

**Illinois Department of Healthcare and Family Services**  
**FY2013 Medical Expenditures**  
**For Services Provided in Prior Fiscal Years**  
**Report Required Under 30 ILCS 105/25(e)(i)**  
**(In thousands)**

Physicians	\$138,294.4
Optometrists	3,233.9
Podiatrists	862.8
Chiropractors	231.1
Inpatient/Outpatient	1,484,047.4
Prescribed Drugs	105,643.5
Long Term Care - Geriatric	275,323.5
Institutions for Mental Disease	28,013.2
Supportive Living Facilities	37,664.6
Community Health Centers	18,744.0
Hospice	31,361.4
Laboratories	17,008.4
Home Health Care	23,268.7
Division of Specialized Care for Children	3,300.5
Appliances	22,634.3
Transportation	17,411.0
Other Related	8,937.7
Managed Care	11,099.8
Renal	126.4
Hemophilia Services	1,355.6
Sexual Assault Treatment	271.5
<b>General Revenue and Related Subtotal</b>	<b>\$2,228,833.6</b>
University of Illinois - Hospital Services	36,597.7
County Provider Trust Fund (Cook County)	104,319.9
Special Education Medicaid Matching Fund	40,899.9
Medical Interagency Program Fund (including Children's Mental Health)	6,150.8
Electronic Health Record Incentive Fund	145,034.8
<b>TOTAL</b>	<b>\$2,561,836.7</b>

The annual Section 25 caps, related to unpaid GRF and related fund bills at June 30, found in 30 ILCS 105/25 (k) do not apply to the date reported herein. Those annual limitations are effective for fiscal year 2013 and subsequent years' HFS Medical Assistance liability paid from future year GRF and related fund appropriations. The Section 25 report due on November 30, 2014, reflecting fiscal year 2013 and prior liabilities paid from fiscal year 2014 appropriations, will be the first report reflecting the new Section 25 caps.

**Illinois Department of Healthcare and Family Services**  
**FY 2013 Medical Expenditures**  
**Claims were Received in Prior Fiscal Years**  
**Report Required Under 20 ILCS 105/25(e)(i)**  
**(In Thousands)**

Physicians	\$36,575.8
Optometrists	1,076.1
Podiatrists	156.3
Chiropractors	55.6
Inpatient/Outpatient	839,725.0
Prescribed Drugs	81,864.1
Long Term Care - Geriatric	79,954.9
Institutions for Mental Disease	15,173.7
Supportive Living Facilities	20,573.2
Community Health Centers	7,532.2
Hospice	8,523.5
Laboratories	10,824.0
Home Health Care	8,503.7
Appliances	3,562.7
Transportation	7,028.0
Other Related	289.0
Managed Care	626.2
Renal	1.4
Hemophilia Services	270.1
Sexual Assault Treatment	161.9
<b>General Revenue and Related Subtotal</b>	<b>\$1,122,477.3</b>
University of Illinois - Hospital Services	38.8
County Provider Trust Fund (Cook County)	3,208.8
Special Education Medicaid Matching Fund	15,837.6
Medical Interagency Program Fund (including Children's Mental Health)	353.5
Electronic Health Record Incentive Fund	38,467.9
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<b>TOTAL</b>	<b>\$1,180,383.9</b>

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**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 that newly imposed Section 25 unpaid bill deferral caps, found in 30 ILCS 105/25 (k), are not effective this reporting period. The impact of those changes on the Department of Healthcare and Family Services' (HFS) Medical Assistance annual Section 25 liability will not be reflected until the report of fiscal year 2014 spending for services rendered in prior fiscal years. That report is statutorily required to be filed by November 30, 2014.

At the end of fiscal year 2012, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be \$2.224 billion. After the close of fiscal year 2013, fiscal year 2012 actual Section 25 liabilities were \$2.562 billion. The fiscal year 2012 actual amount represents an almost \$1.7 billion increase over the program's fiscal year 2011 Section 25 liability as reported in last year's report of spending for services rendered in prior fiscal years (Section 25 report).

The difference between estimated and actual liabilities can be attributed to a variety of factors, including the use of historic trends between service dates and provider claim submittal dates. While these 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.

The significant increase in Section 25 liability experienced for fiscal year 2012 was due mainly to the State's under-budgeting of the Department's liabilities. Fiscal year 2012's enacted budget, passed by the General Assembly, was over \$1 billion less than the Governor's request. That budgetary reduction was not accompanied by a comparable change to the underlying Medical Assistance statutory program requirements. The increase in unpaid Medical Assistance bills during fiscal year 2012 provided a major impetus for the program modifications and additional dedicated revenue sources contained in the Saving Medicaid Access and Resources Together (SMART) Act package of legislation enacted to close a projected \$2.7 billion shortfall in the fiscal year 2013 budget.

## **2. Factors relating to HFS medical liability.**

HFS continues to improve client access to quality healthcare and institute cost control measures to support management of its annual Section 25 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. Due to cost control efforts and slower enrollment growth, HFS' fiscal year 2012 General Revenue and related fund Medicaid program liability experienced little change compared to fiscal year 2011.

In fiscal year 2012, HFS provided access to full benefit health coverage for an average of approximately 2.8 million Illinoisans. Those receiving healthcare through the Department's programs included almost 1.7 million children, about 644,000 adults without disabilities, approximately 265,200 adults with disabilities and nearly 175,000 seniors. The aggregate average enrollment grew by about 2.6% compared to fiscal year 2011.

HFS' fiscal year 2013 average full benefit health coverage aggregate enrollment was essentially unchanged at approximately 2.8 million Illinoisans. Those receiving healthcare through the Department's programs included almost 1.7 million children, about 657,000 adults without disabilities, nearly 266,400 adults with disabilities and approximately 180,500 seniors.

Even with relatively unchanged liability and small enrollment growth in fiscal year 2012, HFS experienced a large growth in Section 25 liability mainly related to the budgetary underfunding noted in the response to question #1. That increase in deferred bills encouraged the SMART Act legislative package designed to close an estimated \$2.7 billion Medical Assistance funding shortfall in the fiscal year 2013 budget.

In addition to implementing the SMART Act's eligibility, optional service, reimbursement and program utilization changes, HFS is working to improve health outcomes and the cost effectiveness of the Medical Assistance Program through other strategies. For example, recent Medicaid Reform efforts require advances in the area of coordinated care management. HFS is currently planning to meet the requirement that 50% of (or approximately 1.5 million) Medical Assistance clients be enrolled in a coordinated care program by January 1, 2015. Actually, it is the Department's goal to have 60% of our clients in care coordination by the 2015 deadline.

In Illinois, "care coordination" will be provided through various strategies: traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments; Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; and

Care Coordination Entities/Accountable Care Entities (CCE/ACE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis (ACEs are planned to convert to risk-based capitated payments after 18 months of operation).

HFS is 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 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 funded by the Department of Human Services (DHS) and the Department on Aging. 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 is also working with sister state agencies to implement judicial consent decrees involving the Williams, Ligas and Colbert class action lawsuits. These 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 nursing home residents will need to be offered community-based services under these consent decrees.

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

HFS is also collaborating with providers and other stakeholders to redesign reimbursement systems for hospitals and nursing homes. In large part, current reimbursement structures reflect historical service levels and do not reflect changes in acuity levels or service needs. Reimbursement reform is critical to the success of the Department's coordinated care efforts in that cost savings will result from coordinating the care of high-cost clients if hospital payments are more aligned with acuity and services provided.

The Department's efforts at improving both the health outcomes of Medical Assistance clients and the program's cost-effectiveness, combined with the recently enacted unpaid bill deferral limitations in the State Finance Act, should allow for lower 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 FY2013 (7/1/12 to 6/30/13)

**Providers**

The HFS Office of the Inspector General (OIG) established approximately \$32.8 million dollars as a result of its program integrity efforts for FY2013. These efforts include the completion of 687 provider audits through the audit administrative process for FY2013 and restitution through 10 criminal judgments. Also during FY2013, the Department collected approximately \$47.1 million from established overpayments determined by audits completed during or prior to FY2013 and global settlements.

FY13 Collected		FY13 Established		# Est.
Fraud & Abuse	\$ 8,434,876.82	Fraud & Abuse	\$ 32,482,011.89	687
Restitution	\$ 229,455.88	Restitutions	\$ 364,273.92	10
Global Settlements	\$ 38,478,704.58			
	<b>\$ 47,143,037.28</b>		<b>\$ 32,846,285.81</b>	

OIG audits review the billing practices of specific providers enrolled in the Medical Assistance Program. Providers audited included individual practitioners, hospitals, nursing homes, pharmacies, laboratories, transportation entities and other provider types.

In FY2013, 161 medical providers were referred to the Medicaid Fraud Control Unit for investigation, 36 medical providers were terminated and 1 medical provider was suspended from the program due to the Department's program integrity efforts.

**Clients**

During FY2013, the Recipient Restriction Program restricted 671 clients who over utilized their medical privileges. Each client (339 for 12 months, 332 for 24 months) were restricted to a primary care physician and/or pharmacy. Cost avoidance savings for the clients' locked-in through the program for FY2013 was \$6,000,963.

**Employee/Provider Investigations**

During FY2013, 2 complaints involving employee, provider or contractor fraud and abuse in the Medicaid Program were reviewed. One case was referred due to a jurisdictional issue and the other case remains under investigation.