

Illinois Department of Healthcare and Family Services

Attachment 1

FY2025 Medical Expenditures
Claims for Services Rendered in Prior Fiscal Years
Report Required Under 30 ILCS 105/25(e)(i)
(In Thousands)

Physicians	\$22,001.3
Dentists	823.5
Optometrists	111.2
Podiatrists	53.6
Chiropractors	1.7
Hospitals	188,160.8
Prescribed Drugs	87,385.4
Long Term Care	38,632.8
Specialized Mental Health Rehabilitation Facilities	1,369.7
Supportive Living Facilities	1,574.2
Community Health Centers	3,425.5
Hospice	2,174.7
Laboratories	3,319.2
Home Health Care	989.3
Division of Specialized Care for Children	26,648.6
Appliances	3,349.3
Transportation	13,972.3
Other Related Medical Services	1,750.2
Family Support Program	2,475.8
Medically Complex for the Developmentally Disabled Facilities	9,339.4
Community Mental & Behavioral Health Clinics	4,097.1
Pathways To Success	56.8
Childrens Mental Health	5,744.0
Managed Care	420,874.0
State Renal Program	7.9
Sexual Assault Treatment	90.6

General Revenue and Related Subtotal **\$838,428.8**

University of Illinois - Hospital Services	\$25,110.5
Special Education Medicaid Matching Fund	156,458.6

TOTAL **\$1,019,997.9**

Illinois Department of Healthcare and Family Services

Attachment 2

FY2025 Medical Expenditures

Claims were Received in Prior Fiscal Years

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

(In Thousands)

Physicians	\$2,298.0
Dentists	773.6
Optometrists	11.8
Podiatrists	1.2
Hospitals	30,360.9
Community Health Centers	419.9
Laboratories	592.9
Home Health Care	89.1
Division of Specialized Care for Children	10,863.3
Appliances	530.4
Transportation	1,937.4
Other Related Medical Services	323.1
Community Mental & Behavioral Health Clinics	11.7
Childrens Mental Health	105.7
Sexual Assault Treatment	7.0

General Revenue and Related Subtotal	\$48,326.0
---	-------------------

University of Illinois - Hospital Services	\$237.2
Special Education Medicaid Matching Fund	30,566.8

TOTAL	\$79,130.0
--------------	-------------------

Illinois Department of Healthcare and Family Services

Attachment 2B

FY2025 Medical Expenditures

Claims were Received in Prior Fiscal Years

Report Required Under 30 ILCS 105/25(k)(2)(A)

(In Thousands)

Physicians	\$2,297.8
Dentists	773.6
Optometrists	11.8
Podiatrists	1.2
Hospitals	30,360.9
Community Health Centers	419.9
Laboratories	592.9
Home Health Care	89.1
Division of Specialized Care for Children	5,599.3
Appliances	530.4
Transportation	1,937.4
Other Related Medical Services	323.1
Community Mental & Behavioral Health Clinics	11.7
Childrens Mental Health	105.7
Sexual Assault Treatment	7.0

General Revenue and Related Total**\$43,061.8**

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 2024 non-adjusted Medical Assistance liabilities, received on or before June 30, 2024, that may be paid from fiscal year 2025 appropriations to the General Revenue and related funds. As is reflected in attachment 2B, HFS is well under that cap, at approximately \$43.1 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 (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 2024, HFS' all funds Medical Assistance Section 25 liabilities were estimated to be approximately \$1.292 billion. After the close of the fiscal year 2025 lapse period, fiscal year 2024 actual Section 25 liabilities were \$1.020 billion, or \$272.1 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 2024 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 2024 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 2024, HFS provided access to full benefit health coverage for an average of approximately 3.734 million Illinoisans. Those receiving healthcare through the Department's programs included just over 1.527 million children, approximately 726,300 adults without disabilities, 247,300 adults with disabilities, 305,000 seniors, 862,800 ACA clients and 66,100 individuals eligible through the Health Benefits for Immigrant Adults and Seniors Program.

HFS' fiscal year 2025 average full benefit health coverage aggregate enrollment decreased to 3.314 million. Those receiving healthcare through the Department's programs included approximately 1.466 million children, 544,100 adults without disabilities, 227,100 adults with disabilities, 283,200 seniors, 750,500 ACA clients and 42,800 individuals eligible through the Health Benefits for Immigrant Adults and Seniors Program. Health Benefits for Immigrant Adults eligibility sunset on June 30, 2025.

During fiscal year 2025, an average of approximately 2.55 million, or about 77% of Medical Assistance clients were covered by managed care plans.

Medical Assistance average enrollment decreased between fiscal years 2024 and 2025 mainly due to the annualization effect of the reintroduced 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. Illinois completed the reintroduced eligibility redeterminations in May 2024, so fiscal year 2025 average enrollment numbers reflected a full 12-month annualized decline impact.

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 improving the Medical Assistance Program. Recent activities include federal approval of an enhanced hospital assessment program which carries an additional \$2 billion in payments to hospitals, launching a Program of All-Inclusive Care for the Elderly (PACE), introducing the Pathways to Success Program, implementing and expanding the Certified Community Behavioral Health Clinic program, rolling out a medical debt relief program which, to date, has alleviated more than \$430.6 million in medical debt for 358,686 beneficiaries across the state, implementing a federally approved 1115 waiver to provide infrastructure focused enhancements and provider supports as well as Health Related Social Needs (HRSN) services and working with Get Covered Illinois to develop a state-based marketplace that will allow for more integration between Medical Assistance and the

marketplace, ensuring that Illinoisans are more easily connected with the coverage that best fits their needs. These efforts will advance Medical Assistance enrollee healthcare as well as operational and cost efficiency.

The Department is 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 has been successful in securing federal grant funding aimed at improving the health of Medical Assistance clients. The Department has been accepted recently into both the Cell Gene Therapy (CGT) Access Model and the Transforming Maternal Health (TMAH) Model. The CGT Access Model is an agreement among states and drug manufacturers to increase Medical Assistance customers' access to emerging treatments. Illinois will receive up to \$9.5 million in federal dollars over the course of a decade to support implementation, with the goal of directly resolving documented barriers to care. TMAH will bring \$17 million in new federal funding over a decade to pilot a more comprehensive and integrated model of care aimed at improving maternal health outcomes in the pilot communities.

In response to recent federal action in House Resolution 1, HFS has applied to participate in the Rural Provider Relief Fund (RPRF). The RPRF creates a temporary, five-year pool of federal funding to support Medicaid providers in rural communities. The fund is intended to stabilize providers facing unique financial challenges in low volume and underserved areas to support continued access to care for rural Medical Assistance beneficiaries. Approved states may expect up \$200 million in annual funding beginning in calendar 2026.

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 2025 (07/01/2024 to 06/30/2025)

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 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 2025, OIG received 1,966 complaints through phone calls, internet, email, and mail. During the year, OIG opened 325 matters and referred 247 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 45 audits in fiscal year 2025. BMI also oversees external contractors that audit Medical Assistance contractors. As a result of BMI's audit activities, OIG established approximately \$82 million 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 2025, the RAC completed complex claim reviews identifying nearly \$76 million in overpayments. The UPIC works both with OIG and the U.S Centers for Medicare and Medicaid Services (CMS) to identify overpayments made to Medical Assistance providers and determine if fraud, waste, or abuse occurred. In fiscal year 2025, the UPIC initiated 21 new audits and completed 10 audits. The UPIC identified \$306,000 in overpayments.

Medical Assistance providers enrolled in an 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 2025, OIG received 598 referrals from MCO SIUs. OIG approved the MCOs' recovery of nearly \$69 million 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 2025, BOI completed 220 Medical Assistance provider investigations, substantiating allegations in 103 cases. Through these investigations BOI established almost \$56 million in overpayments.

OIG referred 82 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 176 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 2025, the Peer Review Unit reviewed 27 cases which resulted in two letters of education, one letter of concern, two audit referrals, and twelve letters of no concern.

Medical Assistance Applicants and Recipients

In fiscal year 2025, 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 nearly \$44 million in unallowable transfers, almost \$28 in excess resources, and established approximately \$48 million in cost avoidance due to withdrawn applications. LTC-ADI's total cost savings for fiscal year 2025 approached \$120 million.

During fiscal year 2025, BOI completed 57 recipient fraud investigations from which it substantiated 43 allegations. BOI established over \$316,000 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 2025, OIG reviewed 1,650 cases from which it recommended 108 recipients for lock-in to the MCOs and implemented eight restrictions for fee for service. MCOs implemented 1,451 recipient restrictions in fiscal year 2025, resulting in nearly \$12 million 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 2025, OIG initiated 229 administrative actions against providers. OIG sought provider termination in 153 actions, overpayment recovery in 26 actions, exclusion from the program in 35 actions, and denial of provider enrollment applications in seven actions. In addition, the OIG summarily terminated and excluded eight 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 eight settlement agreements, through which it recovered approximately \$638,000 from providers. Finally, OIG imposed payment withholds against 31 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 federal 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 2025, OIG's NPV unit conducted 2,394 application, modification, and revalidation reviews and performed 444 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 2025, the OIG's Bureau of Internal Affairs (BIA) received 105 misconduct investigations. BIA referred 59 matters, unsubstantiated 16, administratively closed one and substantiated one.

The OIG's fiscal year 2025 Annual Report with greater detail on all its activities will be available at: <https://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx>