Illinois Department of Healthcare and Family Services

FY2024 Medical Expenditures
Claims for Services Rendered in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(i)
(In Thousands)

Physicians	$23,785.5
Dentists	928.2
Optometrists	76.8
Podiatrists	110.1
Chiropractors	0.6
Hospitals	147,527.8
Prescribed Drugs	11,090.2
Long Term Care	15,266.1
Specialized Mental Health Rehabilitation Facilities	52.2
Supportive Living Facilities	2,394.8
Community Health Centers	1,524.4
Hospice	1,693.5
Laboratories	9,415.7
Home Health Care	582.3
Division of Specialized Care for Children	40,780.3
Appliances	2,141.1
Transportation	12,289.3
Other Related Medical Services	1,866.5
Family Support Program	3,432.1
Medically Complex for the Developmentally Disabled Facilities	629.4
Community Mental & Behavioral Health Clinics	801.9
Pathways To Success	42.0
Childrens Mental Health	6,070.9
Managed Care	360,475.5
State Renal Program	1.3
Sexual Assault Treatment	20.8
School Based Health Services	74,979.5
General Revenue and Related Subtotal	**$717,978.8**
University of Illinois - Hospital Services	$34,556.8
County Provider Trust Fund (Cook County)	28,740.3
Special Education Medicaid Matching Fund	61,099.2
TOTAL	**$842,375.1**

Illinois Department of Healthcare and Family Services

FY2024 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(ii)
(In Thousands)

Physicians	$741.3
Dentists	864.7
Optometrists	1.8
Podiatrists	20.3
Hospitals	11,419.4
Community Health Centers	219.3
Labs	30.7
Home Health Care	104.7
Division of Specialized Care for Children	9,414.4
Appliances	71.8
Transportation	2,050.8
Community Mental & Behavioral Health Clinics	279.7
Childrens Mental Health	166.2
Sexual Assault Treatment	2.8
General Revenue and Related Subtotal	**25,387.8**
University of Illinois - Hospital Services	69.1
County Provider Trust Fund (Cook County)	3.0
TOTAL	**$25,460.0**

Illinois Department of Healthcare and Family Services

FY2024 Medical Expenditures
Claims were Received in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(k)(2)(A)
(In Thousands)

Physicians	$741.1
Dentists	864.7
Optometrists	1.8
Podiatrists	20.3
Hospitals	11,419.4
Community Health Centers	219.3
Labs	30.7
Home Health Care	104.7
Division of Specialized Care for Children	9,414.4
Appliances	71.8
Transportation	2,050.8
Community Mental & Behavioral Health Clinics	279.7
Childrens Mental Health	166.2
Sexual Assault Treatment	2.8
General Revenue and Related Total	**$25,387.6**

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 2023 non-adjusted Medical Assistance liabilities, received on or before June 30, 2023, that may be paid from fiscal year 2024 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately $25.4 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 2023, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be approximately $1.0523 billion. After the close of the fiscal year 2024 lapse period, fiscal year 2023 actual Section 25 liabilities were $842.4 million, or $209.9 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.

   In this instance, a major driver behind the variance between estimated fiscal year 2023 Section 25 liability and actual to date is the effect of outstanding Disproportionate Share Hospital (DSH) payments. Once payments are completed for a federal fiscal year, any DSH authority remaining for that federal fiscal year is held pending completion of the federally required DSH audit. Upon completion of the audit for that federal fiscal year, which normally takes multiple years to finish, any remaining amounts are generally distributed. It is anticipated the amounts reported as estimated fiscal year 2023 Section 25 liability will be distributed as the relevant audits are completed.

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 2023, HFS provided access to full benefit health coverage for an average of approximately 3.82 million Illinoisans. Those receiving healthcare through the Department's programs included just over 1.52 million children, approximately 771,800 adults without disabilities, 250,300 adults with disabilities, 299,100 seniors, 919,700 ACA clients and 50,800 individuals eligible through the Health Benefits for Immigrant Adults and Seniors Program.

HFS' fiscal year 2024 average full benefit health coverage aggregate enrollment decreased to 3.73 million. Those receiving healthcare through the Department's programs included approximately 1.53 million children, 726,300 adults without disabilities, 247,300 adults with disabilities, 304,900 seniors and 862,800 ACA clients and 66,100 individuals eligible through the Health Benefits for Immigrant Adults and Seniors Program.

During fiscal year 2024, an average of approximately 2.87 million, or about 77% of Medical Assistance clients were covered by managed care plans.

Medical Assistance enrollment decreased between fiscal years 2023 and 2024 mainly due to the reintroduction of the annual eligibility redetermination process upon expiration of the public health emergency (PHE). Eligibility redeterminations had been suspended as the federal Families First Coronavirus Response Act required states to maintain continuous client eligibility during the PHE in order to receive enhanced federal matching revenue for services provided to those with non-Affordable Care Act eligibility. The enhanced federal matching revenue associated with the PHE expired on December 31, 2023.

Illinois was one of the leading states in the nation for keeping eligible customers enrolled by maintaining 78% of those eligible through the redetermination process. HFS achieved this success largely through its comprehensive Ready to Renew campaign which utilized various means such as E-mails, text messages, billboards, Internet advertising and public service announcements to inform Medical Assistance clients of the eligibility redetermination process. The Department also assisted those enrollees deemed ineligible for Medical Assistance during the redetermination process by providing information regarding other options for maintaining healthcare coverage such as through their employer or getcoveredillinois.gov.

Under the Pritzker Administration, HFS is committed to efforts to improve the Medical Assistance Program. These activities include 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), introducing the Pathways to Success Program, implementing a family planning program, rolling out a medical debt relief program which has initially purchased $72 million in medical debt impacting over 52,000 individuals from 100 counties at a cost of only $500,000 to the state, receiving federal approval to implement an 1115 waiver to provide infrastructure focused enhancements and provider supports as well as Health Related Social Needs (HRSN) services, introducing new non-General Revenue Fund resources to support program improvements, and maximizing federal revenue. These efforts will advance Medical Assistance enrollee healthcare as well as operational and cost efficiency.

The Department is also making available an average of $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 distributed federal Coronavirus Aid, Relief and Economic Security Act (CARES), American Rescue Plan Act (ARPA) and General Revenue Fund 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 fiscal year 2021, approximately $330 million in CARES and ARPA funds in fiscal year 2022, slightly over $277 million in ARPA funds in fiscal year 2023 and over $31 million in General Revenue Fund provider support in fiscal year 2024.

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 2024 (07/01/2023 to 06/30/2024)

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 Medical Assistance 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.

Hotline/Referrals

OIG operates a toll-free hotline number and online portals to facilitate referrals for fraud, waste, and abuse from the public and managed care organizations (MCOs). 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 fiscal year 2024, OIG received 2,285 complaints through phone calls, Internet, email, and mail. From these complaints, OIG opened 353 matters and referred 741 complaints to other entities.

Provider Audits

The OIG, through its Bureau of Medicaid Integrity (BMI), conducts in-house audits of Illinois Medical Assistance providers that bill HFS directly under the traditional fee-for-service (FFS) system. BMI selects auditees based upon complaints and risk analysis, utilizing OIG's Dynamic Network Analysis system to identify outliers, billing trends, and fraud schemes. BMI completed 49 audits in fiscal year 2024. BMI also oversees external contractors that audit Medical Assistance contractors. As a result of BMI's audit activities, OIG established $36,716,759 in overpayments.

BMI has oversight responsibility for the federally mandated Recovery Audit Contractor (RAC) and the federally authorized Unified Program Integrity Contractor (UPIC). In fiscal year 2024, the RAC – Health Management Systems, a Gainwell Technologies company – completed 8,032 claim reviews identifying $33,026,327 in overpayments. The UPIC – CoventBridge – 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 Medical Assistance providers and to determine if fraud, waste, or abuse occurred. In fiscal year 2024, the UPIC initiated 13 new audits and completed 11 audits. The UPIC identified $623,057 in overpayments.

Medical Assistance providers enrolled in a MCO's network are audited by their respective MCO with OIG oversight. Each of the MCOs contracted to provide services to Illinois' Medical Assistance 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 fiscal year 2024, OIG received 671 referrals from MCO SIUs. OIG approved the MCOs' recovery of $23,041,619 in provider overpayments

established by SIU audits and investigations.

Criminal and Administrative Provider Investigations

OIG's Bureau of Investigations (BOI) investigates allegations of fraud by Medical Assistance providers. During these investigations BOI coordinates with state and federal law enforcement partners, as well as the MCO SIUs. BOI's investigations may result in administrative actions, such as monetary recoupments or terminations from the Medical Assistance program or referrals to law enforcement for criminal investigation and prosecution. In fiscal year 2024, BOI opened 240 provider investigations and completed 89 Medical Assistance cases, substantiating allegations in 57 cases. Through these investigations BOI established $26,418,144 in overpayments.

OIG referred 57 cases to the Medicaid Fraud Control Unit housed in the Office of the Illinois Attorney General after identifying credible allegations or evidence of fraud. OIG also responded to 92 law enforcement requests for data or information in support of criminal investigations related to Medical Assistance.

Provider Quality Review

OIG's Peer Review Unit monitors the quality of care and the utilization of services rendered by Medical Assistance providers. Treatment patterns of selected providers are reviewed to determine if medical care provided is grossly inferior, potentially harmful or in excess of needs. In fiscal year 2024, the Peer Review Unit reviewed 26 cases which resulted in four letters of concern, one audit referral, one referral for termination from the program, and five referrals to the Medical Quality Review Committee (MQRC). The MQRC is a panel of the provider's peers, who further evaluate the quality of their care. In fiscal year 2024, the OIG conducted five MQRCs, resulting in three letters of concern, one letter of no concern, and one denial of reinstatement to the Medical Assistance program.

Medical Assistance Applicants and Recipients

In fiscal year 2024, OIG continued its Long-Term Care-Asset Discovery Initiative (LTC-ADI) to identify long term care applicants attempting to hide or divert assets. Through these reviews LTC-ADI identified $34,722,690 in unallowable transfers, $24,843,291 in excess resources, and established $45,156,753 in cost avoidance due to withdrawn applications. LTC-ADI's total cost savings for fiscal year 2024 was $104,722,734.

During fiscal year 2024, BOI completed 210 recipient fraud investigations from which it substantiated 90 Medical Assistance fraud cases. BOI established $1,133,772 in recipient overpayments.

OIG's Recipient Restriction Program seeks to detect and prevent abuse of medical and pharmaceutical benefits by restricting Medical Assistance 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 fiscal year 2024, OIG reviewed 811 cases from which it recommended 67 recipients for lock-in. MCOs implemented 1,589 recipient restrictions in fiscal year 2024, resulting in $18,097,659 in cost avoidance.

Sanctions

OIG attorneys represent the State's interests in administrative hearings against Illinois Medical Assistance providers. OIG initiates sanctions, including terminations or suspensions of Medical Assistance providers, recoupment of overpayments, appeals of recoveries, application denials, implementation of integrity agreements, payment withholds, imposition of civil remedies and monetary penalties, debarment, and joint hearings with the Department of Public Health to de-certify long-term care facilities.

During fiscal year 2024, OIG initiated 154 administrative actions against providers. OIG sought provider termination in 102 actions, overpayment recovery in 28 actions, exclusion from the program in 6 actions, and denial of provider enrollment applications in 9 actions. In addition, the OIG summarily terminated and excluded 9 other providers based on actions by the U.S. Department of Health and Human Services or as the result of a breach of a settlement or payment agreement. OIG also entered 5 settlement agreements, through which it recovered $992,292 from providers. Finally, OIG imposed payment withholds against 14 providers based on credible allegations of fraud, credible evidence of fraud, or criminal charges related to the Medical Assistance 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)

The OIG is tasked with federally required enhanced screening of new providers and the revalidation of existing providers. These processes require OIG to perform background checks, fingerprint checks and compliance reviews of high-risk provider types. OIG also performs on-site reviews of some high and medium-risk providers. During fiscal year 2024, OIG's NPV unit conducted 1,733 application, modification, and revalidation reviews and performed 530 on-site reviews as part of Medical Assistance provider screening. During providers' one-year conditional enrollment, OIG reviews the quality of new providers' billings for any evidence of fraud, waste, or abuse, which may result in disenrollment or termination.

Employee/Contractor Investigations

During fiscal year 2024, the OIG's Bureau of Internal Affairs (BIA) conducted 107 misconduct investigations and 492 background investigations. BIA's misconduct investigations resulted in 12 substantiated cases for administrative or criminal violations, leading to 8 resignations or terminations.

The OIG's Fiscal Year 2024 Annual Report with greater detail on all its activities is available at: https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx