secretary - Programs
Ryan Croke, Chief of Staff
Robert Brock, Chief Financial Officer
Tim Verry, Acting Director Division of Family and Community Services

Attachment

Fiscal Year 2018 Covering ALL KIDS Health Insurance Program Audit

RECOMMENDATION - 001: REDETERMINATION OF ELIGIBILITY

The auditors found that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code were not being adequately implemented.

Recommendation:

The Department of Healthcare and Family Services and the Department of Human Services should annually redetermine ALL KIDS elibibility as required by the Covering ALL KIDS Health Insurance Act contained in the federal regulations and the Illinois Administrative Code.

Department Response:

The Department of Human Services accepts the recommendation that All Kids cases should be redetermined annually.

Fiscal Year 2018 Covering ALL KIDS Health Insurance Program Audit

RECOMMENDATION - 003: CLASSIFICATION OF DOCUMENTED IMMIGRANTS

Auditors found that the expanded ALL KIDS data continued to have recipients who are incorrectly coded as "undocumented."

Recommendation:

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 accepts the recommendation. Due to the complexity of proper classification of documented and undocumented immigrants, additional communication and/or training to staff is needed. Given the population of documented and undocumented immigrants is small relative to the remainder of the population, the related policy is not as widely and confidently understood as policy related to the programs administered to the US Citizen population. For this reason, IES should be modified to assist with the proper classification of immigrants as much as possible. An IES enhancement request is pending with the system developer that will assist in ensuring proper classification of immigration status.

RECOMMENDATION - 004: ELIGIBILITY DOCUMENTATION

The Department of Healthcare and Family Services and the Department of Human Services did not ensure that all necessary eligibility documentation to support residency and birth/age is received to ensure that eligibility is determined accurately. In addition, the departments did not ensure that one month's worth of income verification is reviewed for determining eligibility.

Recommendation:

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

- Ensure all necessary eligibility documentation to support residency and birth/age is received in order to ensure that eligibility is determined accurately; and
- Ensure one month's worth of income verification is reviewed for determining eligibility.

Department Response:

The Department of Human Services accepts the recommendation. The Department will continue to communicate with staff regarding the uploading of supporting documentation for eligibility determinations. The Department will also continue to communicate to staff the necessity of ensuring one month's worth of income verification is reviewed for determining eligibility. The Department of Human Services will consult with the Department of Healthcare and Family Services regarding the incorporation of rules requiring the verification of birth for children. Although in most cases other than the Expanded ALL KIDS Program which covers undocumented immigrant children, the child's birth certificate or other document proves the date of birth, for medical programs, we are not required to verify age for children unless questionable due to conflicting information.

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