LEGISLATIVE AUDIT COMMISSION

Program Audit
Of The
Covering ALL KIDS
Health Insurance Program

Fiscal Year 2012

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RECOMMENDATIONS – 10
Repeated – 10

Accepted and Partially Implemented – 4
Implemented - 6

Matter for Consideration by the General Assembly - 1

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 (Act) to include all uninsured children not previously covered, 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, auditors will 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 who were added as a part of the expansion were 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.

This FY12 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. The report contained 10 recommendations, eight were specifically for HFS and two recommendations were for both HFS and DHS. The Departments agreed with all 10 recommendations. Many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY13. Since this annual audit's time period is FY12, auditors will review those changes in future audits.

Recent Changes to the Covering ALL KIDS Health Insurance Program

Two events in recent years will have a significant impact on the EXPANDED ALL KIDS program and the audits. The first was the passage of Public Act 96-1501, which added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income is above 300% of the federal poverty level (FPL) are no longer eligible after June 30, 2012. Eliminating eligibility for children in families with household income above 300% of the FPL will reduce the number of Program participants and expenditures to be audited.

The second occurred on June 4, 2013. HFS received a notification from the federal Department of Health and Human Services (HHS) that Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300% of the FPL under Title XXI of the Social Security Act. HFS applied for this reimbursement on March 31, 2009. HFS officials noted that the only State law that provides coverage to children in families with income between 200 and 300% of the FPL is the Covering ALL KIDS Health Insurance Act.

Prior EXPANDED ALL KIDS audits have only included children whose medical care was totally State-funded. The federal government granted the State retroactive reimbursement for this population (children from families with income between 200% and 300% of FPL) dating back to July 1, 2008. As of September 2013, HFS officials indicated they are in the exploratory phase as to their approach for recovering these federal matching funds. Auditors will follow up on HFS's efforts to obtain retroactive reimbursement as part of the FY13 audit.

Report Conclusions

This FY12 audit follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings and found:

- In FY12, 92,879 children were enrolled in the EXPANDED ALL KIDS program.
- Total claims paid in FY12 for the EXPANDED ALL KIDS enrollees were $77.2 million.
- FY12 ALL KIDS claim data included 193 recipients who received 1,802 services totaling $80,752 after the month of their 19th birthday, when their eligibility ended. Additionally, the data included 246 individuals who appeared to be enrolled with more than one identification number.
- The FY12 review indicated a continued problem with HFS incorrectly categorizing documented immigrants as undocumented in its data. However, HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by the previous audit had been received.

- While HFS and DHS took action to address the previous recommendations, many of these actions did not occur within this audit period (FY12). Auditors determined that one recommendation was implemented and 10 were repeated.

Future audit populations will be decreased due to the passage of PA 96-1501, which made children whose families' household income is above 300 percent of the federal poverty level (FPL) ineligible for EXPANDED ALL KIDS.

In June 2013, Illinois was retroactively approved back to July 1, 2008, to receive federal reimbursement under Title XXI of the Social Security Act for citizens and documented immigrant children in EXPANDED ALL KIDS Premium Level 2.

Due to the limited time for HFS and DHS to implement prior audit recommendations, 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.

ALL KIDS Program

In FY12, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $2.6 billion in claims. In FY12, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 92,879. On June 30, 2012, there were 67,616 enrollees as a result of the expansion of which 47,282 (70%) were classified as undocumented immigrants in the HFS data.

Auditors analyzed claim data and determined that the cost for EXPANDED ALL KIDS services provided in FY12 was $87,796,066. The cost for services provided in FY10 was $88,977,725 and in FY11 the cost was $89,340,554. However in FY12, the total payments for services dropped to $77,174,711. Auditors questioned HFS about the large decrease in payments and HFS indicated that the decrease was due to the payment cycle and not a decrease in services.

Payments for undocumented immigrants totaled $54.9 million in FY09, $59.2 million in FY10, $58.8 million in FY11, and $48.3 million in FY12. Therefore, in FY11 and FY12, undocumented immigrants made up approximately 63% of the total payments for the EXPANDED ALL KIDS program over the last two fiscal years. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated.

In FY11, HFS received approximately $10.8 million in premiums from enrollees, thus making the net payment for the ALL KIDS expansion approximately $85.8 million, an increase of approximately $11.3 million from FY10. In FY12, based on a HFS report, HFS received

almost $10.5 million in premiums, thereby decreasing the net cost of the ALL KIDS expansion to almost $66.7 million. Auditors requested the amount of unpaid premiums for EXPANDED ALL KIDS in FY12, and HFS officials indicated the accounts receivable system tracks unpaid premiums by family and not by individual. As a result, since families could have family members in various medical programs, outstanding premium payments for a specific program such as EXPANDED ALL KIDS could not be provided.

Updated responses to the following recommendations were provided to the Legislative Audit Commission by DHFS and DHS on March 31, 2014 and April 2, 2014, respectively.

Recommendations

1. The Department of Healthcare and Family Services and the Department of Human Services should review one month's income for determining continued eligibility as required by Public Act 96-1501. (Repeated-2009)

Findings: In the FY09 audit, auditors concluded that the required annual reviews of ALL KIDS eligibility – also called redeterminations – were not being adequately implemented by HFS. Prior to the end of the eligibility period, HFS sent each family an annual renewal notice to enrollees in the Assist, Share and Premium level 1 categories. 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 (passive redetermination). In contrast, to continue coverage, enrollees in Premium levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in the FY10 and FY11 audits. Effective October 1, 2011, Public Act 96-1501 required verification of one month's income for determining continued eligibility (instead of passive redetermination). According to HFS officials, the passive renewal process ended in July 2012, but corrective action did not begin until January 2013. Actions taken to implement this recommendation were included in the contract with a third party vendor, which began performing electronic eligibility verifications after this audit period. Since corrective action was not taken during FY12, detailed testing will be performed in the next audit cycle.

DHFS Response: Accepted. The Department is using the 'Work Number' and AWVS (automatic wage verification system), which provides employment earnings and unemployment insurance benefit information as available on the Illinois Department of Employment Security files, to obtain income information for a full 30 day period. One month of income data is requested from the recipient if the information is not available electronically.

DHFS Updated Response: Implemented.

DHS Response: The Department agrees with the recommendation. In July 2012, the State of Illinois ceased generating administrative renewal notices, which advised families that they did not have to respond if nothing relevant to their child's eligibility, including income, had changed. Instead, eligibility is now reviewed by a third party vendor using electronic data matches when the Social Security numbers of the responsible relatives to the children are known and verified. Those eligibility reviews are used in making recommendations to the State of Illinois Department of Human Service (IDHS) and the Department of Healthcare and Family Services (HFS) employees, who then carry out the recommendation by either continuing eligibility, modifying eligibility, or canceling eligibility.

Effective with medical applications on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System (IES), policy has now been changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs.

DHS Updated Response: Implemented. Effective with medical applications on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System (IES), policy has now been changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs.

2. The Department of Healthcare and Family Services should:

- **terminate ALL KIDS coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340;**
- **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 89 Ill. Adm. Code 123.210(c)(2); 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. (Repeated-2009)**

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 as required. 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.

During the FY11 audit, HFS noted that it was in discussion with DHS regarding system enhancements that could be made to the Automated Intake System so the proper coding would be automatically applied to these cases to prevent re-enrollment of children with

outstanding premium debt. According to HFS officials, DHS has been providing reports to HFS for individuals that did not pay premiums since October 2012. Consequently, corrective action taken by HFS and DHS staff did not occur until FY13 and the effects of corrective action would not be reflected in the FY12 eligibility data.

DHFS Response: The Department accepts the recommendation. Administrative rules have been revised and a report was developed to identify cases that are approved in error.

DHFS Updated Response: Implemented.

3. 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: During the review of the FY12 EXPANDED ALL KIDS eligibility data, auditors continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. 246 individuals appeared to be enrolled with more than one identification number. Additionally, 193 recipients received 1,802 services totaling $80,752 after the month of their 19th birthday.

DHFS Response: Accepted. A programming error that allowed a one day of eligibility the month following a child's 19th birthday has been corrected. A process to identify individuals assigned more than one identification number is in development.

Updated Response: Partially implemented. The Department and DHS work together to ensure each individual is only actively receiving benefits under one recipient identification number, and identify and deactivate duplicate recipient IDs regularly. The average duplicate recipient ID remains active for just over 100 days. The Department will continue to review and correct duplicate IDs and to recover any improper payments. Additionally, when the Integrated Eligibility System is fully operational in 2015, we can expect improved controls that will minimize the creation of duplicate IDs.

4. 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. (Repeated-2009)**

Findings: During the FY09 audit, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. According to HFS officials, to ensure that federal matching funds were not requested for documented immigrants who were ineligible for matching funds (i.e., those documented immigrants who had not been in the country for five years), those documented immigrants were classified as undocumented immigrants.

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. HFS noted the error was corrected on October 29, 2010.

In an updated response to the FY11 audit, HFS noted that the recommendation was partially implemented and new coding now more accurately records immigration status. HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by the audit had been received.

In a response to the previous audit, HFS indicated that the incorrect classification of immigrants was due to a matching problem with the Social Security Administration. Auditors met with HFS to review the matching process. According to HFS, the matching process is done monthly to continuously improve its data. HFS officials noted that HFS continues to try to clean up problems with social security numbers as they are identified; however, it is hard to do without additional staff. HFS officials noted changes are made when they identify an undocumented recipient with a social security number that is matched incorrectly. Due to the incorrect classification of documented and undocumented immigrants, the enrollee and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants.

DHFS Response: Accepted. New coding to more accurately record immigration status has been implemented. HFS received Federal approval to claim Federal matching funds for lawfully residing children under Section 214 of CHIPRA.

DHFS Updated Response: Implemented.

5. 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. (Repeated-2010)

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

HFS officials indicated that implementation of this recommendation is still in progress.

DHFS Response: The Department accepts the recommendation. The Department continues to enhance the data warehouse query to identify duplicates and reviews the data monthly.

DHFS Updated Response: Partially implemented.

6. 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;**
- **require one month's worth of income verification for determining eligibility; and**
- **implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly. (Repeated-2009)**

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

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

According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was completed to verify residency. Auditors tested whether HFS and DHS were verifying Illinois residency after March 14, 2012. Auditors selected 50 cases identified by DHS that had eligibility beginning in June 2012. Both DHS and HFS pulled electronic and paper files for review. HFS and DHS could not locate three of the recipient files, and an additional recipient file sampled had an application date prior to March 2012. Of the remaining 46 files reviewed, residency was verified in 44 of the 46 files. Of the 44 recipients verified, 20 had eligibility verified by the Secretary of State clearance and 24 were verified by various forms of documentation. Documentation of residency verification included a social security number match with the Illinois Secretary of State's Office or hard copy documentation such as addresses on bills, Mexican Consular identification cards,

driver's licenses, or pay stubs. Each of these documents contained the applicant's Illinois address.

HFS and DHS indicated that the new income requirement was not addressed in FY12. Also according to both HFS and DHS, neither agency has addressed the portion of the recommendation related to applicants who are self-employed.

DHFS Response: Accepted. The Department has implemented electronic verification of citizenship, identity, residency, and income. Paper verification is requested when these items cannot be verified electronically. These procedural changes assure HFS is fully compliant with both State and Federal law.

DHFS Updated Response: Implemented.

DHS Updated Response: Implemented.

- In March 2012, an automated Secretary of State residency clearance is generated for new medical applicants and requestors over the age of 16 registered in the Automated Intake System (AIS) or the Integrated Eligibility System (IES) in the All Kids unit, and in all DHS Family and Community Resource Centers (FCRCs).

  That clearance is to be filed in the case record. The Department currently follows policy created by HFS regarding eligibility documentation supporting birth and identity.

- Effective with medical applications submitted on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System, policy has now changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs.

- The DHS - Division of Family and Community Services has verified with Federal CMS (Center for Medicaid Services) Departmental compliance on the verification and identification of self-employment income.

7. 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. (Repeated-2010)**

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 do not contain edits for pickup or drop off times or locations.

In its updated responses, HFS officials indicated that corrective action was taken to address this recommendation prior to the current audit period. This includes implementing system edits to allow only one round trip per day and sending notices to providers reminding them to submit accurate claim details.

Auditors reviewed FY12 transportation claims and continued to find duplicate transportation claims and claims with inaccurate details. The review identified seven providers that billed 202 duplicate services totaling $1,524 in FY12, and 141 services totaling $2,925 that did not have the necessary information to make any determinations about the services that were provided. There were several instances where all the origin and destination times for a given day for a recipient were all the same. Likewise, there were several instances where the origin and destination locations were all the same. Since it was not possible to determine where and when these recipients were picked up and where and when they were dropped off, it is unclear how the claims were approved for payment.

DHFS Response: The Department accepts the recommendation. A Project Initialization Request was prepared to program a system edit that will only allow one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail.

DHFS Updated Response: Implemented.

8. 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. (Repeated-2010)

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. Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient.

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 was in the early stages of auditing this provider. Auditors followed up with the OIG in the FY11 audit; the OIG failed to act on the referral and noted it could not find a case on this provider.

In an updated response to this recommendation, the HFS Office of the Inspector General (OIG) stated that it was in the process of developing predictive modeling routines related to optical care. The OIG also noted it ran data mining routines to determine children with multiple eyeglass expenditures, and requested charts to determine whether the multiple eyeglasses were medically necessary or if there was evidence of fraud, waste, or abuse. During the FY12 review, the OIG had not completed a review, but indicated it was currently auditing the provider that was identified in the FY10 audit.

DHFS Response: Accepted. 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. A provider notice will be sent reminding providers to retain documentation that exams or glasses exceeding the benefit limitation are either medically necessary, due to a change in prescription, or the glasses were lost, stolen or broken beyond repair. It should be noted that for Title XIX and XXI over 99% of the exam claims were for two exams or less and over 99% of the claims for glasses were for one to two pairs in FY13.

DHFS Updated Response: Partially implemented. The Department has issued an informational notice to providers reminding providers of the record requirements related to the Optometric Program. In addition, the Office of the Inspector General (OIG) has specifically developed algorithms to target the potential fraud, waste and abuse in the area of eye glasses. OIG was presented with a specific provider that has been referred to law enforcement and had a payment suspension imposed. That matter is currently under investigation. While OIG has been reviewing recipients who have received an unusually high number of eye glasses, we have discovered that recipient loss and breakage are the basis for the high volume.

9. 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. (Repeated-2010)

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. In the FY10 EXPANDED ALL KIDS claim data, auditors identified 1,013 recipients that received three or more preventive medicine services for healthy children.

As a result, auditors recommended HFS more clearly define how providers should bill preventive medicine services and should ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services. HFS accepted this recommendation and provided the following updated response in May 2012: "*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.*"

During the review of the FY12 data, auditors identified numerous EXPANDED ALL KIDS recipients that received preventive medicine services for healthy children during FY12 that exceeded the benefit limitation. Auditors identified 2,255 recipients that received 2,732 preventive medicine services in excess of the limit. According to HFS, controls were not set up to address this until December 2012.

DHFS Response: Accepted. The Department has issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes. The Department is working to institute systematic edits to limit the number of preventive service billings.

DHFS Updated Response: Implemented.

10. The Department of Healthcare and Family Services should ensure that dental policies and other information available to the public accurately state frequency of benefits. (Repeated-2010)

Findings: During a review of FY10 EXPANDED ALL KIDS dental claims, auditors 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 irregularities which were reported to HFS for follow-up and/or investigation.

In the FY12 review, 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. HFS

indicated that it was in the process of revising the Dental Office Manual and Administrative Rules to accurately state frequency and benefits.

During this audit, auditors followed up on providers that were referred to the HFS OIG during the FY10 audit. For one provider, the OIG initiated a Special Project Audit in FY10 which was never completed. For FY12, this provider continued to have a high average cost per client or other outliers, and was again referred this provider to the OIG. According to the OIG, it is currently auditing this provider.

DHFS Response: Accepted. The Department will revise Administrative Rules to accurately state frequency of benefits. In addition, HFS will update the Dental Office Reference Manual as well as the website to be consistent with the Administrative Rules.

DHFS Updated Response: Partially implemented.