LEGISLATIVE AUDIT COMMISSION

Program Audit
of the
Covering ALL KIDS
Health Insurance Program

October 2012

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Springfield, Illinois 62706
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RECOMMENDATIONS – 14

ACCEPTED – 7
IMPLEMENTED – 7

Background

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

Throughout this report, 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." The children that were added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.

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 first audit covering FY09 was released in May 2010 and contained 13 recommendations. The second audit covering FY10 was released in April 2011 and contained 14 recommendations. The FY10 audit had five new recommendations and three new areas added to previous recommendations. This is the third annual audit and covers FY11 which began on July 1, 2010. The Act requires that the audit include:

- Payments for health services covered by the program; and
- Contracts entered into by HFS in relation to the program.

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

Recent Changes to the Covering ALL KIDS Health Insurance Act

Following the initial audit of the EXPANDED ALL KIDS program that was released in May 2010, the Illinois Senate and House of Representatives held hearings on reforming the State's medical assistance program. Legislation was passed and Public Act 96-1501 was signed into law on January 25, 2011. The Public Act amended the Covering ALL KIDS Health Insurance Act and addressed several matters raised in the initial and second audit of the EXPANDED ALL KIDS program including:

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

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

Report Conclusions

This report examines the status of the 14 recommendations from the FY10 audit. Many of the recommendations were not addressed by HFS and DHS within the audit period since the audit was not released until April 2011. Therefore, most of the recommendations were repeated. Of the 11 repeated recommendations, eight are specifically for DHFS and three are for both DHFS and DHS. The audit found the following:

- In FY11, 97,030 children were enrolled in the EXPANDED ALL KIDS program.
- Total claims paid in FY11 for the EXPANDED ALL KIDS enrollees were $96.6 million.
- HFS received approximately $10.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $85.7 million. The children added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.
- FY11 ALL KIDS claim data included 414 individuals who received 2,543 services totaling $126,092 after the month of their 19th birthday after their eligibility ended. Additionally, the data also included 315 individuals who appeared to be enrolled with more than one identification number.
- The FY11 review indicated a continued problem with HFS incorrectly categorizing documented immigrants as undocumented in its data. As a result, HFS did not submit and receive federal matching funds for these misclassified documented immigrants.
- While HFS and DHS took action to address the 14 recommendations, many of these actions did not occur within this audit period (FY11). As of May 2012, auditors

determined that three recommendations were implemented, one was partially implemented, and 10 were repeated. For six of the recommendations that were repeated, the action taken by HFS or DHS did not occur until after the FY11 audit period.

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

The updated responses to the following recommendations were provided to the Legislative Audit Commission by DHFS and DHS in March 2013.

RECOMMENDATION NUMBER 1
Covering ALL KIDS Health Insurance Act Requirements

The Covering ALL KIDS Health Insurance Act [215 ILCS 170/20(a)(3)], which became effective on July 1, 2006, required HFS in collaboration with the Department of Financial and Professional Regulation, Division of Insurance (now the Department of Insurance) to adopt rules governing the exchange of information under this section.

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

RECOMMENDATION NUMBER 2
ALL KIDS Policies and Procedures

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

Auditors met with HFS and HFS demonstrated changes that had been made to the on-line policies and procedures. Auditors reviewed the changes to the policy manual and determined that HFS addressed this recommendation. Therefore, the status of this recommendation is implemented.

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

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

Findings: In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code were not being adequately implemented by HFS.

Prior to the end of the eligibility period, HFS sent each family an annual renewal notice. The renewal notice listed the eligibility information for the family and instructed the family to return the form only if any of the information had changed. If there were no changes, the family was instructed to do nothing. Therefore, a "passive" redetermination only required families to return the annual renewal form if there was a change in their information.

DHFS Updated Response: Implemented. The Department has replaced the passive renewal process with an annual active electronic review of eligibility. HFS has launched the Illinois Medicaid Redetermination Project to revamp the eligibility redetermination process. Working with the state's Chief Procurement Officer under the provisions of the SMART Act, HFS contracted with Maximus, and its partner HMS, to supply electronic verifications, follow-up on missing information or data discrepancies, make preliminary determinations of eligibility or ineligibility and develop an Internet-based portal to make the results of its work readily available to state caseworkers who must make actual eligibility determinations. The contractors' efforts will allow the State to increase program integrity by making timely and accurate redeterminations on all medical cases.

DHS Updated Response: Corrective Action Implemented:

- The contractor (Maximus), on 2/4/13 began sending recommendations to the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) as to the continuation, cancelation, or modification of medical cases selected for redetermination.

- 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 **r**ecommendation, 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**.**

- Effective March 14, 2012, a new automated Secretary of State (SOS) Illinois residency clearance will be generated when a SNAP, cash or medical application is registered in the Automated Intake System (AIS) in the All Kids Unit and all DHS Family and Community Resource centers (FCRCs). The change regarding verifying income for Family Health Plans (FHPs) is delayed.

- An active electronic renewal process has been implemented. Currently, HFS All Kids Unit staffs are reviewing medical cases that would have formerly been selected for administrative (passive) renewal. The review includes electronic checks and clearances in order to verify earned income, unearned income, child support receipt, and Illinois residence. This new process has been set up using the guidance of the Federal Center for Medicare and Medicaid Services (CMS). Supporting documentation includes a Head's Up to all staff dated 7/3/12, describing the change in redetermination procedure

Corrective Action to be completed:

- HFS and DHS worked to contract with an outside vendor (Maximus) to perform eligibility redeterminations. The vendor will perform each of the aforementioned eligibility factor verifications. Discussion continues with the selected vendor regarding the process and system requirements for implementation.

% of CORRECTIVE ACTION COMPLETED = *90%*
Estimated Date of Completion: 12/30/2015

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.

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

DHFS Response: The Department accepts the recommendation and has revised policy to require use of stepparent income when determining eligibility for this population.

DHS Updated Response: Corrective action implemented:

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

- As a result of the meeting on 9/21/11, a Policy Alert on "Determining Eligibility for Family Health Plan Cases" when a stepparent is in the home was developed and posted for staff on DHS One Net on 1/25/11.

- HFS agreed to clarify/revise the use of stepparent's income for undocumented children only, in compliance with federal regulations/requirements.

- Manual Release 11.17 was distributed on 7/29/11, and clarifies the use of stepparent's income for undocumented children.

% of CORRECTIVE ACTION COMPLETED = 100%
Date Completed: 12/31/2011

5. The Department of Healthcare and Family Services should carry out the following actions as required by the Administrative Code:

- **terminate ALL KIDS coverage to families that do not pay monthly premiums;**
- **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; 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.**

Findings: During the FY09 and FY10 audits, auditors found that HFS did not terminate ALL KIDS coverage when the enrollee failed to pay premiums timely. Auditors also found that HFS and DHS did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code.

DHFS Updated Response: Accepted and partially implemented. The Department has revised the rules at 123.340 and policy and procedures are now in sync. HFS has submitted a request to DHS for a new report to identify cases with premiums that must be paid prior to activation of new coverage that are incorrectly approved rather than put on in enrolled status pending payment. DHS programming is required to create the new report.

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.

Findings: Auditors identified five specific issues associated with both the FY09 and FY10 data provided by HFS. These five areas were: 1) data included individuals that were older than 18 years of age; 2) data included duplicate enrollees with two different recipient identification numbers, and/or different birth dates or addresses; 3) 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.

Auditors indentified 414 individuals who received 2,543 services after the month of their 19th birthday. These services totaled $126,092. Auditors also found that the eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY11 data, 315 individuals appeared to be enrolled with more than one identification number.

DHFS Updated Response: Partially Implemented. The Department corrected a programming error that allowed one day of eligibility the month following a child's 19th birthday as of September 26, 2011. A process to identify individuals assigned more than one identification number is in development.

Work to minimize duplication of identification numbers continues in the design and development of the new Integrated Eligibility System that HFS expects to be launched In October 2013.

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: During the FY09 audit, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. During the FY10 audit, HFS officials stated they researched the cases from the FY09 audit and found that a system error was causing the misclassifications.

According to HFS, this recommendation was implemented prospectively. The system error was corrected to prevent incorrect coding from occurring on new approvals beginning October 29, 2010. The children that were previously coded incorrectly will require a

manual review to determine the correct coding. The new active electronic review process that is being implemented to replace the existing annual passive renewal will provide the opportunity to code these children correctly. A vendor will be assisting the state in verifying a number of eligibility factors, one of which will be immigration status. The code will be updated when the redetermination is recorded in the system.

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

DHFS Updated Response: Accepted and partially implemented. The Department implemented new coding to more accurately record immigration status. Staff are in the process of manually reviewing individuals who appear to have been identified as undocumented in error. As of February 1, 2013 HFS has received over $1.2 million in federal match for the individuals identified by the audit. It is not the case that HFS can claim federal matching funds for all children who have SSNs. The Department is continuing to review the cause of the coding errors but believes many of them are incorrectly added automatically through a cross match with the Social Security Administration. HFS is continuing to work toward a solution for this part of the problem.

RECOMMENDATION NUMBER 8
Payment of Non-Emergency Transportation

As part of the FY09 audit, auditors reviewed FY09 claims paid, and determined that HFS paid for services that were excluded by Illinois Administrative Code such coverage for non-emergency medical transportation for enrollees in Premium levels 2 through 8. Although payments for non-emergency transportation are excluded, auditors found 1,159 payments totaling $27,393 for non-emergency transportation services in FY09. In FY10, auditors found 575 payments totaling $22,474.

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

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

explanation. HFS reviewed each of the 20 potential duplicate pairs of claims and determined that 7 were duplicates.

The Department has developed a query to monitor for duplicate claims. The Bureau of Claims Processing is working with the query but it is not ready to be implemented because there are still some modifications needed. HFS has been unable to complete this plan due to four vacancies.

DHFS Updated Response: Accepted. The Department's Bureau of Claims Processing has been working to implement a data warehouse query to identify duplicate claims.

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 ensure that adequate information is provided and eligibility is determined correctly.**

Findings: Due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS did not obtain documentation to support eligibility in some instances. This included documentation for residency, birth, and income. As a result, during the FY09 and FY10 audits, auditors could not determine whether eligibility was determined correctly by HFS and DHS. Due to changes in eligibility criteria that occurred after the audit period, file testing was not conducted for the FY11 audit.

DHFS Updated Response: Implemented. The Department established policy requiring Social Security Administration citizenship and identity inquiry at application and at renewal if citizenship and identity have not been verified. The policy includes instructions on requesting other acceptable documentation if the SSA inquiry does not verify citizenship and identity. Electronic reviews of other eligibility factors are in process. HFS has implemented electronic verification of residency through the Secretary of State. As part of the Illinois Medicaid Redetermination Project implemented under the SMART Act, Maximus is under contract to offer additional resources for verification.

DHS Updated Response: Corrective Action Implemented:

- A policy alert on the importance of documentation was posted and made available to staff on DHS One Net on 12/2/10.

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

- As a result of the passage of Public Act 96-1501, effective July 1, 2011, verification of Illinois residency will be required. DHS will work closely with HFS in the formulation of policy in order be in compliance with this new requirement.

    - Prior to the SMART Act, passed and signed into law in June 2012, HFS and DHS implemented an enhanced residency verification process as part of the eligibility determination process.
    - For medical cases with questionable residency, this process is available for staff to verify Illinois residency via an automated Secretary of State clearance.

% of CORRECTIVE ACTION COMPLETED = 100%
Date Completed: 12/31/2011

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. As a result, transportation providers were able to bill multiple trips in a single day for the same recipient. Additionally, controls in the billing system did not contain edits for pickup or drop off times or locations.

DHFS stated the system change to restrict one trip per day as authorized by the prior approval has not been implemented because testing revealed some issues. Further, testing is being conducted to ensure all transportation provider types are handled properly and changes to restrict origin and destination times are also working.

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

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 allowed children to receive as many eyeglasses as needed through the Department of Corrections – Illinois Correctional Industries (ICI) without prior approval. As a result, optical providers were able to bill for multiple frames and fittings for the same recipient during the year. Specifically, auditors identified one provider that billed multiple frames for 41 recipients. These 41 recipients had 180 frames ordered through ICI and had 186 fittings during FY10.

When auditors reviewed this matter with the HFS Office of the Inspector General (OIG) during the FY10 audit, the OIG noted it was aware of this provider's billing patterns and noted it was in the early stages of auditing the provider. When OAG auditors requested an update on the audit (investigation) as part of this audit, the current Inspector General noted that former staff failed to act on the referral.

Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient. In FY10, 376 recipients received more than one eye exam. These 376 recipients received 793 exams from 198 different providers.

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

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 preventative medicine service claims. According to an HFS official, preventative medicine services are

used for annual doctor visits and are not to be used numerous times per year. These services generally bill at a higher rate than a problem focused visit. In the FY10 EXPANDED ALL KIDS claim data, 1,013 recipients received three or more preventative medicine services for healthy children.

In May 2012, DHFS stated that 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.

Since corrective action was not taken until the FY11 audit period was almost completed, resulting changes were not reflected in the FY11 data.

DHFS Updated Response: Implemented. The Department issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes. Billing edits have been implemented to allow children to receive the allowable number of preventive visits. Those claims over the limits will be reviewed by the Department to determine if appropriate coding was submitted.

14. The Department of Healthcare and Family Services should:

- **strengthen controls to ensure that dental providers are not paid for services; and**
- **ensure that dental policies or other information available to the public accurately states frequency of benefits.**

Findings: During a 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. These irregularities were reported to the Department of Healthcare and Family Services for follow-up and/or investigation.

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

In the FY10 audit, auditors also recommended that HFS strengthen controls to ensure that dental providers are not paid for services beyond benefit limitation. In response HFS accepted this part of the recommendation and provided the following response: "*The Department is requiring DentaQuest, the contracted vendor responsible for administration of the dental claims processing, to have an audit performed to ensure the business rules of*

their claims processing system are properly configured as detailed in the Dental Office Reference Manual. DentaQuest's Quality Assurance team will test the edits and continue to audit claims on an ongoing basis to ensure that processing policies are working according to the Department's Dental Program requirements." In May of 2012, HFS provided an updated response which stated, "*A complete audit of the Windward system was completed in August 2011 to ensure all edits are working.*" Auditors reviewed a copy of the Windward System audit.

Lastly, in the FY10 audit, auditors recommended that HFS ensure that dental policies or other information available to the public accurately states frequency of benefits. HFS accepted this part of the recommendation and updated the Dental Policy Review manual in August 2011. HFS also provided the updated Dental Office Reference Manual. However, as stated in the previous audit, the ALL KIDS Dental services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting.

DHFS Updated Response: Partially Implemented. The Department's Dental Section will continue to perform routine reconciliations to ensure that dental providers are not paid for services beyond benefit limitations. Staff is in the process of revising the Dental Office Reference manual and Administrative Rules to ensure that dental policies or other information available to the public accurately state frequency of benefits.