Illinois Department of Healthcare and Family Services

FY2020 Medical Expenditures
Services Provided in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(i)
(In Thousands)

Physicians	$9,352.7
Dentists	838.5
Optometrists	116.6
Podiatrists	83.7
Chiropractors	0.5
Hospitals	272,317.3
Prescribed Drugs	53,002.7
Long Term Care - Geriatric	69,095.4
Institutions for Mental Disease/Specialized Mental Health Rehabilitation Facilities	1,801.7
Supportive Living Facilities	6,660.2
Community Health Centers	1,776.8
Hospice	8,225.2
Laboratories	200.2
Home Health Care	391.7
Division of Specialized Care for Children	2,478.5
Appliances	2,537.7
Transportation	914.2
Other Related	1,849.1
Individual Care Grant - Family Support Program	6,928.9
Medically Complex for the Developmentally Disabled Facilities	182.6
Behavioral & Community Mental Health Clinics	428.0
Managed Care	532,355.7
Renal	8.1
Sexual Assault Treatment	9.3
General Revenue and Related Subtotal	**$971,555.3**
University of Illinois - Hospital Services	$28,769.4
County Provider Trust Fund (Cook County)	40,747.5
Special Education Medicaid Matching Fund	34,321.7
Medical Interagency Program Fund (including Children's Mental Health)	5,096.8
TOTAL	**$1,080,490.8**

Illinois Department of Healthcare and Family Services

FY2020 Medical Expenditures
Services Provided in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(ii)
(In Thousands)

Physicians	$666.0
Optometrists	$14.5
Podiatrists	$14.5
Chiropractors	$0.3
Hospitals	$87,491.6
Supportive Living Facilities	$29.0
Community Health Centers	$88.5
Hospice	$2,923.4
Laboratories	$18.2
Home Health Care	$0.7
Division of Specialized Care for Children	$6.5
Appliances	$131.8
Transportation	$38.7
Other Related	$1,121.2
Behavioral & Community Mental Health Clinics	$62.0
General Revenue and Related Total	**$92,606.9**
University of Illinois - Hospital Services	$714.2
Medical Interagency Program Fund (including Children's Mental Health)	$119.7
TOTAL	**$93,440.8**

Illinois Department of Healthcare and Family Services

FY2020 Medical Expenditures
Services Provided in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(k)(2)(A)
(In Thousands)

Physicians	$666.0
Optometrists	$14.5
Podiatrists	$14.5
Chiropractors	$0.3
Hospitals	$63,580.7
Supportive Living Facilities	$29.0
Community Health Centers	$88.5
Hospice	$2,923.4
Laboratories	$18.2
Home Health Care	$0.7
Division of Specialized Care for Children	$6.5
Appliances	$131.8
Transportation	$38.7
Other Related	$1,121.2
Behavioral & Community Mental Health Clinics	$62.0
General Revenue and Related Total	**$68,696.0**

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 2019 non-adjusted Medical Assistance liabilities, received on or before June 30, 2019, that may be paid from fiscal year 2020 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately $68.7 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 2019, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be $692.5 million. After the close of the fiscal year 2020 lapse period, fiscal year 2019 actual Section 25 liabilities were $1.08 billion. The main reasons for the variance are the timing of processing a significant amount of managed care adjustment payments and certain hospital payments. Other items impacting the variance amount include some non-General Revenue and related fund payments to the University of Illinois Hospital and federal revenue pass-through payments to local school districts paid using fiscal year 2020 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 statues and regulations.

    In fiscal year 2019, HFS provided access to full benefit health coverage for an average of approximately 2.97 million Illinoisans. Those receiving healthcare through the Department's programs included just under 1.40 million children, approximately 516,400

adults without disabilities, 265,100 adults with disabilities, just under 216,000 seniors and approximately 574,900 ACA clients.

HFS' fiscal year 2020 average full benefit health coverage aggregate enrollment declined slightly to 2.96 million. Those receiving healthcare through the Department's programs included approximately 1.39 million children, 501,600 adults without disabilities, just over 262,800 adults with disabilities, approximately 224,300 seniors and just over 578,500 ACA clients.

HFS continues efforts to improve health outcomes and the cost effectiveness of the Medical Assistance Program. For example, the Department has made advances in the managed care program.

"Managed Care" is provided through various organizations accepting full-risk capitated payments. During fiscal year 2020, an average of approximately 2.18 million, or about 74% of Medicaid clients were covered by one of the managed care plans.

The Department developed a system to accept and screen all Medicaid provider claims and forward to the Managed Care Organizations (MCOs) to provide more transparency into billing and denial issues. HFS also updated the Managed Care Resolution Portal to ensure fair resolution of disputes involving MCOs and providers in an electronic and secure format. Lastly, enhanced federal funding was leveraged to connect health care providers and MCOs in a unified, state-wide Healthcare Data Exchange System (HL7 format).

Under the Pritzker Administration, HFS is committed to efforts to improve the Medical Assistance Program beyond managed care. These activities include improvements to the Integrated Eligibility System (IES), reducing program eligibility application processing delays, 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.

HFS responded to the early stages of the COVID-19 public health emergency during FY20 by ensuring healthcare access through eligibility maintenance and new access points, such as telehealth. MCO partners distributed food and worked on multiple social determinants of health projects as well as implemented rate add-ons for behavioral health. COVID-19 enhanced federal Medicaid matching revenue was utilized to fund $75 million in stability payments to hospitals.

HFS is distributing federal CARES Act resources to Illinois healthcare providers as appropriated by the General Assembly during the spring 2020 legislative session. Funding may be used by providers to offset COVID-19 related costs from March 1 through December 30, 2020, such as hazard pay for direct care workers, personal protective equipment purchases, and other allowable expenditures.

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 for 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 2020 (07/01/2019 to 06/30/2020)

The Office of Inspector General (OIG) for the Illinois Department of Healthcare and Family Services has authority over the entire Medicaid system in the State of Illinois, including the Department of Healthcare and Family Services, the Department of Human Services (DHS) and the Illinois Department on Aging's Community Care Program. OIG implemented a comprehensive program integrity work plan, which included an aggressive regulatory framework, expansion of audits, investigations and quality of care reviews. This aggressive work plan resulted in a cost savings, cost avoidance and recoupments of over $173.0 million dollars.

Providers

While determining the process for performing audits in the managed care world, OIG continued its fee-for-service (FFS) audit capabilities, completing 3,612 audits of providers, including both desk audits and traditional field audits completed in-house and with external contracted vendors. Some of the audits were developed using the Dynamic Network Analysis ("DNA") analytical system. Overall, the audit bureau collected over $17.8 million in overpayments. OIG also enhanced its collaboration with external audit entities like the Medicaid Integrity Contractor provided by the federal Centers for Medicare and Medicaid Services ("CMS"), contractual audit providers, and the Illinois Recovery Audit Contractor required by the Affordable Care Act ("ACA").

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. During fiscal year 2020, OIG gave 8 providers Letters of Concern; referred 1 provider for sanction; requested 7 corporate integrity agreements for providers in lieu of termination; and had 3 providers voluntarily withdraw from the system.

Clients

OIG continued its Long Term Care-Asset Discovery Investigations initiative to identify long term care applicants attempting to hide or divert assets. During fiscal year 2020, OIG completed 2,070 investigations, resulting in imposed penalty periods on 648 of those cases, providing $65.5 million in savings and $59.9 million in cost avoidance.

During FY 2020, the Bureau of Investigations (BOI) completed 599 investigations that led to the denial or cancellation of benefits for those individuals in 407 cases and 5 criminal convictions. Cost avoidance/savings on investigative matters neared $5.7 million. BOI investigations into childcare matters (Temporary Assistance for Needy Families -TANF) resulted in established overpayments exceeding $267,237. OIG also performed recipient Supplemental Nutrition Assistance Program (SNAP) food stamp investigations resulting in identified overpayments of $1.4 million and a cost avoidance of 777,288.

OIG's Recipient Restriction Program (also called "lock-in") continued to increase capacity due to technological innovations. As of June 30, 2020, 1,597 clients were restricted in FFS (214 recommended to MCOs) resulting in over $131,953 in cost avoidance.

Law Enforcement

OIG is the primary liaison with all state and federal law enforcement agencies. OIG is statutorily mandated to report suspected criminal cases to the Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU). During fiscal year 2020, OIG made 13 referrals to law enforcement and provided 116 data requests for ISP-MFCU investigations, including FFS and MCO requests.

Sanctions

OIG acts as the "prosecutor" in administrative hearings against 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 fiscal year 2020, OIG sanctions resulted in just over $2.5 million in cost savings and avoidance.

Analytics

OIG continues to be a leader nationwide in the implementation, development and deployment of in-house analytics to assist in auditing, predictive modeling, data mining, link analysis and data aggregation for executive and law enforcement use. OIG has developed, with the financial assistance of federal CMS, the Dynamic Network Analysis ("DNA") system. The DNA provides in depth provider and recipient profiles, link analysis and data mining tools for use by the 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 the OIG to perform background checks, fingerprint checks and on-site visits to high risk provider types. SMART Act probationary periods and this NPV process have allowed the OIG to review the quality of billings submitted by new providers to determine if evidence of fraud, waste or abuse is present; and may result in disenrollment or termination.

Hotline/Referrals·

OIG operates a toll free hotline number to facilitate referrals for fraud, waste and abuse. The number, 1-844-ILFRAUD, allows any person to call and speak with specialists that use databases to try and confirm the caller's allegations. These cases are then either sent for overpayment recoupment through the Bureau of Collections or forwarded to the Bureau of Investigations for formal investigation. During fiscal year 2020, OIG received 6,851 fraud referral allegations received through phone calls, internet, email, and hard copy referrals.

Employee/Contractor Investigations

During fiscal year 2020, the OIG's Bureau of Internal Affairs investigated 637 individuals for criminal/non-criminal workplace rules violations, resulting in 81 substantiated cases. Referrals are also taken from/made to the Office of the Executive Inspector General as needed.

The OIG fiscal year 2020 Annual Report will be available at:
https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx