ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

November 30, 2021

Tim Anderson
Secretary of the Senate
401 Capitol Building
Springfield, IL 62706

Dear Secretary Anderson:

Pursuant to the requirements of Illinois Compiled Statutes 30 ILCS 105/25, as amended, the following reports are attached:

- FY 2021 Expenditures for Services Provided in Prior Fiscal Years (Section (e)(i)) (Attachment 1).
- Medical Services for which Claims were Received in Prior Fiscal Years (Section (e)(ii)) (Attachment 2).
- Portion of Medical Services for which Claims were Received in Prior Fiscal Years subject to Annual Caps (Section(e)(ii)) and 305 ILCS 105/25 (k)(2)(A) (Attachment 2B).
- Explanations of the causes of the variance between the previous year's estimated and actual liabilities (Section 25(g)(1)) (Attachment 3).
- Factors affecting the Department of Healthcare and Family Services liabilities, including but not limited to numbers of aid recipients, levels of medical service utilization by aid recipients, and inflation in the cost of medical services (Section 25(g)(2)) (Attachment 3).
- The results of the Department's Efforts to Combat Fraud and Abuse (Section 25(g)(3)) (Attachment 4).

If you have any questions, please contact Michael Casey, Administrator, Division of Finance at (217) 524-7480.

Sincerely,

Theresa Eagleson by MGE

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Director

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Springfield, Illinois 62763-0002

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November 30, 2021

John W. Hollman
Clerk of the House
420 Capitol Building
Springfield, IL 62706

Dear Mr. Hollman:

Pursuant to the requirements of Illinois Compiled Statutes 30 ILCS 105/25, as amended, the following reports are attached:

- FY 2021 Expenditures for Services Provided in Prior Fiscal Years (Section (e)(i)) (Attachment 1).
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- Explanations of the causes of the variance between the previous year's estimated and actual liabilities (Section 25(g)(1)) (Attachment 3).
- Factors affecting the Department of Healthcare and Family Services liabilities, including but not limited to numbers of aid recipients, levels of medical service utilization by aid recipients, and inflation in the cost of medical services (Section 25(g)(2)) (Attachment 3).
- The results of the Department's Efforts to Combat Fraud and Abuse (Section 25(g)(3)) (Attachment 4).

If you have any questions, please contact Michael Casey, Administrator, Division of Finance at (217) 524-7480.

Sincerely,

Theresa Eagleson by MC

Theresa Eagleson
Director

Attachment 1

Illinois Department of Healthcare and Family Services

FY2021 Medical Expenditures
Claims Incurred in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(i)
(In Thousands)

Physicians	$9,659.6
Optometrists	148.4
Podiatrists	66.5
Community Mental & Behavioral Health Clinics	6.3
Chiropractors	0.2
Dentists	423.7
Hospitals	235,869.3
ICG - Family Support Services	2,542.7
Prescribed Drugs	7,663.8
Long Term Care - Geriatric	35,002.6
Institutions for Mental Disease	873.0
Supportive Living Facilities	4,010.7
Community Health Centers	3,486.0
Hospice	5,753.8
Laboratories	2,613.0
Home Health Care	571.1
Division of Specialized Care for Children	26,455.2
Appliances	2,015.7
Transportation	2,030.0
Other Related Medical Services	5,564.9
Managed Care	409,571.9
MCDD	529.0
Renal	5.0
Behavioral Health Pilots	165.3
Sexual Assault Treatment	301.7
General Revenue and Related Subtotal	**$755,329.6**
University of Illinois Hospital Services Fund	$17,796.6
County Provider Trust Fund (Cook County)	21,943.2
Special Education Medicaid Matching Fund	24,530.8
Medical Interagency Program Fund (including Children's Mental Health)	729.8
TOTAL	**$820,330.1**

Illinois Department of Healthcare and Family Services

FY2021 Medical Expenditures
Claims Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(ii)
(In Thousands)

Physicians	$1,582.7
Optometrists	1.8
Podiatrists	3.3
Community Mental & Behavioral Health Clinics	0.5
Dentists	395.4
Hospitals	58,091.7
Prescribed Drugs	230.9
Community Health Centers	7.3
Hospice	210.1
Home Health Care	52.6
Division of Specialized Care for Children	1.1
Appliances	132.5
Transportation	46.7
Other Related Medical Services	2.8
Managed Care	33,341.8
Sexual Assault Treatment	41.3
General Revenue and Related Subtotal	**94,142.7**
University of Illinois Hospital Services Fund	1,007.7
Medical Interagency Program Fund (including Children's Mental Health)	5.9
TOTAL	**$95,156.4**

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

FY2021 Medical Expenditures
Claims Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(k)(2)(A)
(In Thousands)

Physicians	$1,582.7
Optometrists	1.8
Podiatrists	3.3
Community Mental & Behavioral Health Clinics	0.5
Dentists	395.4
Hospitals	51,633.3
Prescribed Drugs	230.9
Community Health Centers	7.3
Hospice	210.1
Home Health Care	52.6
Division of Specialized Care for Children	1.1
Appliances	132.5
Transportation	46.7
Other Related Medical Services	2.8
Sexual Assault Treatment	41.3
General Revenue and Related Total	**$54,342.4**

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 2020 non-adjusted Medical Assistance liabilities, received on or before June 30, 2020, that may be paid from fiscal year 2021 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately $54.3 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 2020, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be $310.8 million. After the close of the fiscal year 2021 lapse period, fiscal year 2020 actual Section 25 liabilities were $820.3 million. The main reasons for the variance are the value of issued retroactive mandated rate increases and certain hospital payments. 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 2021 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 2020, HFS provided access to full benefit health coverage for an average of approximately 2.96 million Illinoisans. Those receiving healthcare through the Department's programs included just under 1.39 million children, approximately 501,600

adults without disabilities, 262,800 adults with disabilities, 224,300 seniors and 578,500 ACA clients.

HFS' fiscal year 2021 average full benefit health coverage aggregate enrollment increased to 3.29 million. Those receiving healthcare through the Department's programs included approximately 1.47 million children, 597,900 adults without disabilities, 260,300 adults with disabilities, 248,700 seniors and 712,800 ACA clients.

During fiscal year 2021, an average of approximately 2.62 million, or about 79% of Medicaid clients were covered by one of the managed care plans.

Medical Assistance enrollment increased between fiscal years 2020 and 2021 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 expanding coverage for diabetes prevention and management programs, providing state-funded Medicaid-like coverage for immigrants who are 55-64 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, 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 new 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. COVID-19 enhanced federal Medicaid matching revenue was utilized to fund $75 million in stability payments to hospitals.

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. During fiscal year 2021, HFS distributed almost $700 million in CARES funds. The Department received $280 million in ARPA appropriations and $58.4 million in CARES reappropriations in fiscal year 2022.

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 2021 (07/01/2020 to 06/30/2021)

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

Illinois Medicaid providers are audited by OIG, OIG's external auditors, and Illinois' Managed Care Organizations (MCOs). OIG plays a role in all of these audits. First, OIG audits Fee For Service (FFS) claims submitted to the State. OIG completed 251 audits of providers. As with all OIG activities over the course of FY2021, OIG audits were impacted by the Public Health Emergency (PHE) resulting from the Covid-19 pandemic. Only desk audits were conducted during this time period; no field audits were initiated. OIG uses its Dynamic Network Analysis (DNA) system to both identify potential providers to audit and to support auditors' open projects. In FY2021, the audit bureau collected over $12.6 million in overpayments.

Second, OIG continues to strengthen its collaboration with its external audit entities—the Medicaid Integrity Contractor provided by the federal Centers for Medicare and Medicaid Services (CMS), which is currently CoventBridge Group, and Illinois' Recovery Audit Contractor required by the Affordable Care Act (ACA), which is currently HMS. OIG makes referrals and develops audit scenarios with these contractors and takes appropriate administrative action based on their findings. In FY2021, OIG collected overpayments in 397 audits completed by its Recovery Audit Contractor.

Third, OIG oversees the program integrity activities of Illinois' Medicaid MCOs. 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 FY2021, the MCO SIUs referred 385 allegations of fraud, waste, and abuse to OIG in the Illinois Medicaid program.

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). OIG is working to transition the MQRC to a remote environment. During FY2021, OIG issued Letters of Concern to seven providers; executed six corporate integrity agreements for providers in lieu of termination from the Medicaid program; and had six providers voluntarily withdraw from Medicaid.

Clients

In FY2021, 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 has prepared recommendations on 178 cases to be implemented upon the expiration of the PHE. In these cases, OIG identified applicants with $8 million in excess resources and $10.4 million in unallowable transfers. OIG also closed out 1,276 backlogged cases of which 411 had $22.0 million in unallowable transfers and 486 had $22.4 million of excess resources. Due to the PHE, HFS was unable to act on most of these findings.

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 FY2021, the Bureau completed 1,155 investigations. BOI made findings in 721 cases that led to the denial or cancellation of benefits. During that fiscal year, BOI referred six 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 $8.4 million, consisting of $6.9 million from client eligibility investigations, $655,954 in estimated overpayments and $468,210 in cost avoidance resulting from SNAP fraud investigations, and $354,614 in estimated overpayments from childcare benefit 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 FY2021, OIG had restrictions on 1,513 Medicaid customers.

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 FY2021, OIG made 19 referrals to MFCU and responded to 72 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 FY2021, OIG sanctions resulted in over $15.3 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 on-site visits to 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. Intake specialists then either send the matter for overpayment recoupment through the Bureau of Collections or forward the complaint to the Bureau of Investigations for further investigation. During FY2021, OIG received 6,636 fraud referral allegations received through phone calls, internet, email, and hard copy referrals.

Employee/Contractor Investigations

During FY2021, the OIG's Bureau of Internal Affairs investigated 524 individuals for criminal/non-criminal workplace rules violations, resulting in 40 substantiated cases. Referrals are also received from and made to the Office of the Executive Inspector General as appropriate.

The OIG fiscal year 2021 Annual Report will be available in January 2022 at:
https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx