

Illinois Department of Healthcare and Family Services

FY2016 Medical Expenditures
 Services Provided in Prior Fiscal Years
 Report Required Under 30 ILCS 105/25(e)(i)
 (In Thousands)

Physicians	\$19,531.2
Dentists	4,801.7
Optometrists	474.8
Podiatrists	67.5
Chiropractors	3.9
Hospitals	227,898.4
Institutions for Mental Disease	127.4
Supportive Living Facilities	2,785.3
Long Term Care - Geriatric	19,475.2
Community Health Centers	2,348.9
Hospice	6,037.9
Laboratories	782.7
Home Health Care	867.3
Appliances	1,637.1
Transportation	1,180.4
Renal	26.5
Hemophilia Services	8.7
Sexual Assault Treatment	9.1
Prescribed Drugs	944.4
Other Related	3,261.5
Managed Care	5,195.3
Division of Specialized Care for Children	<u>2,703.7</u>
General Revenue and Related Subtotal	\$300,168.9
University of Illinois - Hospital Services	\$35,946.6
County Provider Trust Fund (Cook County)	42,962.3
Special Education Medicaid Matching Fund	25,843.6
Medical Interagency Program Fund (including Children's Mental Health)	<u>13,326.8</u>
TOTAL	\$418,248.1

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 2015 Medical Assistance liabilities, received on or before June 30, 2015, that may be paid from fiscal year 2016 appropriations (or court-ordered spending authority) to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at about \$5.1 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 (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.

Absent a fully enacted state budget, HFS processed Medical Assistance payments under authority of court order during fiscal year 2016. For purposes of calculating the actual fiscal year 2015 Section 25 liability contained in this report, the Department is including spending for prior year services from the court-ordered spending authority as well as from enacted fiscal year 2016 appropriations.

At the end of fiscal year 2015, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be \$417.0 million. After the close of fiscal year 2016, fiscal year 2015 actual Section 25 liabilities were \$418.2 million, a \$1.2 million, or 0.3%, variance compared to the estimate.

HFS' Section 25 liabilities have been greatly reduced in recent years. That improvement can be attributed to sufficient fiscal year appropriations/court-ordered spending authority (which had not always been provided in the past) as well as the transition to capitated coordinated care programs and Section 25 caps contained in the Save Medicaid Access and Resources Together (SMART) Act package of legislative actions.

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. The application of retroactive payment adjustments, the scope of which were not known when the Section 25 estimates were calculated over one year prior to this report, may also impact the variance compared to the original estimate.

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. HFS' fiscal year 2015 General Revenue and related fund Medicaid program liability increased by \$1.714 billion, or 16.1% compared to fiscal year 2014. The increase was mainly driven by the continued enrollment of 100% federally-funded Affordable Care Act (ACA) Medicaid clients as well as by programmatic expansions and reimbursement adjustments resulting from Public Act 98-651 (Senate Bill 741). Absent those major cost drivers, fiscal year 2015 Medicaid enrollment would have been relatively flat and liability would have increased by about \$84 million, or less than 1%.

In fiscal year 2015, HFS provided access to full benefit health coverage for an average of approximately 3.2 million Illinoisans. Those receiving healthcare through the Department's programs included just over 1.5 million children, 644,300 adults without disabilities, approximately 251,100 adults with disabilities, about 192,500 seniors and nearly 586,600 ACA clients.

HFS' fiscal year 2016 average full benefit health coverage aggregate enrollment remained essentially flat at 3.2 million. Those receiving healthcare through the Department's programs included over 1.5 million children, about 617,600 adults without disabilities, nearly 236,600 adults with disabilities, just over 194,500 seniors and approximately 655,100 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 coordinated care management and long-term care services rebalancing.

"Care coordination" is provided through traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments and Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments. To date, approximately 2.1 million, or about 66% of Medicaid clients are currently covered by one of the coordinated care options.

HFS is also actively participating with other state agencies in efforts to transition Medical Assistance clients from institutional to community-based care as appropriate. For instance, HFS was awarded enhanced federal match funding from both the Balancing Incentive Program (BIP) and Money Follows the Person (MFP) demonstration project. BIP and MFP both encourage states to shift the provision of long-term care services between institutional and community settings through the use of enhanced federal matching dollars on state expenditures for rebalancing efforts. The programs' goal, as with other 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 to 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). Over the next few years, several thousand institutional residents will need to be offered community-based services under those consent decrees.

As long-term care services are rebalanced under BIP, MFP, the consent decrees or other initiatives, financial resources will shift from institutional services (nursing homes) to community programs.

Care coordination and long-term care services rebalancing efforts are consistent with the State's Health and Human Services Transformation that places a focus on prevention and public health, pays for value and outcomes rather than volume and services, makes evidence-based and data driven decisions, and moves individuals from institutions to community care to keep them more closely connected with their families and communities.

Beyond care coordination and long-term care services rebalancing, the initial focus of the Transformation effort is on behavioral health (mental health and substance abuse) and specifically the integration of behavioral and physical health service delivery. Building a nation-leading behavioral health strategy will not only help bend Illinois' healthcare cost curve, but also help turn the tide of the opioid epidemic, reduce violent crime and improve maternal and child health.

A major component of the behavioral health transformation strategy is the 1115 Medicaid waiver HFS recently filed with the federal Centers for Medicare and Medicaid Services. The benefits in the 1115 waiver are critical elements in supporting fully integrated behavioral and physical health homes, which will be most effective when they have the right core, preventative, supportive behavioral health services with which to integrate.

HFS believes that rebalancing behavioral health services and the integration of physical and behavioral healthcare will produce significant savings to the Medicaid program. The Waiver essentially asks the federal government to allow Illinois to reinvest the resulting savings (including portions attributable to federal funding) into improvements in the behavioral healthcare system. Between the Waiver and various related State Medicaid Plan Amendments (SPAs), HFS expects to draw down \$2.7 billion in federal funding over five years to support behavioral healthcare transformation in Illinois.

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.

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 2015 (07/01/2014 to 06/30/2015)

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 and the Department on Aging. OIG implemented a comprehensive program integrity work plan, which included an aggressive regulatory framework, expansion of audits, investigations and quality of care reviews. This work plan resulted in cost savings, cost avoidance and recoupsments of over \$204 million dollars.

Providers

OIG continued expansion of its audit capabilities, completing 403 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 \$22 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 2015, OIG gave 22 providers Letters of Concern; referred 5 providers for sanction; 3 providers for audit; and had 4 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 2015, OIG completed 3,544 investigations, resulting in imposed penalty periods on 762 of those cases, providing \$68 million in savings and \$83 million in cost avoidance.

OIG has also expanded and developed its Bureau of Investigations (BOI) in an attempt to increase the number of investigators available to identify and fight fraud, waste and abuse in the Medicaid system. The Bureau investigated 934 Medicaid cases that led to the denial or cancellation of benefits for those individuals found ineligible. Cost avoidance/savings on investigative matters exceeded \$8 million. OIG also performed recipient Supplemental Nutrition Assistance Program (SNAP) food stamp investigations resulting in cost avoidance/savings of \$8 million.

OIG's Recipient Restriction Program (also called "lock-in" programs) continued to increase capacity due to technological innovations. As of June 30, 2015, 1,924 clients were restricted, resulting in over \$6.9 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 2015, OIG made 87 referrals to law enforcement and provided 63 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 2015, OIG sanctions resulted in over \$4 million in cost avoidance.

Analytics

OIG continues to be a nationwide leader 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. Those processes require the OIG to perform background checks, fingerprint checks and on-site visits to high risk providers. 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. Those 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 2015, OIG received over 7,000 calls in alleged fraudulent recipient activities.

Employee/Contractor Investigations

During fiscal year 2015, the OIG's Bureau of Internal Affairs investigated 318 individuals for criminal/non-criminal workplace rules violations, resulting in 34 substantiated cases. Referrals were also taken from/made to the Office of the Executive Inspector General as needed.

The OIG fiscal year 2015 Annual Report is available at:
<https://www.illinois.gov/hfs/oig/Pages/AnnualReports.asp>

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November 30, 2016

Timothy D. Mapes
Clerk of the House
300 Capitol Building
Springfield, IL 62706

Dear Mr. Mapes:

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

- FY 2016 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,

Felicia F. Norwood
Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

November 30, 2016

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

Dear Secretary Anderson:

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

Sincerely,

Felicia F. Norwood
Director