LEGISLATIVE AUDIT COMMISSION

Program Audit
of the
Covering ALL KIDS
Health Insurance Program

April 2011

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RECOMMENDATIONS – 14
REPEAT RECOMMENDATIONS - 9

Background

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

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

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

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

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

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

Report Conclusions

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

- In FY10, 94,628 children were enrolled in the EXPANDED ALL KIDS program.
- Total claims paid in FY10 for the EXPANDED ALL KIDS enrollees were $84.2 million. The Department of Healthcare and Family Services (HFS) received approximately $9.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $74.4 million. The children added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.
- As in the prior audit, testing identified documented immigrants that were misclassified as undocumented immigrants in HFS data. By not correctly classifying them, HFS did not submit and receive federal matching funds for these misclassified documented immigrants. HFS officials stated they found that a system error was causing the misclassifications and corrected it in October 2010.
- HFS does not terminate ALL KIDS coverage when the enrollees fail to pay premiums as required by 89 Ill. Adm. Code 123.340(a).
- HFS and the Department of Human Services (DHS) did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code.

- When determining ALL KIDS eligibility, HFS and DHS did not require individuals who are self-employed to provide detailed business records to verify income.
- FY10 claim data had billing irregularities in areas such as transportation, optical, preventive medicine, and dental claims. These irregularities may have been billing errors or may have been fraudulent. The irregularities were reported to HFS or to the HFS Office of the Inspector General (HFS-OIG) for follow-up and/or investigation.
- HFS paid for non-emergency transportation services that were excluded by the Illinois Administrative Code.
- HFS and DHS agreed with all 14 recommendations.

RECOMMENDATIONS

1. The Department of Healthcare and Family Services should comply with the rulemaking requirement found in the Covering ALL KIDS Health Insurance Act [215 ILCS 170]. (Repeated-2009)

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

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

DHFS Updated Response: The proposed rule was published on January 14, 2011 in the Illinois Register. The second notice is still pending. Public notification of rule adoption is anticipated to be published by February 1, 2012.

2. DHFS and DHS should work together to organize the policies in one section that contains only policies relevant to ALL KIDS and the EXPANDED ALL KIDS program. Additionally, the agencies should ensure that policies are consistent with applicable laws and rules and are up to date. (Repeated-2009)

Findings: During the FY09 audit, auditors determined that policies and procedures utilized by HFS and DHS for the administration of the EXPANDED ALL KIDS program were confusing and difficult to follow.

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

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

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

DHS Updated Response: Corrective action implemented:

DHS continues to collaborate with HFS on ensuring ALL Kids Policy is incorporated into the Policy Manual.

Recent policy incorporated into the manual, includes:

- 6/30/11 Manual Release - All Kids and Family Care Policy Changes
- 5/18/11 Manual Release- All Kids and Family Care Online Application
- HFS has now incorporated all but two Policy Releases containing All KIDS/Expanded All Kids policy into the Policy Manual.

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

- **review the current process for performing eligibility redeterminations to ensure compliance with the Covering ALL KIDS Health Insurance Act and the Illinois Administrative Code;**

- **at a minimum, require EXPANDED ALL KIDS enrollees with family income at or below 200 percent of the federal poverty level to return an annual redetermination to verify that there were no changes to their eligibility information; and**
- **establish a maximum number of 12-month eligibility periods for which a child with family income at or below 200 percent of the federal poverty level can be eligible for coverage without providing updated eligibility documentation. (Repeated-2009)**

Findings: In the FY09 audit, auditors concluded that the redetermination of ALL KIDS eligibility required by the Illinois Administrative Code were not being adequately implemented by HFS. For ALL KIDS enrollees that fall in the Assist, Share, and Premium level 1 categories (i.e., at or below 200 percent of the FPL), an annual "passive" redetermination is used by HFS. Prior to the end of the eligibility period, HFS sends each family an annual renewal notice and instructs the family to return the form **only** if any of the information has changed. If there have been no changes, the family is instructed to do nothing.

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

Auditors reviewed the applications for programs that provide medical coverage for children in 24 other states. None of the other 24 states had a process in which the family was not required to submit any information to the State and still received benefits.

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

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

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

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

DHFS Updated Response: To assure that the state's federal match was not lost as a result of making the changes in the Medicaid reform law, HFS wrote to CMS on April 29, 2011 requesting guidance regarding Medicaid reform laws and MOE requirements. A detailed list of the law changes, current procedures and proposed changes to procedures in order to implement the new law was provided with a request for CMS to note their approval or denial of each proposed change. CMS responded in two letters, one dated June 24, 2011 and the other dated September 30, 2011. CMS advised that the State may move forward to develop more reliance on electronic methods of verifying eligibility. CMS found, however, that requiring additional documents and outright elimination of passive renewal would violate the MOE requirements of the PPACA. CMS requested that the state submit its plan for using more electronic forms of income and residency verification for federal approval. HFS has begun work on its plan. We are working with DHS on developing an online option for families to renew their medical coverage. We anticipate that it will be ready in the next month or two depending on other pressing priorities at DHS.

DHS Updated Response: Corrective action implemented:
DHS has reviewed federal and state material that authorizes the administrative renewal process, in order to ensure that current procedure is in accordance with state and federal requirements:

- A letter was sent to HFS staff requesting a meeting to discuss the Administrative Renewal Process.
- Based on the audit recommendation, the Department of Human Services (DHS) met with the Department of Health Care and Family Services (HFS) on 9/21/2010 and 11/9/2010 to discuss the necessity to ensure compliance with the Federal regulations and impact on operations.

DHS participated in ongoing meetings with HFS to discuss implementing changes to the Administrative Renewal process and other eligibility processes related to Illinois Medicaid Reform legislation.

As a result, HFS drafted a letter to the Federal Department of Health and Human Services Center for Medicaid and Medicare Services (CMS). Per letter of response from CMS dated 6/24/11, procedural changes identified as having a 10/1/11 implementation date in the legislation, including implementing an active REDE process, will be responded to by CMS at a later date.

HFS received a response/letter back from CMS dated 9/30/11. The CMS letter agreed that Illinois should change its "passive renewal" process by incorporating the use of more automated data matching.

Corrective action to be implemented:
DHS is working with HFS to develop more automated means to verify eligibility including contracting with a vendor to verify earned income and developing a cross-match with the Secretary of State to verify residence.

4. The Department of Healthcare and Family Services and the Department of Human Services should ensure that the income of the stepparent is included in the income calculation for the EXPANDED ALL KIDS program as required by the Administrative Code. (Repeated-2009)

Findings: During the review of HFS and DHS policies during the FY09 audit, auditors determined that DHS did not calculate family income for EXPANDED ALL KIDS eligibility as required by the Administrative Code. The Administrative Code defines family as the child applying for the program and individuals who live with the child, which includes "the spouse of the child's parent" (i.e., the child's stepparent).

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

As of October 1, 2010, HFS and DHS were still in the process of implementing these revisions.

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

DHS Updated Response: Corrective action implemented:
DHS met with HFS in order to review the Administrative Code, the Illinois Compiled Statutes, and current All Kids Policy to ensure that all required income is used in the eligibility calculations for Expanded All Kids Programs.

- A letter was sent to the Department of Health Care and Family Services (HFS) staff requesting a meeting to discuss proper budgeting of stepparent income.

- The Department of Human Services (DHS) and the Department of Health Care and Family Services (HFS) staff met on September 21, 2010. At the meeting, HFS

agreed to DHS request that written clarification be provided to all staff on the correct use of stepparent income.

HFS agreed to clarify/revise the use of stepparent's income for undocumented children only, in compliance with federal regualtions/requirements. Manual Release 11.17 was distrubuted on 7/29/11, and clarifies the use of stepparent's income for undocumented children.

HFS issued updated policy on 7/29/11 regarding the counting of stepparent income when determining eligibility for undocumented children covered under the Expanded All Kid programs.

5. The Department of Healthcare and Family Services should:

- **terminate ALL KIDS coverage to families that do not pay monthly premiums as required by the Administrative Code;**

- **ensure that prior to re-enrollment in ALL KIDS, families pay all premiums due, for periods in which a premium was owed and not paid, as required by the Code; and**

- **ensure that before being re-enrolled, the first month's premium was paid if there was an unpaid premium on the date the child's previous coverage was cancelled as required by the Code.**

Findings: The Covering ALL KIDS Health Insurance Act states that children enrolled in the program are subject to cost-sharing, which includes co-pays and monthly premiums. The Act states that HFS, by rule, shall set the requirements.

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

Non-Payment of Premiums

Although the Act requires enrollees to pay monthly premiums, HFS' administrative rules allow for enrollees to receive services without ever making any premium payments.

During the FY09 audit and in this audit, auditors found that HFS did not terminate ALL KIDS coverage when the enrollee failed to pay premiums timely as required. Enrollees who did not pay premiums received an extra month of coverage in addition to what is allowed by the Administrative Code. HFS officials concurred that they are using a two month grace period instead of the one month grace period prescribed by the

Administrative Code, which is resulting in three months of coverage without payment of premiums.

Auditors reviewed the March 2010 cancellation report, which contained 1,292 individuals, and determined that 418 individuals on the March cancellation report received services during March, after the required month grace period ended. The State paid for 1,400 services totaling $42,893 for these individuals during March 2010.

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

Re-enrollment without Payment of Past Due Premiums

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

During the review of the March 11, 2010 cancellation report, auditors identified 21 families that appeared to have been re-enrolled in ALL KIDS without paying their past due premiums. HFS reviewed seven of the 21 families identified and determined that they should not have been approved, but were approved due to caseworker error. Three of the families, which had previously unpaid premiums, received services during March without ever paying any past or current premiums.

DHFS Updated Response: Accepted. A reminder was sent in June 2011 to HFS and DHS staff regarding the proper coding needed to prevent re-enrollment of children with outstanding premium debt. HFS is also in discussion with DHS regarding system enhancements that could be made to AIS so the coding would be automatically applied to these cases.

6. The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility and claim data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible, ensuring that enrollees are not enrolled in ALL KIDS more than once, and ensuring that enrollees are no longer eligible for services after their end date. (Repeated-2009)

Findings: Unlike FY09, HFS provided data timely for the FY10 audit. Also, during the FY10 audit, auditors experienced no problems obtaining requested information from HFS.

Issues with EXPANDED ALL KIDS Data

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

Individuals Older Than 18 Years of Age

HFS and DHS did not have adequate controls in place to ensure that individuals over the age of 18 were terminated from ALL KIDS eligibility as required. According to HFS policy, enrollees have eligibility through the end of the month in which they reach 19 years of age.

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

Duplicate Enrollees

In FY10, auditors identified 303 individuals that appeared to be enrolled with more than one identification number. These 303 individuals identified were reported to HFS for follow-up.

Inaccurate End Dates

During the last audit, the data provided by HFS contained 30 cases where an individual's end date was not until the first day of the month following the month in which the enrollee turned 19 years of age instead of the last day of the month in which the enrollee turns 19. Auditors followed up on this during the FY10 audit and HFS noted that it had not implemented any system changes to correct the problem.

Irregularities Between Claims and Eligibility Data

Similar to the FY09 data provided by HFS, the data from FY10 had irregularities when comparing the claims data with the eligibility data. Auditors again found claims for services provided during FY10 for individuals that were not found in the eligibility data provided by HFS. In FY10, there were 3,810 claims for 1,020 recipients who were not included in the recipient eligibility data for that year. Those FY10 claims totaled $124,056. As a result,

either the total recipients reported in this audit are understated by 1,020, or the cost of the EXPANDED ALL KIDS program is overstated by $124,056 if the recipients were not eligible for coverage during FY10, or a combination of both.

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

DHFS Updated Response: A system error that allowed coverage for the first day of the month following the child's 19th birthday has been identified and corrected as of September 2011.

7. The Department of Healthcare and Family Services should:

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

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

Auditors reviewed 50 claims from FY10 in which enrollees were classified by HFS as undocumented immigrants and found seven out of the 50 (14%) were **incorrectly classified** as undocumented immigrants. These seven individuals had documentation in the case file, such as permanent resident cards, social security cards, or alien registration numbers, to support their documented immigrant status.

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

Auditors expanded the testing in this area and DHS provided either social security numbers or alien registration numbers for 12,601 of the 60,580 (21%) EXPANDED ALL KIDS recipients classified as undocumented. Some of these that were misclassified as undocumented immigrants may have been in the country for more than five years, and as a result, claims paid for these recipients would have been eligible for federal matching

funds. None of the $12.4 million in services was submitted for federal matching funds. From the data provided by HFS and DHS, auditors could not determine how long these immigrants had been in the country.

According to HFS officials, prior to February 2009, claims for documented immigrants were not eligible for federal matching funds until the documented immigrant had been in the country for five years. In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 eliminated the five year waiting period and states could receive federal match for documented immigrants immediately. As of November 17, 2010, the State had not received approval of its State Plan to allow Illinois to begin receiving matching funds for the individuals.

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

8. The Department of Healthcare and Family Services should have controls in place to ensure that no payments are made for non-emergency transportation services that are excluded from coverage by the Administrative Code. (Repeated-2009)

Findings: The Administrative Code specifically excludes coverage for non-emergency medical transportation for enrollees in Premium levels 2 through 8. Although payments for non-emergency are excluded, auditors found 1,159 payments totaling $27,393 for non-emergency transportation services in FY09. In FY10, auditors found 575 payments totaling $22,474.

HFS officials indicated that they reviewed the exceptions and "discovered an error in the programming that caused some claims to pay improperly." A programming change was implemented on June 15, 2010, but since these claims were pre-approved, it had not recouped any of the $49,867 in unallowable payments from FY09 or FY10.

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

9. The Department of Healthcare and Family Services should review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid.

Findings: As part of the review of EXPANDED ALL KIDS payments, auditors analyzed FY10 claim data and identified potential duplicate payments. A judgmental sample of 20 possible duplicate claims was provided to HFS for explanation.

HFS reviewed each of the 20 potential duplicate pairs of claims and determined that seven were duplicates. The seven duplicate claims totaled $1,428. According to an HFS official, adjustments have been made.

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

DHFS Updated Response: The Department has developed a query to monitor for duplicate claims. The Bureau of Claims Processing is working with the query but it is not ready to be implemented because there are still some modifications needed.

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

- **ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;**
- **develop a system to verify eligibility criteria such as family size and family income to ensure that complete and accurate information was provided by the applicant; and**
- **implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly. (Repeated-2009)**

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

Proof of Age, Identity, Residency, and Family Size

To be eligible for the ALL KIDS program, a child must be under 19 years of age and must be a resident of the State of Illinois. Neither the Covering ALL KIDS Health Insurance Act nor the Administrative Code provides any guidance on how proof of age, identity, or residency is to be verified. The ALL KIDS application asks U.S. citizens to provide documentation to support place of birth (such as a birth certificate) and identity (such as driver's license, State ID card, or school ID card). Identity for children under age 16 can be documented with school or day care records, a report card, or with a parent or guardian's signature. If the child is not a citizen, the application asks applicants to provide a valid alien registration number and to provide proof.

Additionally, the ALL KIDS application does not require that any birth or identity documentation be provided by undocumented immigrants. According to HFS, children

who do not meet citizenship/immigration requirements are not required to submit birth or identity documentation. During a review of the 99 cases sampled, 40 enrollees (17 citizen/documented immigrants and 23 undocumented immigrants) did not provide documentation of place of birth (e.g., birth certificate). Although actual documentation was not in the case file, HFS noted the birth records for the citizen/documented immigrants were verified through cross-matches or were verified electronically through the Illinois Department of Public Health. According to HFS officials, birth is not required to be verified for undocumented immigrants. While most of the cases reviewed contained proof of identity, two cases did not. Without such information, it is questionable how the Departments can verify that the child meets the Act's age requirements, as well as confirm the identity of the child.

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

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

Proof of Income

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

According to a policy provided by DHS, as of January 2004, only one pay stub was required to determine eligibility for all Family Health Plans which includes ALL KIDS. This does not include individuals who are self employed. Self employed individuals are required to submit a month's worth of financial records. For a variety of reasons, eligibility based on a single pay stub may not be an accurate representation of actual income. Families that are paid hourly wages may have income that fluctuates weekly.

Self-Employment

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

Auditors reviewed other State's children's medical programs and their requirements for income eligibility and found that 19 of 24 reviewed use federal income tax returns and schedules from the previous year as proof of income for individuals who are self-employed. Nineteen of the 24 states reviewed listed tax returns as a source of documentation to support income. Although not required by Illinois law, federal income tax returns and schedules would be beneficial in determining the income of individuals.

During the review, auditors found that HFS and DHS did not properly determine whether individuals actually were or were not self employed. Auditors found two cases in the sample of 99 where individuals originally indicated they were self employed, but later indicated they were not self employed when asked to submit 30 days of detailed records.

Social Security Numbers

According to HFS officials, enrollees are not required to submit social security numbers to be eligible for ALL KIDS. During the review, auditors determined that 31 of 99 enrollees did not provide social security numbers for either of the enrollee's parents. Of these 31 enrollees, 28 were undocumented immigrants. In 17 of 99 files reviewed, a social security number was provided for only one parent. Of these 17 applicants, eight were undocumented immigrants. Also, auditors found no control in place at HFS to verify the income reported by enrollees other than requiring the enrollee to provide a single pay stub or one month of financial records for the self-employed.

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

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

DHFS Updated Response: HFS is working with DHS to implement the automated SVES data match available through the Social Security Administration which would verify citizenship and identity for anyone with a Social Security number. HFS is reviewing options to determine the appropriate documentation to request for children who do not have a SSN. A manual process will be in place by November 1, 2011. The automated match will not be in place until January 1, 2012.

DHS Response: The Department agrees with the recommendation. As a result of the passage of Public Act 96-1501, effective July 1, 2011, verification of Illinois residency and one month of income will be required for eligibility redetermination. The Department follows current policy and procedure as created by the Department of Healthcare and Family Services (HFS) regarding eligibility documentation supporting birth, residency and identity. The Department will continue to work with HFS to review current written policy and operational issues related to verification of eligibility documentation.

DHS Updated Response: Corrective action implemented:

DHS will remind casework staff of the importance of proper documentation of eligibility factors:

- The Department of Human Services (DHS) has reviewed with casework staff the importance of proper documentation of eligibility factors. The Department will continue to reiterate to casework staff the importance of proper documentation of eligibility factors.

- A "Head's Up" document has also been drafted, reminding staff of the importance of proper documentation of eligibility factors that require verification, and case record contents.

A Policy Manual Release titled "Documenting U.S. Citizenship and Identity for Medical" was also released to staff on 2/9/11.

11. The Department of Healthcare and Family Services should:

- **ensure that proper electronic billing edits are in place to prevent payment of duplicate transportation claims. In addition, HFS should identify and recoup past duplicate payments made to providers; and**

- **ensure that transportation providers submit accurate claim detail with their request for payment to ensure HFS has the information necessary for monitoring.**

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

Duplicate Transportation Bills

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

Inaccurate Transportation Claim Details

HFS does not have effective controls in place to ensure that transportation providers provide accurate and complete details on their claims. According to the HFS Handbook for Transportation Providers, providers must submit the facility name and city or street address and city for origin and destination locations. HFS officials noted that the computer system does not edit based on origin or destination times and locations

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

DHFS Updated Response: A Project Initialization Request (PIR) has been written to initiate edits for origin time, destination time and address/city information to be required, but has not been placed in production or tested yet.

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

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

During calendar year 2010, this provider ordered four or more frames and lenses for 307 ALL KIDS recipients. In total, the 307 recipients received 1,295 frames and 1,299 pairs of lenses for a total cost of $30,041. In many instances, the provider ordered several pairs of complete glasses (frames and lenses) for multiple individuals with the same last name during 2010.

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

Eye Exams

Auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient. HFS only allows for more than one examination per year when the optometrist or physician documents the need for the additional examination.

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

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

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

DHFS Updated Response: The Department has reviewed the exceptions identified by the auditors and determined no new edits will be implemented. The Department will continue to monitor for potential abuse by providers.

13. The Department of Healthcare and Family Services should more clearly define how providers should bill preventive medicine services and should distinguish between preventive services and office visits for established patients. The Department should also ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services.

Findings: During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over the billing of preventive medicine service claims. The claims are for preventive medicine services for healthy children who are established patients. According to an HFS official, preventive medicine services are used for annual doctor visits and are not to be used numerous times per year. These services generally bill at a higher rate than a problem focused visit. For example, a preventive medicine service claim for an adolescent between the age of 12 and 17 years old costs $84.62, while a 10 minute office visit costs $25.65.

Auditors identified 1,013 EXPANDED ALL KIDS recipients that received 3 or more preventive medicine services for healthy children during FY10. For these 1,013 recipients, providers billed 3,558 preventive medicine services totaling $268,930 during FY10. Auditors reviewed billing instructions used by providers and found it difficult to determine whether billing multiple preventive medicine claims for healthy children is allowable.

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

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

14. The Department of Healthcare and Family Services should:

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

Findings: During the review of FY10 ALL KIDS Expansion dental claims, auditors found deficiencies in controls related to dental billings. Auditors found instances in FY10 data where dental services were paid for in excess of the allowed benefit schedule. Auditors also found instances where the allowed benefit schedule differed from what officials said was allowed and from what was posted on HFS' ALL KIDS Dental services webpage. Additionally, auditors identified billing outliers within the dental claims and reported these

irregularities to the Department of Healthcare and Family Services for follow-up and/or investigation.

Expenditures for dental services totaled $12.1 million in FY10 for EXPANDED ALL KIDS recipients. HFS contracts with DentaQuest (previously Doral Dental) to be the dental adminsitrator for the State of Illinois.

Inconsistencies in Dental Benefit Frequency Policies

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

Prophylaxis (Teeth Cleaning)

Auditors found 1,149 recipients that received more than the allowed two prophylaxes (teeth cleanings) in FY10. When auditors discussed this with HFS and DentaQuest officials, officials noted that recipients can get their teeth cleaned twice in a dentist's office and twice in a school setting for a total of four in a year. For other services (such as topical application of fluoride and periodic oral exams), the Dental Office Reference Manual notes an additional benefit can be provided in a school setting. However, there is no such note for cleanings. HFS officials noted, "It is mentioned in the School-based Program FAQ section, but is not clearly stated elsewhere in the Dental Office Reference Manual (DORM)." HFS officials noted that they will work on making the language clearer in the DORM and include it in the next manual update.

Case Example 7

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

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

Sealants

Auditors identified 13 recipients that received more than the allowed eight sealants in FY10. Ten of the 13 occurred before an edit went into effect on January 28, 2010, which was intended to prevent billings for greater than eight sealants per patient. Three of the 13

happened after the edit went into effect. For 2 of the 3 recipients, the excess sealant billings were recouped. For one, the provider realized their billing error and the claims were manually voided before the corrected claims were submitted.

Fluoride Varnishes

Auditors identified 38 recipients that received fluoride varnishes beyond the frequency allowed during FY10. Nine of the 38 had service dates that were between 1 and 56 days apart. Three of the 9 had service dates that were less than four days apart.

Billing Outliers

We identified outliers within the dental billing claims. The outliers deviated from the average dental claims that were billed from the ALL KIDS expansion population. Of the seven dentists auditors identified and provided to the HFS-OIG, three had already been reviewed by the HFS-OIG. One of the three had quality of care concerns identified. Three others were undergoing an audit as of August 2010.

The following are examples of outliers identified by the auditors and provided to HFS-OIG for their review. The HFS-OIG responded that it will utilize these findings to assess the impact across all Medical Assistance Programs and will take appropriate action as needed.

Resins and Amalgams (Fillings)

Fillings bill at different rates depending on how many sides of the tooth are filled. For example, a 1 surface amalgam is billed at $30.85; a 2 surface amalgam is billed at $48.15; and a 3 or 4 surface amalgam bills at $58.05.

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

Average Cost and Services per Recipient Outliers

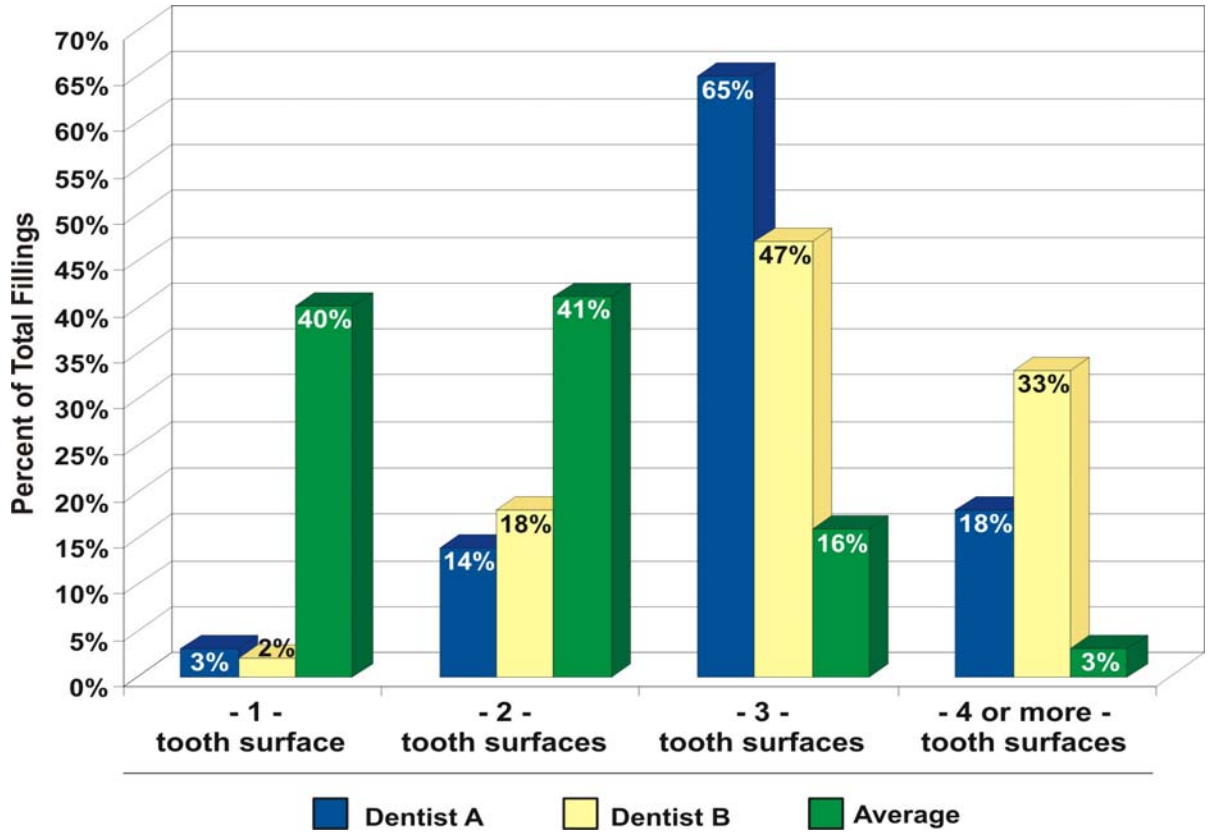
Auditors found dentists that had average number of services and average costs per recipient that were significantly higher than the average dental provider. For example, the average number of services per recipient for FY10 was 5.9; however, four dentists charged, on average, double the number of services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

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

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

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

Exhibit 3-5
FY10 FILLING OUTLIER EXAMPLES



Source: OAG analysis of HFS data.

DHFS Response: The Department accepts the recommendation. The Department is requiring DentaQuest, the contracted vendor responsible for administration of the dental claims processing, to have an audit performed to ensure the business rules of their claims processing system are properly configured as detailed in the Dental Office Reference Manual. DentaQuest's Quality Assurance team will test the edits and continue to audit claims on an ongoing basis to ensure that processing policies are working according to the Department's Dental Program requirements. The Dental Office Reference Manual will be

reviewed by the Department's dental program staff and DentaQuest and any policies that are unclear or incorrect will be updated. The Department has reduced DentaQuest's March 2011 administrative payment to recover the funds that were overpaid to dental providers in 2009 and 2010.

DHFS Updated Response: A complete audit of the Windward system was completed in August 2011 to ensure all edits are working. The Dental Policy Review manual was updated in August 2011 The administration payment was offset by any duplicate payment amounts in March 2011.