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
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November 27, 2019

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 2019 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
Director

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Healthcare and Family Services

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Theresa Eagleson, Director

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November 27, 2019

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

Dear Mr. Hollman:

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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).
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- The results of the Department's Efforts to Combat Fraud and Abuse (Section 25(g)(3)) (Attachment 4).

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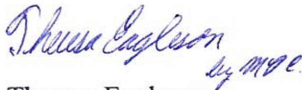

Theresa Eagleson
Director

Attachment 1

Illinois Department of Healthcare and Family Services

FY2019 Medical Expenditures

Services Provided in Prior Fiscal Years

Report Required Under 30 ILCS 105/25(e)(i)

(In Thousands)

Physicians	$18,627.2
Dentists	832.4
Optometrists	231.3
Podiatrists	57.4
Chiropractors	0.3
Hospitals	281,380.0
Prescribed Drugs	51,862.3
Long Term Care - Geriatric	68,001.6
Inst. for Mental Disease/Specialized Mental Health Rehab. Fac.	1,454.6
Supportive Living Facilities	10,213.6
Community Health Centers	2,417.2
Hospice	5,012.9
Laboratories	215.5
Home Health Care	238.2
Appliances	1,131.3
Transportation	746.6
Renal	33.1
Sexual Assault Treatment	236.1
Other Related	2,730.9
Managed Care	220,159.4
Division of Specialized Care for Children	10,855.6
Individual Care Grant	1,064.3
General Revenue and Related Subtotal	**$677,501.9**
University of Illinois - Hospital Services	$46,487.1
County Provider Trust Fund (Cook County)	3,933.7
Special Education Medicaid Matching Fund	30,831.4
Medical Interagency Program Fund (including Children's Mental Health)	1,175.6
Total	**$759,929.7**

Illinois Department of Healthcare and Family Services
FY2019 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(ii)
(In Thousands)

Physicians	$984.8
Dentists	$81.3
Optometrists	76.3
Podiatrists	3.1
Chiropractors	0.1
Hospitals	34,164.6
Prescribed Drugs	53.2
Long Term Care - Geriatric	136.7
Supportive Living Facilities	17.0
Community Health Centers	579.4
Hospice	223.2
Laboratories	3.9
Appliances	124.6
Transportation	66.4
Other Related	1,868.0
Division of Specialized Care for Children	8.7
General Revenue and Related Total	**$38,391.5**
University of Illinois - Hospital Services	$2,845.4
Medical Interagency Program Fund (including Children's Mental Health)	117.7
Total	**$41,354.7**

Illinois Department of Healthcare and Family Services

FY2019 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(k)(2)(A)
(In Thousands)

Physicians	$984.3
Dentists	81.3
Optometrists	76.3
Podiatrists	3.1
Chiropractors	0.1
Hospitals	34,085.9
Prescribed Drugs	53.2
Long Term Care - Geriatric	136.7
Supportive Living Facilities	17.0
Community Health Centers	579.4
Hospice	223.2
Laboratories	3.9
Appliances	124.5
Transportation	66.4
Other Related	1,868.0
Division of Specialized Care for Children	8.7
General Revenue and Related Total	**$38,312.2**

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 2018 non-adjusted Medical Assistance liabilities, received on or before June 30, 2018, that may be paid from fiscal year 2019 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately $38.3 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 2018, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be $681.0 million. After the close of the fiscal year 2019 lapse period, fiscal year 2018 actual Section 25 liabilities were $759.9 million, $78.9 million more than the estimate. The main reasons for the variance are the timing of processing certain hospital payments, 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 2019 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 2018, HFS provided access to full benefit health coverage for an average of approximately 3.11 million Illinoisans. Those receiving healthcare through the Department's programs included just under 1.45 million children, approximately 573,100

adults without disabilities, 257,500 adults with disabilities, just over 208,200 seniors and approximately 624,900 ACA clients.

HFS' fiscal year 2019 average full benefit health coverage aggregate enrollment declined to 2.97 million. Those receiving healthcare through the Department's programs included approximately 1.39 million children, 516,400 adults without disabilities, just over 265,100 adults with disabilities, almost 216,000 seniors and approximately 575,900 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 areas of managed care and long-term care services rebalancing.

"Managed Care" is provided through various organizations accepting full-risk capitated payments. During fiscal year 2019, an average of approximately 2.2 million, or about 73% of Medicaid clients were covered by one of the managed care plans.

HFS is also actively participating with other state agencies in efforts to transition Medical Assistance clients from institutional to community-based care as appropriate. The goal of long-term care rebalancing efforts is to shift clients from nursing homes to community-based services. Over time, moving clients out of institutional settings is expected offer appropriate quality care to clients and be a cost savings for the State, as community-based services are assumed to be less expensive.

The Department continues to work with sister state agencies to implement judicial consent decrees involving the Williams, Ligas and Colbert class action lawsuits. Those lawsuits challenged Illinois' use of institutional care for certain individuals with severe mental illness (Williams), developmental disabilities (Ligas) and those with disabilities (other than developmental disabilities) residing in skilled nursing facilities within Cook County (Colbert). Qualifying institutional residents will be offered community-based services under those consent decrees.

Under the Pritzker Administration, HFS is engaging in further efforts to improve the Medical Assistance Program. These activities include managed care enhancements, improvements to the Integrated Eligibility System (IES), addressing program eligibility application processing delays, strengthening behavioral health services, 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.

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.

Attachment 4

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 2018 (07/01/2017 to 06/30/2018)

The Office of Inspector General (OIG) for the Illinois Department of Healthcare and Family Services has authority over the entire Medical Assistance 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 $191.1 million dollars.

Providers

While determining the process for performing audits in the managed care world, OIG continued expansion of its Fee for Service (FFS) audit capabilities, completing 1,170 audits of providers, including both desk audits and traditional field audits. Some of the audits were developed using the Dynamic Network Analysis ("DNA") analytical system. Overall, the audit bureau collected over $13.5 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 2018, OIG gave 17 providers Letters of Concern; referred 3 providers for sanction; 1 provider for audit; and had 5 providers voluntarily withdraw from the system.

Clients

OIG continued its Long Term Care-Asset Discovery Investigations initiative to catch long term care applicants attempting to hide or divert assets. During fiscal year 2018, OIG completed 2,407 investigations, resulting in imposed penalty periods on 728 of those cases, providing $74.9 million in savings and $65.8 million in cost avoidance.

During FY 2018, the Bureau of Investigations (BOI) completed 824 investigations that led to the denial or cancellation of benefits for those individuals in 615 cases and 5 criminal convictions. Cost avoidance/savings on investigative matters neared $7.7 million. BOI investigations into child care matters (Temporary Assistance for Needy Families -TANF) resulted in established overpayments exceeding $106,457. OIG also performed recipient Supplemental Nutrition Assistance Program (SNAP) food stamp investigations resulting in cost avoidance/savings of $3.8 million.

OIG's Recipient Restriction Program (also called "lock-in") continued to increase capacity due to technological innovations. As of June 30, 2018, 378 clients were restricted in FFS (816 recommended to MCOs) resulting in over $2.2 million 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 2018, OIG made 31 referrals to law enforcement and provided 110 data requests for ISP-MFCU investigations.

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 2018, OIG sanctions resulted in just over $1.5 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. The Save Medicaid Access and Resources Together (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 2018, OIG received 22,438 fraud referral allegations received through phone calls, internet, email, and hard copy referrals.

Employee/Contractor Investigations

During fiscal year 2018, the OIG's Bureau of Internal Affairs investigated 520 individuals for criminal/non-criminal workplace rules violations, resulting in 18 substantiated cases. Referrals are also taken from/made to the Office of the Executive Inspector General as needed.

The OIG fiscal year 2018 Annual Report is available at:
https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx