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**THE ALL KIDS PROGRAM, ENROLLMENT POLICIES, AND THE MAY 2010
“PROGRAM AUDIT OF THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM”**

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I. Introduction and Brief History of Program

The All Kids program is the marketing name for Illinois’ health insurance program for uninsured Illinois children, which had over 1.67 million children enrolled in 2009.¹ All Kids is marketed and administered to consumers as one program, with one set of rules and forms and procedures, one sliding scale for premiums and co-payments, and one benefits package. Behind the scene, however, All Kids is authorized by three Illinois statutes: the Medical Assistance article of the Public Aid Code, the Children’s Health Insurance Program Act (CHIPA), and the Covering All Kids Health Insurance Act. This is further complicated by the fact (also invisible to consumers) that most expenditures for children under all three state statutes are eligible, for federal matching funds under two federal programs: Medicaid and the State Children’s Health Insurance Program (SCHIP).

Under Republican and Democratic Governors, with fluctuating party control in the houses of the General Assembly, Illinois has steadily embraced the public policy of providing and expanding health care coverage for children. The General Assembly long ago established, and over the years has consistently reaffirmed, that providing coverage for children is cost-effective, produces beneficial long-term outcomes, and is a sound investment that profits not just children but the entire state. Illinois repeatedly increased the income eligibility level for children

¹ Program Audit of the Covering All Kids Health Insurance Program, Office of the Illinois Auditor General, William G. Holland, May 11, 2010 at 8, [hereinafter *Illinois Auditor General report*] available at: <http://www.auditor.illinois.gov>

under Medicaid throughout the 1980s and 1990s. Then, in 1998, Illinois implemented KidCare, the state version of the newly enacted federal SCHIP program. Illinois also expanded eligibility for coverage on top of Medicaid (which topped out at 133% of the poverty level) by setting KidCare eligibility at 185% of the poverty level. The General Assembly then expanded KidCare eligibility to 200% of the poverty level in 2003. The Covering All Kids Health Insurance Act, effective July 1, 2006, completed this process and extended coverage to all remaining uninsured children residing in Illinois who did not have access to affordable private coverage, requiring substantial sliding scale premiums and co-payments from families above the prior eligibility levels, with much higher premiums and contributions above 400% of the poverty level.² In preparation for the expansion, at the end of 2005 Illinois began to market and administer all of the programs together under the name “All Kids”.

The legislative findings of the Covering All Kids Health Insurance Act repeated the longstanding public policy position in Illinois on coverage for children:

“The General Assembly finds that, for the economic and social benefit of all residents of the State, it is important to enable all children of this State to access affordable health insurance that offers comprehensive coverage and emphasizes preventive healthcare.... The effects of lack of insurance also negatively impact those who are insured because the cost of paying for care to the uninsured is often shifted to those who have insurance in the form of higher health insurance premiums.... It is, therefore, the intent of this legislation to provide access to affordable health insurance to all uninsured children in Illinois.”³ Public Act 094-0693

This action by the General Assembly was recognized that children’s health insurance coverage is good public policy; it has important positive impacts on Illinois’ economy, work force, and public health condition.⁴ Children are the least expensive population to cover.⁵

² The Covering ALL KIDS Health Insurance Act, Public Act 094-0693; 215 Ill. Comp. Stat. 170/5 (2005).

³ The Covering ALL KIDS Health Insurance Act, Public Act passed with significant bi-partisan support, including a “yes” from current U.S. Representative Aaron Schock.
http://www.ilga.gov/legislation/votehistory/94/house/09400HB0806_10272005_009000C.pdf

⁴ Illinois’ Medicaid program stimulates the local economy. Medicaid funding has an economic “multiplier effect” because money comes into the state economy through federal matching funds. Under ARRA, state and federal Medicaid funding resulted in \$46 billion in increased business activity in 2009 and \$15.8 billion in wages. This means that state and federal Medicaid funding supported 385,742 jobs. “Medicaid Plays a Critical Role in Illinois’ Economy,” Heather O’Donnell, Center for Tax and Budget Accountability, December 2009. Untreated health conditions cause uninsured children to lose opportunities for normal development. Their educational achievement

Uninsured children are less likely to be immunized or receive treatment for chronic conditions such as diabetes and asthma.⁶ Lack of health insurance leads to poorer health in childhood, greater rates of avoidable hospitalizations, higher childhood mortality, delay in care, and more unfilled prescriptions.⁷ Better health in childhood has been linked in adulthood to higher incomes, higher wealth, more weeks worked, and a higher growth rate in income.⁸

The All Kids' program availability to all uninsured Illinois children allows children whose parents' lost their employer-sponsored health insurance coverage through job loss to enroll.⁹ Illinois' unemployment rate was 11.2% as of April of 2010.¹⁰ In February 2010, the unemployment rate in the Rockford area was 18.6%, 16.1% in the Kankakee-Bradley area, and 14.6% in Decatur.¹¹ The program is an important support for families coping with unemployment.

The Department of Healthcare and Family Services (DHFS) has implemented the program to effectuate the intent of the legislature. It has recognized that the purposes and beneficial impacts of the program can only be accomplished by enrolling children and connecting them to primary and preventive care. It has implemented what national research and experience has shown to be the best practices for enrolling and retaining children in public health insurance programs. The All Kids program is applauded nationally for its use of enrollment and retention tools known as "passive renewal" and "12-month continuous eligibility", as well as its requirement that applicants produce one pay stub to document income at intake.¹² In the

suffers because they are absent more from school. "How Does Insurance Coverage Improve Health Outcomes," Jill Bernstein, Deborah Chollet, and Stephanie Peterson, Mathematica Policy Research Issue Brief, (April 2010).

⁵ Illinois Department of Healthcare and Family Services, Theresa Eagleson, Presentation to Taxpayer Action Board's Medicaid Subcommittee, (April 10, 2009).

⁶ Bernstein et al., *supra* note 4. See also "The Economic Impact of Uninsured Children on America," Baker Institute Policy Report, James A. Baker III Institute for Public Policy of Rice University, No. 40, (June 2009) [hereinafter *Baker Institute Report*].

⁷ *Id.*

⁸ *Id.*

⁹ The Covering ALL KIDS Health Insurance Act, Public Act 094-0693, Section 20 (a)(3)(ii).

¹⁰ Illinois Department of Economic Security website, viewed May 27, 2010, available at: <http://www.ides.state.il.us/>.

¹¹ Illinois Department of Economic Security website, Local Area Unemployment Statistics: LAUS, viewed May 27, 2010, available at: <http://www.ides.state.il.us/>.

¹² "Maximizing Enrollment in Illinois: Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids," Eileen Ellis and Jennifer Edwards, National Academy for State Health Policy and the Robert Wood Johnson Foundation (February 2010). U.S. Department of Health and Human Services press release, "States Get Bonuses for Boosting Enrollment in Children's Health Coverage," (17 December 2009) [hereinafter *HHS Press Release*], available at: <http://www.hhs.gov/news/press/2009pres/12/20091217a.html>

Children’s Health Insurance Reauthorization Act (CHIPRA), which renewed and amended SCHIP in January 2009, Congress delineated eight measures aimed at simplifying Medicaid enrollment and renewal for children and established financial rewards to states via “State Bonus Payments” that adopt these favored policies. The policies are:

- 12-month continuous coverage eligibility to promote continuity of care by assuring kids don’t lose coverage due to fluctuations in income;
- Administrative or passive renewal forms that are pre-populated with data regarding active household members and income so that if there are no changes in the family’s circumstances, the family is not required to return the form,
- Liberalization of asset requirements,
- The same application and renewal process for Medicaid and CHIP,
- Express lane eligibility,
- Premium Assistance,
- Presumptive eligibility, and
- No face-to-face interview requirement at time of application or renewal.¹³

Not only are these measures proven to be effective in increasing enrollment and retention of eligible children, but this in turn promotes children’s access to preventive care and improvement in the quality of care and health outcomes, which are cost effective over the long term.¹⁴ The promotion of these features is a direct result of extensive national research finding that children with continuous coverage are more likely to visit a doctor, receive preventive care, and have prescriptions filled.¹⁵ Disruptions in insurance coverage have been associated with less access to care, lower service use, and increases in unmet medical needs.¹⁶ The National Academy for State Health Policy and the Robert Wood Johnson Foundation’s February 2010 Diagnostic Assessment of Illinois’ All Kids’ program deemed the program’s simplified “one pay stub” income documentation and the administrative or “passive” renewal process as “outstanding feature[s].”¹⁷ And in December 2009, Illinois was one of just nine states to win an incentive

¹³ Department of Health and Human Services, Center for Medicaid and State Operations, Letter to State Health Officials Re: CHIPRA Performance Bonus Payments, (SHO #09-015)(December 16, 2009).

¹⁴ “Medicaid Performance Bonus ‘5 of 8’ Requirements,” The Kaiser Commission on Medicaid and the Uninsured and Georgetown University Healthy Policy Institute Center for Children and Families, (April 2009) [hereinafter *Kaiser Report*].

¹⁵ Bernstein et al, *supra* note 4. See also *Baker Institute Report*, *supra* note 6.

¹⁶ *Id.*

¹⁷ Ellis et al, *supra* note 12.

bonus from the federal government (and the \$9 million amount of the bonus was second highest in the nation) for increasing All Kids' enrollment and for exemplary performance in adopting measures that facilitate participation and increase enrollment and retention rates, including 12-month continuous eligibility; no asset test; no requirement for face-to-face interview; joint application and renewal forms regardless of funding; presumptive eligibility; and administrative renewals.¹⁸ Moreover, streamlining enrollment and retention processes may reduce state administrative burdens and costs by reducing paperwork and unnecessary office visits.¹⁹

As the national research and clear federal policy direction show, fraud by consumers has not been and is not a significant problem, and the benefits, financial and otherwise, of simplified enrollment and continuous eligibility far outweigh any incremental risk of fraud or mistake. Illinois has struck a sensible balance, however, and pays close attention to eligibility factors through data matches, file reviews, and communications with consumers. Even with Illinois' current simplified renewal process, approximately one thousand All Kids-enrolled children each month are "disenrolled," mostly due to procedural problems, such as failing to renew their eligibility within a certain timeframe or not having complete documentation, rather than because of changes in eligibility.²⁰ As a result, many of these children lose coverage at renewal, subsequently reapply for All Kids' benefits, and get re-enrolled a few months later.

II. Limited scope of Illinois General Assembly's charge to the Illinois Auditor General

In 2007, The Covering All Kids Health Insurance Act was amended by adding Section 63 providing for an audit by the Auditor General. This section states in its totality:

"The Auditor General shall annually cause an audit to be made of the Program, beginning June 30, 2008 and each June 30th thereafter. The audit shall include payments for health services covered by the Program and contracts entered into by the Department in relation to the Program."²¹ Public Act 095-0985

¹⁸ HHS Press Release, *supra* note 12.

¹⁹ *Kaiser Report*, *supra* note 14.

²⁰ Ellis et al, *supra* note 12.

²¹ Illinois Public Act 095-0985.

This unusual requirement of an annual audit was not supported by any data or legislative findings or even a bald assertion of legislative concern about the existence of fraud or mismanagement in the program. There was no statement about why the Covering All Kids Insurance Act was singled out for this unusual and administratively costly annual scrutiny. There is no evidence that the audit requirement flowed from any concern about the public policy behind children’s health insurance programs or the enrollment and retention policies that DHFS had adopted (the chief sponsor of the audit amendment had voted for the Covering All Kids Insurance Act, which itself was an extension of the KidCare program that already had many of the enrollment policies in place). Instead, the audit amendment was an artifact of the ongoing and pervasive distrust and power struggle between the legislative and executive branches during the second term of former Governor Rod Blagojevich and the rumors of possible undue influence or corruption. By its express terms focusing on “payments” and “contracts”, the amendment makes clear that the legislature’s concern was about whether providers or contractors might receive unusual payments for medical services or win contracts under the program in unethical ways (e.g., in return for campaign contributions). To be true to the statutory command and clear intent of the legislature, the focus of the annual audits was to be the amount, nature, and propriety of the payments and contracts.

III. Concerns about the Illinois Auditor General’s audit of the Covering All Kids Health Insurance Program

A. Illinois Auditor General’s report favors critique of Illinois’ children’s health policy choices instead of analysis of payments and contracts per its statutory charge

The first audit report was released by The Illinois Auditor General on May 11, 2010.²² Because it was limited to the coverage expansion under the Covering All Kids Insurance Act, the audit covered less than 6% of the total statewide All Kids enrollment and approximately 3% of all All Kids claims as of FY2009. The audit does not feature upfront, a thorough and detailed examination of which providers are receiving payments under the program and whether any of that activity is unusual or suspicious or administratively flawed. Instead, the audit chooses to

²² *Illinois Auditor General report, supra* note 1.

focus the overwhelming majority of its attention on the public policy behind the Covering All Kids Insurance Act (to cover all children) and the carefully researched administrative policies regarding enrollment and retention in the program that have been adopted by HFS, mostly prior to the passage of the Covering All Kids Insurance Act, and rewarded and applauded nationally. The audit does not explain why it assumes that the General Assembly was inviting an audit of its own public policy choices, nor does it explain why it undertakes to second guess the implementation choices made by the state's experts on these matters within DHFS. The audit does not say why it chose to focus its attention on the children being covered and receiving health care and to underplay what the audit amendment clearly asked it to focus on: the provider and contractor side of the program. The audit provides the Auditor General's unsolicited opinions on children's health policy. It does not provide the "follow the money" information that the General Assembly clearly wanted to monitor.

B. The Auditor General's report criticizes DHFS administrative procedures that have ensured eligible Illinois children are enrolled in the All Kids health program and for which Illinois has been nationally recognized

In making its policy analysis and recommendation, the audit disregards children's health policy in general as well as the history and purpose of the All Kids program and the Covering All Kids Insurance Act in particular. For instance, the audit complains about the lack of documentation in case files differentiating the types of immigrant children covered by the program, because, according to the audit, the correct documentation would entitle the state to federal matching funds that Illinois would otherwise forego. However, an in-depth understanding of the complexities of federal children's health coverage financing would reveal that the audit should not have made so much of this issue. The difference in documentation among immigrant children did not become relevant to federal financing until Congress passed CHIPRA in January 2009 (allowing federal matching funds for certain immigrant children for the first time) and its implementation months later. There was no reason prior to that for DHFS to spend the staff time and money on those documentation issues – DHFS was faithfully implementing state law by covering those children, and it was efficiently conserving state

resources by not spending them investigating irrelevant factors.²³ If the Auditor General’s office understood children’s health care financing as the experts of DHFS do, the audit would also note that DHFS can now go back and obtain the documentation needed to maximize federal funds – retroactively – and not miss any funds the state can claim for the time period in question. No harm, no foul.

The Auditor General’s foray into the General Assembly’s policy choices for children’s coverage is also predictably short on historical context. The audit makes much of what the program costs, even as it is describing how DHFS is covering exactly the children the legislature told it to cover, as if the General Assembly wanted the auditor to remind it that the programs it authorized cost money. The audit fails to cite the history of how the program was to be paid for, even though the method of payment was front and center when the General Assembly passed the Covering All Kids Insurance Act. The program was to be paid for by the savings generated by the simultaneous adoption in Illinois of new case management programs for the entire array of state medical programs. And that is precisely what happened. At the same time All Kids’ coverage expanded, Illinois also initiated a Disease Management and Primary Care Case Management program. In addition to promoting preventive care and improving health outcomes, the cost-savings achieved from these programs were intended to fund the cost of the All Kids expansion.²⁴ The total amount saved by the state in fiscal years 2008 and 2009 was approximately \$500 million dollars.²⁵ The audit found that the net cost of the All Kids Expansion subset to be \$70.2 million.²⁶ Since the Auditor General’s office does not know the

²³ The audit identified two individuals who had been in the country for five years when they enrolled in the All Kids program, and were incorrectly classified as undocumented when they enrolled. These individuals qualified for federal matching funds. The audit recommended that HFS and DHS ensure that documented immigrants are classified correctly to ensure that the State receives federal matching funds for all eligible claims. HFS responded that it “accepts the recommendation and recognizes the need for staff training to assure individuals are classified correctly.” DHS also agreed.

²⁴ “A Race to the Top: Illinois’s All Kids Initiative,” Teresa A. Coughlin and Mindy Cohen, The Urban Institute and the Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured (August 2007). “On the Spot in Illinois: Working toward Reaching and Enrolling All Children and Adolescents,” Maureen Hensley-Quinn, National Academy for State Health Policy (October 2008).

²⁵ “Illinois Credits Program Change with \$300M Medicaid Savings,” Mike Colias, Crain’s Business, (April 27, 2010), available at: <http://www.chicagobusiness.com/cgi-bin/news.pl?id=37995>; “Hot Line is Healthy for State Budget,” Dean Olsen, Springfield State Journal Register, 17 May 2009, <http://www.sj-r.com/homepage/x1194178152/Health-care-hotline-saves-patients-time-states-money>.

²⁶ *Illinois Auditor General report, supra* note 1.

history of the expansion, the audit did not note that the program has been entirely paid for as intended by the General Assembly when it passed the law.

C. Some of the Auditor General's suggestions could result in the waste of scarce state resources

Some of the suggestions made by the Auditor General may be helpful around the edges for creating a more efficient program for administrators and consumers alike. But other suggestions dispense with important tenets of children's healthcare policy. Currently, most children enrollees with incomes at or below 200% of the poverty level are eligible for administrative or "passive" renewal, whereby the forms are pre-populated with data regarding active household members' income and health insurance and, if there are no changes in the family's circumstances, the family is not required to return the form and eligibility for the children is automatically renewed.²⁷ In the audit, the Auditor General recommended that All Kids' enrollees "return an annual redetermination to verify that there are no changes to their eligibility information" and "establish a maximum number of 12-month eligibility periods for which a child with family income...can be eligible for coverage without providing updated eligibility documentation."²⁸ Federal law does not require a renewal form or a signature to confirm ongoing eligibility under Medicaid or the State Children's Health Insurance Program (SCHIP).²⁹ Illinois' current administrative passive renewal policy contributes to cost savings. Changing this policy to add administrative verification steps will unnecessarily increase administrative costs, disrupt coverage and health care itself, and increase the rates of uninsured.³⁰ Additionally, lessons from other states clearly show that moving to active renewal for the entire All Kids' enrollee population would be fiscally unwise and would result in eligible children losing their coverage. One study examined the impact of changing from a passive renewal process to an active renewal process in Florida's children's health insurance program. The researchers looked at how this change may affect children's risk of disenrolling, controlling for sociodemographic

²⁷ Ellis et al, *supra* note 12.

²⁸ *Illinois Auditor General report*, *supra* note 1.

²⁹ *Kaiser Report*, *supra* note 14.

³⁰ Bernstein et al, *supra* note 4.

characteristics. The study revealed that children faced almost a ten-fold greater risk of disenrolling in their renewal month under active renewal than under passive renewal.³¹

The audit also recommends that HFS and the Department of Human Services (DHS) “implement a system for independently verifying eligibility criteria.”³² This recommendation constitutes an additional administrative step beyond the current application that collects family size and income, residency and birth date information from applicants under penalty of perjury. If this recommendation were enacted, the additional administrative burden and associated cost would be unlikely to pay for itself in cost-savings and would likely result in eligible children not receiving health coverage. Additionally, federal law does not require families to provide *any* proof of income, as long as the state has the ability to check this information via internal systems such as data matches.³³

D. Auditor General’s recommendations could cost Illinois billions of dollars in federal funding

Some of the Auditor General’s recommendations may jeopardize federal match money because of maintenance of effort (MOE) provisions in both the American Recovery and Reinvestment Act (ARRA) and the Patient Protection and Affordable Care Act (PPACA).³⁴ The PPACA requires that states maintain the eligibility standards and enrollment procedures in Medicaid and SCHIP that were in place as of March 23, 2010, and this requirement applies to children until September 30, 2019.³⁵ The requirements under ARRA are restrictive but do not go as far as those under PPACA in so far as penalties to the state for changing status; the guidance on ARRA’s maintenance of effort provisions are both instructive and prescriptive for states compliance with PPACA.³⁶ The PPACA asserts that states cannot adopt changes in eligibility

³¹ “The Effect of Renewal Policy Changes on SCHIP Disenrollment,” Jill Boylston Herndon, W. Bruce Vogel, Richard L. Bucciarelli, and Elizabeth A. Shenkman, Health Research and Educational Trust, 43(6): 2086-2105 (2008).

³² *Illinois Auditor General report, supra* note 1.

³³ *Kaiser Report, supra* note 14.

³⁴ The Patient Protection and Affordable Care Act (PPACA), Public Law 111-148. The Health Care and Reconciliation Act of 2010, Public Law 111-152.

³⁵ *Id.*

³⁶ ARRA’s Maintenance of Efforts provisions can be found in Section 5001(f)(1) of Public Law 11-5, American Recovery and Reinvestment Act of 2009. See also Center for Medicaid and State Operations, “American Recovery

rules and procedure that would make someone ineligible for Medicaid or SCHIP coverage, who would have been eligible for Medicaid or SCHIP on March 23, 2010.³⁷ Examples of changes that are likely to be prohibited by PPACA's MOE include scaling back income eligibility or eliminating coverage for an entire eligibility category in Medicaid or SCHIP, reducing or eliminating an income disregard, and imposing a new paperwork requirement such as a more frequent renewal period.³⁸ If a state violates PPACA's maintenance of effort requirement, it would forgo all of its federal Medicaid funding including funding for children, pregnant women, seniors, people with disabilities, and administrative costs.³⁹ In other words, all federal Medicaid funding would be in jeopardy were there violations—not just the extra Medicaid fiscal relief included in ARRA.⁴⁰ ARRA Medicaid match money alone has already brought Illinois' coffers over \$2.3 billion dollars—a fraction of the amount that would be lost if Illinois were to violate federal reform's MOE requirements.⁴¹

and Reinvestment Act of 2009, Frequently Asked Questions from States,” (July 7, 2009), stating, “States are eligible for the increased FMAP only if the State is applying Medicaid eligibility standards, methodologies, and procedures that are no more restrictive than those in effect under the State plan (or any waiver or demonstration project) on July 1, 2008.... ‘Procedures’ refers to those actions taken by the State in administration of their Medicaid eligibility determination or redetermination process. We recognize that States make many policies and operational process decisions which CMS does not review, approve, or monitor. Any changes in those procedures after July 1, 2008 which might negatively impact a person’s eligibility could put the State at risk for being able to receive the increased FMAP. Before drawing the increased FMAP, States should be diligent about reviewing such procedures to see if they fit within the Maintenance of Effort (MOE) provisions and discussing any questions they might have with CMS. When a State has such questions, they should contact their CMS Regional Office with specific questions so that CMS can discuss the specific situation.” CMS also reports that Any change in eligibility determination or redetermination processes or procedures that are more stringent or restrictive than those in effect under the State’s Medicaid program on July 1, 2008 will these affect the States’ ability to receive the increased FMAP. These include, but are not limited to requesting additional evidence concerning resources from individuals when, under previous policy, such additional evidence would not have been requested. See Center for Medicaid and State Operations, Fact Sheet and Questions and Answers on ARRA Section 5001, (March 25, 2009).

³⁷ Public Law 11-148, Title II, Section 2001 indicates that states would be required to maintain the same income eligibility levels through December 31, 2013 for all adults. This “maintenance of effort” (MOE) requirement would be extended through September 30, 2019 for all children currently covered in Medicaid or CHIP.

³⁸ “Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Care reform’s Maintenance-of-Effort Requirements,” Georgetown University Health Policy Institute Center for Children and Families and the Center on Budget and Policy Priorities (March 26, 2010).

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Department of Health Care and Human services (HHS), Recovery Act (ARRA), State Medicaid Funding, available at: <http://www.hhs.gov/recovery/statefundsmmap.html>. In Illinois, the Federal Matching Assistance Percentage (FMAP) for Medicaid with American Recovery and Reinvestment Act (ARRA) Adjustment went from original FMAP of 50.32% in FY2009 to 60.48% under ARRA. In fiscal year 2010, the original FMAP was 50.17%, but adjusted under ARRA is 61.88%. Kaiser Family Foundation’s State Health Facts website, available at: <http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=154&rgn=15>

IV. Conclusion

The expansion of the Medicaid program under federal health reform to allow individuals under age 65 with household incomes up to 133% of poverty level will provide coverage to approximately 630,000 Illinoisans, and the likelihood that they will enroll hinges on the ease of the enrollment process.⁴² This large boost in Medicaid enrollees incentivizes automation and streamlining processes in all of our state public health insurance systems, especially during these times of budget constrictions and workforce reductions. The automation and simplification processes demonstrated by the All Kids program should serve as a model for all of Illinois' health insurance programs. All Kids' enrollees are linked with a medical home of their choosing through Illinois Health Connect, which saved Illinois an estimated \$100 million during the 2008 fiscal year.⁴³ And having a usual source of care (medical home), such as a pediatrician or family practice doctor, has been associated with earlier diagnosis, fewer hospitalizations, lower costs, and increased patient satisfaction.⁴⁴

The Auditor General's office should not be expected to have expertise on any of these extremely important and highly complex matters of public policy and healthcare financing. The problem is that the audit consists almost entirely of the Auditor General's office's views on precisely those issues. It is no surprise that the audit makes numerous mistakes on these issues and, if anyone were to pay attention to the recommendations, would risk billions of dollars to the State of Illinois, not to mention the health of thousands of children.

The legislative purpose of the audit was to monitor expenditures of money and awards of contracts under the program, not to evaluate public policy. There is no evidence of any fraud or unethical practices in the payments and contracts under the All Kids program. But if there are providers or contractors out there right now who gained payments or contracts under the program

⁴² "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL," John Holahan and Irene Headen, Urban Institute and the Kaiser Family Foundation (May 2010). See also Bernstein et al, *supra* note 4. The United States Senate's Democratic Policy Committee brief issued April 5, 2010 reports that PPACA will "provide access to Medicaid for 797,343 newly-eligible Illinoisans, and provide \$18.1 billion in federal funding for the cost of their coverage." Brief available at: http://dpc.senate.gov/docs/sr-111-2-41_states/il.pdf.

⁴³ Illinois Department of Healthcare and Family Services website, available at: http://illinoishealthconnect.com/files/downloads/AdvisorySub/minutes_provider_2009-05-21.pdf. See also Olsen, *supra* note 24.

⁴⁴ *Baker Institute Report*, *supra* note 6.

illegally, unethically, or under irregular procedures, they are probably grateful that the Auditor General ignored the statutory purpose for the audit and chose to audit other things.