Attachment 1

Illinois Department of Healthcare and Family Services

FY2023 Medical Expenditures
Claims for Services Rendered in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(i)
(In Thousands)

Physicians	$9,195.3
Optometrists	109.7
Podiatrists	53.0
Community Mental & Behavioral Health Clinics	6.4
Chiropractors	0.1
Behavioral Health Clinics	0.2
Dentists	707.2
Hospitals	134,143.6
Family Support Services	2,013.1
Prescribed Drugs	505.5
Long Term Care	6,607.1
Specialized Mental Health Rehabilitation Facilities	89.8
Supportive Living Facilities	3,945.0
Community Health Centers	867.7
Hospice	910.0
Laboratories	14,621.6
Home Health Care	436.7
Division of Specialized Care for Children	33,994.2
Appliances	2,814.9
Transportation	27,635.8
Other Related Medical Services	1,145.8
Managed Care	730.2
Medically Complex for the Developmentally Disabled Facilities	116.2
State Renal Program	16.6
Behavioral Health Pilots	0.6
Sexual Assault Treatment	25.2
General Revenue and Related Subtotal	**$240,691.4**
University of Illinois - Hospital Services	$9,599.9
County Provider Trust Fund (Cook County)	29,357.9
Special Education Medicaid Matching Fund	23,389.7
Medical Interagency Program Fund (including Children's Mental Health)	1,312.2
TOTAL	**$304,351.1**

Illinois Department of Healthcare and Family Services

FY2023 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(ii)
(In Thousands)

Physicians	$857.4
Optometrists	7.7
Podiatrists	5.0
Dentists	653.1
Hospitals	2,665.9
Long Term Care	574.3
Supportive Living Facilities	0.3
Community Health Centers	12.1
Home Health Care	55.2
Division of Specialized Care for Children	827.6
Appliances	194.9
Transportation	41.8
Other Related Medical Services	59.8
Managed Care	14,476.9
Sexual Assault Treatment	6.7
General Revenue and Related Subtotal	**20,438.8**
University of Illinois - Hospital Services	22.0
County Provider Trust Fund (Cook County)	376.5
Medical Interagency Program Fund (including Children's Mental Health)	37.0
TOTAL	**$20,874.2**

Illinois Department of Healthcare and Family Services

FY2023 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(k)(2)(A)
(In Thousands)

Physicians	$833.3
Optometrists	7.6
Podiatrists	5.0
Dentists	653.1
Hospitals	1,807.4
Long Term Care	574.3
Supportive Living Facilities	0.3
Community Health Centers	12.0
Home Health Care	55.2
Division of Specialized Care for Children	11.3
Appliances	192.8
Transportation	41.8
Other Related Medical Services	58.5
Sexual Assault Treatment	6.7
General Revenue and Related Total	**$4,259.3**

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 2022 non-adjusted Medical Assistance liabilities, received on or before June 30, 2022, that may be paid from fiscal year 2023 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately $4.3 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 2022, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be approximately $319.8 million. After the close of the fiscal year 2023 lapse period, fiscal year 2022 actual Section 25 liabilities were $304.4 million, or $15.4 million less than originally estimated.

   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 2022, HFS provided access to full benefit health coverage for an average of approximately 3.54 million Illinoisans. Those receiving healthcare through the Department's programs included just under 1.49 million children, approximately 696,500 adults without disabilities, 255,000 adults with disabilities, 287,600 seniors and 819,200 ACA clients.

HFS' fiscal year 2023 average full benefit health coverage aggregate enrollment increased to 3.82 million. Those receiving healthcare through the Department's programs included approximately 1.52 million children, 809,000 adults without disabilities, 250,300 adults with disabilities, 312,700 seniors and 919,700 ACA clients.

During fiscal year 2023, an average of approximately 2.98 million, or about 78% of Medicaid clients were covered by one of the managed care plans.

Medical Assistance enrollment increased between fiscal years 2022 and 2023 mainly due to the federal Families First Coronavirus Response Act which required states to maintain continuous client eligibility during the pendency of the declared public health emergency (PHE) in order to receive enhanced federal matching revenue for services provided to those with non-Affordable Care Act eligibility. No client lost coverage during the public health emergency.

With the end of the COVID-19 federal PHE in the spring of calendar year 2023, the aforementioned continuous eligibility requirement expired, and states must reinstitute regular Medicaid eligibility redeterminations. HFS will be conducting these redeterminations throughout FY24. In order to assist those enrollees deemed ineligible for Medicaid during the redetermination process, HFS will provide information regarding other options for maintaining healthcare coverage such as through their employer or getcoveredillinois.gov. The enhanced federal matching revenue associated with the COVID-19 PHE will decline on a quarterly basis through December 31, 2023.

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, launching a Program of All-Inclusive Care for the Elderly (PACE), implementing a family planning program, 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 Medicaid enrollee healthcare as well as operational and cost efficiency.

The Department is also 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 $393 million in hospital surge staffing during the worst months of COVID over FY21 and FY22.

HFS also distributed 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 was used by providers for workforce investments and to offset COVID-19 related costs as allowable under the federal acts and state statute. HFS distributed nearly $650 million in CARES funds during FY21, approximately $330 million in CARES and ARPA funds in FY22 and slightly over $277 million in ARPA funds in FY23.

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 2023 (07/01/2022 to 06/30/2023)

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 system to identify outliers, billing trends, and fraud schemes. Although audits were impacted by the Public Health Emergency (PHE) resulting from the COVID-19 pandemic, BMI completed 46 audits of providers resulting in the identification of over $2 million in overpayments.

BMI has oversight responsibility for the federally mandated Recovery Audit Contractor (RAC) and the federally authorized Unified Program Integrity Contractor (UPIC). The OIG's RAC contract with Health Management Systems (HMS), a Gainwell Technologies company, expired during FY23 and a new contract was entered with the same vendor. The OIG worked with HMS to reconcile FY22 audits while developing an improved process for future audits. In FY23, the RAC completed 239 audits resulting in the identification of over $5 million in overpayments. UPIC, operating under a Joint Operating Agreement, works both with OIG and the U.S Centers for Medicare and Medicaid Services (CMS) to identify overpayments made to providers or entities receiving federal funds under Medicaid and to determine if fraud, waste, or abuse occurred. The UPIC initiated 8 new audits with 11 already in progress. UPIC completed 2 audits with identified overpayments exceeding $230,000.

From these audits and completed audits in past years, the OIG collected over $8.5 million in overpayments in FY23.

Providers 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 FY23, OIG's Complaint Intake Unit received 1,815 referrals of fraud, waste, and abuse in the Illinois Medicaid program, of which 460 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. OIG transitioned MQRC meetings to a virtual platform to avoid further delays caused by the PHE. In FY23, the OIG conducted three virtual MQRCs. The Peer Review Unit also reviewed 44 quality of care cases which resulted in two Letters of Concern requiring immediate improvement in specific areas of practice, three Letters of Education highlighting areas of recommended improvement, 33 Letters of No Concern indicating acceptable standards of care, and four unsubstantiated allegations.

Clients

In FY23, OIG continued its Long-Term Care-Asset Discovery Investigations (LTC-ADI) initiative to identify long term care applicants attempting to hide or divert assets. During the fiscal year, the resource test for long term care applicants was suspended due to the PHE until May 12, 2023. LTC-ADI continued to review applications referred to this office to make preliminary eligibility findings. OIG was able to use these findings to determine actual eligibility at the end of the PHE when the penalties could 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 FY23, BOI transitioned investigations of SNAP recipients to the Illinois Department of Human Services, and focused more extensively on investigations of fraud, waste, and abuse by Medicaid providers. During that fiscal year, the Bureau completed 394 beneficiary fraud investigations and 92 provider fraud investigations. BOI substantiated 233 beneficiary cases and 63 provider fraud cases. During FY23, BOI referred 13 cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and there were 10 convictions based on past BOI referrals to local state's attorneys.

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 FY23, OIG reviewed 1,171 cases from which it recommended 117 recipients for lock-in. MCOs implemented 1,627 recipient restrictions in FY23.

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 MFCU. During FY23, OIG made 17 referrals to MFCU and responded to 128 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 FY23, OIG initiated 177 administrative actions against providers. Provider terminations were sought in 120 of those actions; of those 120 terminations, 16 also sought the barrment of providers' owners from the Medicaid program. Twenty-six actions were

taken to recover Medicaid funds, and two actions sought both the termination of providers and the recovery of funds.

In addition, the OIG summarily terminated 29 other providers. Twenty-six of those summary terminations were of providers whom U.S. Department of Health and Human Services excluded from the Medicare program, one of a provider based on its breach of a corporate integrity agreement, and two of providers based on their violations of OIG settlement or payment agreements.

OIG also entered nine settlement agreements, through which it recovered $363,077 from discrepant providers.

Finally, OIG imposed payment withholds against 17 providers based on credible allegations of fraud, credible evidence of fraud, or criminal charges related to the Medicaid program.

Analytics

OIG developed, with the financial assistance of CMS, the Dynamic Network Analysis 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 FY23, OIG's NPV unit conducted 930 reviews as part of Medicaid provider screening. 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 were 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 Complaint Intake Unit 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 FY23, OIG received 1,815 fraud referral allegations through phone calls, internet, email, and mail, of these 1,355 were from the public.

Employee/Contractor Investigations

During FY23, the OIG's Bureau of Internal Affairs (BIA) conducted 135 misconduct investigations and 651 background investigations. BIA's misconduct investigations resulted in 10 substantiated cases for administrative or criminal violations.

The OIG Fiscal Year 2023 Annual Report will be available in early 2024 at:
https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx