Illinois Department of Healthcare and Family Services

FY2022 Medical Expenditures
Claims for Services Rendered in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(i)
(In Thousands)

Physicians	$5,358.1
Optometrists	68.3
Podiatrists	58.2
Chiropractors	0.1
Behavioral Health Clinics	11.1
Dentists	795.5
Hospitals	157,546.4
Family Support Services	2,602.6
Prescribed Drugs	569.4
Long Term Care - Geriatric	11,007.6
Institutions for Mental Disease	107.2
Supportive Living Facilities	4,485.4
Community Health Centers	1,415.4
Hospice	1,098.1
Laboratories	2,275.5
Home Health Care	248.5
Division of Specialized Care for Children	39,194.4
Appliances	2,025.2
Transportation	9,080.2
Other Related	700.3
Managed Care	232,945.2
Renal	4.3
Sexual Assault Treatment	35.9
General Revenue and Related Subtotal	**$471,633.0**
University of Illinois - Hospital Services	$12,552.8
County Provider Trust Fund (Cook County)	123,457.0
Special Education Medicaid Matching Fund	25,089.4
Medical Interagency Program Fund (including Children's Mental Health)	3,075.6
TOTAL	**$635,807.9**

Illinois Department of Healthcare and Family Services

FY2022 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(ii)
(In Thousands)

Physicians	$999.8
Optometrists	4.4
Podiatrists	10.4
Dentists	632.6
Hospitals	7,889.2
Prescribed Drugs	110.5
Community Health Centers	61.1
Hospice	11.5
Laboratories	23.6
Home Health Care	14.8
Division of Specialized Care for Children	1,152.1
Appliances	239.9
Transportation	324.5
Other Related	43.8
Managed Care	6,059.9
Sexual Assault Treatment	5.5
General Revenue and Related Subtotal	**17,583.5**
University of Illinois - Hospital Services	127.5
Medical Interagency Program Fund (including Children's Mental Health)	73.0
TOTAL	**$17,784.0**

Illinois Department of Healthcare and Family Services

FY2022 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(k)(2)(A)
(In Thousands)

Physicians	$974.2
Optometrists	4.4
Podiatrists	10.4
Dentists	632.6
Hospitals	7,519.9
Prescribed Drugs	102.6
Community Health Centers	61.0
Hospice	11.4
Laboratories	23.6
Home Health Care	14.8
Appliances	238.6
Transportation	324.5
Other Related	42.5
Sexual Assault Treatment	5.5
General Revenue and Related Total	**$9,966.0**

PA 097-0691 set the maximum amounts of annual unpaid Medical Assistance bills received and recorded by the Department of Healthcare and Family Services on or before June 30th of a particular fiscal year attributable in aggregate to the General Revenue Fund, Healthcare Provider Relief Fund, Tobacco Settlement Recovery Fund, Long-Term Care Provider Fund, and the Drug Rebate Fund that may be paid in total by the Department from future fiscal year Medical Assistance appropriations at $100,000,000 for fiscal year 2014 and each fiscal year thereafter.

Illinois Department of Healthcare and Family Services
Explanation of Variance Between the Previous Year's Estimate and Actual Liabilities and Factors Affecting the Department's Liabilities
Required Under 30 ILCS 105/25 (g)(1)(2)

1. **Explanation of the variance between the previous year's estimated and actual Section 25 liabilities.**

   Please note the Section 25 unpaid bill deferral cap, found in 30 ILCS 105/25 (k), remains unchanged for this reporting period. The relevant cap for this reporting period is $100 million in fiscal year 2021 non-adjusted Medical Assistance liabilities, received on or before June 30, 2021, that may be paid from fiscal year 2022 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately $10.0 million.

   Total Section 25 liability reported on Attachment 1 is greater than the cap amount (and will likely be each year) because the cap applies only to General Revenue and related fund Medical Assistance bills received on or before June 30th of a given fiscal year, as noted in the first paragraph. The cap targets the past state practice of deferring unpaid received General Revenue and related fund bills into future fiscal years for payment (budgeted payment cycle). Bills for services rendered during a fiscal year, but received by HFS after June 30th of that fiscal year, and bills payable from funds other than those statutorily defined as General Revenue and related, may continue to be paid from future year appropriations without limitation.

   At the end of fiscal year 2021, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be approximately $361.0 million. After the close of the fiscal year 2022 lapse period, fiscal year 2021 actual Section 25 liabilities were $635.8 million. The main reason for the variance is the value of issued retroactive mandated rate adjustments. Other items impacting the variance amount include non-General Revenue and related fund federal revenue pass-through payments to local school districts paid using fiscal year 2022 spending authority.

   In addition, the difference between estimated and actual Medical Assistance Section 25 liabilities can be attributed to a variety of factors, including the use of historic trends between service dates and provider claim submittal dates. While those have been the most accurate methods for estimating liabilities, they will still produce degrees of variance each year.

2. **Factors relating to HFS' medical liability.**

   The general drivers of HFS' Medical Assistance liability have traditionally been the number of enrollees, offered services, enrollee service utilization patterns and the established reimbursement rates for those services. Much of HFS' Medical Assistance program eligibility standards, service offerings and reimbursement methodologies are strictly governed by state and federal statutes and regulations.

   In fiscal year 2021, HFS provided access to full benefit health coverage for an average of approximately 3.29 million Illinoisans. Those receiving healthcare through the Department's programs included just under 1.47 million children, approximately 597,900

adults without disabilities, 260,300 adults with disabilities, 248,700 seniors and 712,800 ACA clients.

HFS' fiscal year 2022 average full benefit health coverage aggregate enrollment increased to 3.53 million. Those receiving healthcare through the Department's programs included approximately 1.49 million children, 693,500 adults without disabilities, 255,000 adults with disabilities, 278,600 seniors and 819,200 ACA clients.

During fiscal year 2022, an average of approximately 2.83 million, or about 80% of Medicaid clients were covered by one of the managed care plans.

Medical Assistance enrollment increased between fiscal years 2021 and 2022 mainly due to the federal Families First Coronavirus Response Act which requires states to maintain client eligibility during the pendency of the declared public health emergency in order to receive enhanced federal matching revenue for services provided to those with non-Affordable Care Act eligibility. No client has lost coverage during the public health emergency.

HFS is advancing Medical Assistance program offerings by providing state-funded Medicaid-like coverage for immigrants who are 42-64 years old and are not eligible for Medicaid coverage solely due to their immigration status and is the first state in the nation to garner federal approval to offer postpartum coverage for twelve months.

Under the Pritzker Administration, HFS is committed to efforts to improve the Medical Assistance Program. These activities include improvements to the Integrated Eligibility System (IES), reducing program eligibility application processing delays, long-term care reform to increase nursing home staffing and improve patient care quality, rolling out a five-pillared quality strategy to invest in priorities such as equity and behavioral health, introducing new non-General Revenue Fund resources to support program improvements, and maximizing federal revenue. These efforts will advance client healthcare as well as operational and cost efficiency.

Beginning in fiscal year 2021, the Department is making available as much as $150 million per fiscal year to fund the Healthcare Transformation Program. The program is designed to encourage collaborations of healthcare providers and community partners to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities throughout Illinois. In particular, the program seeks to increase access to community-based services, preventive care, obstetric care, chronic disease management, specialty care and address the social determinants of health in those communities.

HFS responded to the COVID-19 public health emergency by ensuring healthcare access through eligibility maintenance and new access points, such as permanent telehealth options. MCO partners distributed food and worked on multiple social determinants of health projects as well as implemented rate add-ons for behavioral health. In addition, HFS supported approximately $378 million in hospital surge staffing during the worst months of COVID over FY21 and FY22.

HFS is also distributing federal Coronavirus Aid, Relief and Economic Security Act (CARES) and American Rescue Plan Act (ARPA) resources to Illinois healthcare providers as appropriated by the General Assembly. Funding may be used by providers

for workforce investments and to offset COVID-19 related costs as allowable under the federal acts and state statute. HFS distributed almost $650 million in CARES funds during FY21 and approximately $330 million in CARES and ARPA funds in FY22. The Department received $315 million in ARPA appropriations in fiscal year 2023.

The Department's efforts at improving both the health outcomes of Medical Assistance clients and the program's cost-effectiveness, combined with sufficient annual appropriations and the unpaid bill deferral limitations in the State Finance Act, should allow for reasonable Section 25 liability management within HFS' Medical Assistance program in the years to come.

Illinois Department of Healthcare and Family Services
Results of the Department's Efforts to Combat Fraud and Abuse
Report Required under 30 ILCS 105/25(g)(3)

All statistics are for fiscal year 2022 (07/01/2021 to 06/30/2022)

The Office of Inspector General (OIG) for the Illinois Department of Healthcare and Family Services (HFS) is mandated to oversee the program integrity functions for the Medicaid system in the State of Illinois, which includes oversight of HFS, and certain functions of the Department of Human Services (DHS) and the Illinois Department on Aging. OIG employs a comprehensive approach to its mandate, performing audits, investigations, quality of care reviews, and compliance activities, as described below.

Provider Audits

The OIG, through the Bureau of Medicaid Integrity (BMI), conducts regular audits of Illinois Medicaid providers that bill HFS directly under the traditional fee-for-service (FFS) system. BMI selects auditees based upon factors such as risk analysis and utilizes the Dynamic Network Analysis (DNA) system to identify outliers, billing trends, and fraud schemes and to data mine. Although audits were impacted by the Public Health Emergency (PHE) resulting from the Covid-19 pandemic, BMI completed 1,403 audits of providers resulting in the collection of over $3.4 million in overpayments.

OIG also utilizes contractors to supplement audits that require advanced skills and are clinically and technically complex. BMI works closely with the federal Unified Program Integrity Contractor (UPIC) which is currently contracted by CoventBridge. OIG also contracts directly with Health Management Systems as its federally mandated Recovery Audit Contractor (RAC). The UPIC vets leads from various sources such as CMS and OIG to tailor their data mining, investigation, and audit. The RAC uses algorithms to determine its audit scope. In FY2022, the RAC completed 117 audits with collections exceeding $307,000. The UPIC started 7 new audits with 11 already in progress.

Providers that are enrolled in a Managed Care Organization (MCO) are audited by their respective MCO with oversight by the OIG. Each of the MCOs contracted to provide services to Illinois' Medicaid customers is required to have a Special Investigations Unit (SIU) that performs audits and investigations. The MCOs must report their program integrity efforts and results to OIG. OIG evaluates those activities and results, coordinates efforts, and takes follow up action as appropriate. In FY2022, the Complaint Intake Unit received 325 referrals of fraud, waste, and abuse in the Illinois Medicaid program, of which 187 allegations were referred by MCO SIUs.

Provider Quality Review

OIG's Peer Review section monitors the quality of care and the utilization of services rendered by Medicaid providers. Treatment patterns of selected providers are reviewed to determine if medical care provided is grossly inferior, potentially harmful or in excess of need. As the result of Peer Review's work, OIG may refer a provider to the Medical Quality Review Committee (MQRC). The PHE has impacted this process, as no MQRC meetings were held for two years. In FY2022, OIG transitioned MQRC meetings to a virtual platform to avoid further delays caused by the PHE. Three virtual MQRCs were scheduled by the end of FY2022. During FY2022, the Peer Review Unit's reviews resulted in five Letters of Concern indicating required immediate improvement in specific areas of practice, eight Letters of Education highlighting areas of recommended

improvement, and three Letters of No Concern indicating acceptable standards of care.

Clients

In FY2022, OIG continued its Long Term Care-Asset Discovery Investigations initiative to identify long term care applicants attempting to hide or divert assets. During this fiscal year, the resource test for long term care applicants was suspended due to the PHE. Accordingly, the State was unable to process any penalties or resource spenddowns. LTC-ADI continued to review applications referred to this office to make preliminary eligibility findings. OIG hopes to use these findings to determine actual eligibility at the end of the PHE when the penalties and spenddowns can be imposed.

OIG's Bureau of Investigations (BOI) has historically been focused on fraud investigations of recipients of Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and childcare benefits. During FY2022, the Bureau completed 1,065 investigations. BOI made findings in 1,311 cases that led to the denial or cancellation of benefits. During the fiscal year, BOI referred nine cases for prosecution and local state's attorneys obtained four criminal convictions stemming from OIG referrals. BOI's investigations resulted in a total estimated cost avoidance and savings of over $12.2 million, consisting of $7.3 million from client eligibility investigations, $2.8 million in estimated overpayments and $2.1 million in cost avoidance resulting from SNAP fraud investigations. OIG BOI is currently facilitating transitioning SNAP investigations to the Illinois Department of Human Services, which administers the SNAP program. This transition will allow BOI to devote more of its resources in the coming years to investigations of fraud, waste, and abuse by Medicaid providers.

OIG's Recipient Restriction Program (also called "lock-in") seeks to detect and prevent abuse of medical and pharmaceutical benefits by restricting Medicaid recipients to a single primary care provider when OIG identifies a concerning pattern of use. OIG coordinates its lock-ins with the MCOs to ensure a uniform approach. In FY2022, OIG reviewed 1,550 cases from which it recommended 276 recipients for lock-in.

Law Enforcement

OIG is the primary liaison with all state and federal law enforcement agencies. OIG is statutorily mandated to report suspected criminal violations to the Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU). During FY2022, OIG made 13 referrals to MFCU and responded to 139 data and information requests in support of law enforcement investigations related to Medicaid.

Sanctions

OIG attorneys represent the State's interests in administrative hearings against Illinois Medicaid providers. OIG initiates sanctions, including termination or suspension of provider status, recoupment of overpayments, appeals of recoveries, denial/disenrollment during the initial enrollment process, implementation of integrity agreements, application of various payment withholds on suspect providers, imposition of civil remedies and civil monetary penalties, debarment of individuals related to terminated providers, and joint hearings with the Department of Public Health to de-certify long-term care facilities. During FY2022, OIG sanctions resulted in over $4.1 million in cost savings and avoidance.

Analytics

OIG developed, with the financial assistance of federal CMS, the Dynamic Network Analysis (DNA) system, which provides in-depth provider and recipient profiles, link analyses and data mining tools for use by OIG staff for program integrity purposes. OIG continues to develop and implement new features through an intergovernmental agreement with Northern Illinois University.

New Provider Verification (NPV)

Under the Affordable Care Act, the OIG is tasked with the required enhanced screening of all new providers and the revalidation of all remaining providers. These processes require OIG to perform background checks, fingerprint checks and compliance reviews of high-risk provider types. During provider probationary periods imposed by the SMART Act, OIG reviews the quality of new providers' billings for any evidence of fraud, waste, or abuse, which may result in disenrollment or termination. During the PHE, many of these enrollment requirements have been waived.

Hotline/Referrals

OIG operates a toll-free hotline number and an online portal to facilitate referrals for fraud, waste and abuse. A complainant can submit information and documents to https://www2.illinois.gov/hfs/oig/Pages/ReportFraud.aspx or can speak to an intake specialist at the hotline number, 1-844-ILFRAUD. OIG's intake section conducts initial research to investigate the submitted allegations. If OIG decides to open a matter, it routes the complaint to the appropriate section of the office for audit, investigation, or further review. During FY2022, OIG received 7,469 fraud referral allegations received through phone calls, internet, email, and hard copy referrals.

Employee/Contractor Investigations

During FY2022, the OIG's Bureau of Internal Affairs conducted 102 misconduct investigations and 552 background investigations. BIA's misconduct investigations resulted in 16 substantiated cases for administrative or criminal violations.

The OIG fiscal year 2022 Annual Report will be available in early 2023 at:
https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx