

**Office of Inspector General
Illinois Department of Public Aid
Annual Report for 1999**



George H. Ryan
Governor

Robb Miller
Inspector General



Office of Inspector General Illinois Department of Public Aid

400 North 5th Street
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January 31, 2000

To the Honorable George Ryan, Governor, and Members of the General Assembly:

I am pleased to present to you my annual report for calendar year 1999. It also reflects the OIG's accomplishments over its first five years.

Pursuant to Public Act 88-554, this report provides information on payments to medical providers at various earning levels, audits of medical providers, savings generated by the prescription Refill Too Soon program, sanctions against providers and other investigations.

This report includes, in narrative form, several individual activities the Office undertook or participated in that you may find of interest. I hope you find the report useful.

Sincerely,

Robb Miller, CFE
Inspector General

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**Illinois Department of Public Aid
Office of Inspector General
1999 Annual Report**

OIG BACKGROUND

Introduction

The Office of Inspector General (OIG) for the Illinois Department of Public Aid (DPA) recently commemorated its fifth anniversary. In 1994, the General Assembly mandated the Inspector General (IG) to “prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct” in programs administered by DPA. On the occasion of that anniversary, this annual report documents the office’s significant activities since its inception and accomplishments during calendar year 1999.

Duties

The OIG helps enforce policies and investigates misconduct in the Medicaid, food stamp and welfare programs and other programs administered by the Departments of Public Aid and Human Services. Every year the office conducts thousands of investigations, reviews and examinations directed at the prevention, detection and elimination of fraud and abuse. The activities include: audits, physician quality of care reviews, Medicaid quality control reviews, internal investigations of staff and contractors, fraud prevention research, welfare fraud investigations, Medicaid provider sanctions, restrictions on recipients abusing Medicaid privileges, physical security of staff and facilities and special projects aimed at specific problems.

The OIG uses the collective experiences of its investigations, audits and reviews to develop prevention strategies. The office conducts numerous research projects and studies issues affecting the fiscal integrity of the programs it monitors. The single most important such effort was conducted with OIG’s frequent partner, the Division of Medical Programs (DMP). In 1998, the department released the nation’s first statistically valid study of the accuracy of payments in the Medicaid program, the Payment Accuracy Review (PAR). The project’s findings have provided significant guidance to continuing fraud prevention work.

Many OIG responsibilities are also linked to the Department of Human Services (DHS). Even though the responsibility for administering welfare and food stamp programs went to DHS in 1997, the office continues to investigate fraud and employee/vendor misconduct in those programs. Until fall 1998, the OIG also conducted food stamp quality control reviews for DHS.

The OIG cannot prevent fraud and abuse alone. The responsibility is shared by the office and program staffs at DPA and DHS. Through joint workgroups at various levels, improvements have been made in many programs monitored by the OIG.

National Perspective

Various OIG employees have contributed to a better understanding of program integrity issues on a national level. The office is a charter member of the Association of Inspectors General, a national organization supporting the work of IG’s at the state and local levels. The office is also part of the Health Care Finance Administrations’s (HCFA) Medicaid Fraud and Abuse Technical Advisory Group (TAG). Through the TAG, OIG employees have provided guidance to HCFA’s national fraud efforts while learning from counterparts around the country. In 1996, the OIG was invited to HCFA headquarters to help brief central office staff on

fraud vulnerabilities in Medicaid managed care. The OIG also has been involved with the National Association for Program Information and Performance Measurement, the United Council on Welfare Fraud and the National Welfare Fraud Directors Association.

Staffing

The OIG has an authorized staff of 311 employees -- investigators, accountants, nurses, attorneys, data analysts, quality control reviewers, fraud researchers, information technologists and a professional complement of administrative support staff. Although the office is the smallest of DPA's divisions, it represents more than 10% of DPA's total workforce. This level of staffing demonstrates the department's commitment to effective program integrity.

OIG staffing is more than 10% of the DPA workforce, demonstrating the commitment to effective program integrity.

Independence

The position of IG is unique in state government because the IG operates within DPA but reports to the Governor and is subject to confirmation by the Senate. Despite the potential tension such a situation could engender, the department consistently demonstrates its willingness to work with the OIG. Every DPA Director has been supportive of the IG's independence. Conversely, the IG has worked hard to maintain good communications with the DPA Director and executive staff.

It is critical that the OIG never lose sight of the DPA's primary mission: to provide medical and financial assistance to the state's most vulnerable citizens. Program integrity should always be measured against that yardstick. Successfully balancing access and service against program integrity requires the commitment of the entire DPA.

Arguably, the OIG's most daunting challenge is to work effectively with program staff to identify and correct problems without losing the independence required for its oversight responsibilities. It would probably be easier to restrict our role to monitoring program activities and documenting errors and problems. Assuming that narrow role, however, flies in the face of the OIG's commitment to *prevent* fraud and abuse. The office must continue to seek the proper balance of its roles for the long-term fiscal integrity of the human service programs within its jurisdiction.

PREVENTION INITIATIVES

Measuring Payment Accuracy

The completion of Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement marked a historic step for the department. For the first time in the country, a Medicaid program measured payment accuracy in its fee-for-service program. The DPA's leadership agreed it was critical to establish an empirical baseline against which future anti-fraud initiatives could be measured.

The study determined that the department correctly spends 95.28%, plus or minus 2.31%, of the dollars paid to providers. An estimated \$113 million in misspent Medicaid funds is still unacceptable. Nonetheless, it appeared Illinois' accuracy rate exceeded Medicare (for which three separate studies have identified accuracy rates from 86-93%) and Texas Medicaid (89.5%).

Illinois has long been a leader in effectively screening claims for payment. Automated edits and computer surveillance, however, can only go so far. In the Payment Accuracy Review (PAR), staff went far beyond what the claims processing system can do and still continue to pay bills timely. By interviewing clients and closely examining medical histories, the OIG study was able to assess the propriety of the services in the sample.

PAR did not intend to establish a fraud rate. To do so would require establishing the intent of a provider to commit a crime. That is not possible in such a study. The OIG did identify that 55% of the misspent dollars were for questionable services. The remainder was nearly evenly split between inadvertent provider error and agency error.

The project identified 29 providers and seven clients who likely cheated the system. Twenty-eight providers and two clients had already been selected for DPA examination at the time of the PAR study.

One of the project's most significant findings was that almost one-third of all payments to non-emergency medical transportation providers were inappropriate. PAR confirmed the anecdotal belief that OIG staff and law enforcement agencies have shared about this industry. PAR and OIG's earlier medical transportation report were driving forces in DPA's efforts to tighten control and monitor this provider type. DMP is seeking a contractor to handle prior approvals and monitoring of non-emergency medical transportation and has proposed policy changes to increase accountability.

Significant finding: 1/3 of non-emergency medical transportation payments found inappropriate.

The OIG recently completed a review of 64 of the most active non-emergency medical transportation providers. This project validated PAR's findings and confirmed the belief that this provider type is problematic. In one extreme example, one provider had no records to support billings. The study confirmed:

- 6,068 discrepancies were identified in 12,323 services examined. (Some services had more than one discrepancy.)
- 32.1% of the services claimed were not supported by acceptable records.
- 47.9% of the transportation services could not be directly linked to a corresponding Medicaid service.
- 17.2% of the discrepant services involved excess mileage.
- 33% of the money paid to the providers should have been withheld.

These findings were not surprising in light of the OIG's 1997 study of medical transportation. That report included recommendations to automate the prior approval process and strengthen provider monitoring.

Abuses in non-emergency medical transportation is the most troubling finding from PAR. But the project's value goes beyond that and will continue to pay dividends. A 95.28% accuracy rate revealed:

- The claims processing system generally works well.
- The vast majority of providers are honest.
- Pre-payment edits and reviews are effective.
- Post-payment surveillance identifies problem providers and clients.

Preventing Ineligibles from Receiving Benefits

The single most successful fraud initiative in human services today is the Fraud Prevention Investigations (FPI) program. In 1995, the OIG began a partnership with the then DPA now DHS Division of Community Operations to prevent ineligible persons from receiving Medicaid, cash assistance and food stamps. Using fraud-prone criteria, local office staffs refer suspicious applications to the OIG for pre-eligibility investigation. A private investigative firm under contract to the OIG completes its investigation in less than eight days after receiving the referral.

In four calendar years, FPI has investigated 5,489 applicants, resulting in the denial or reduction of benefits to 64%. This program has avoided a four-year average cost of \$12.51 for each \$1 spent by the state.

Four years of FPI: \$12.51 in costs avoided for each \$1 spent.

FPI has expanded from its pilot area of five Cook County local offices to include all 23 non-specialty DHS local offices in Cook County. The OIG has requested a budget initiative for FY 2001 to expand the program to 11 more counties with major metropolitan areas.

Partnering with Medical Programs

One of the DPA's biggest challenges since the creation of the OIG has been to build and maintain partnerships with Medicaid policy and program staffs. The best example of success comes from the Medicaid Fraud Prevention Executive Workgroup (MFPEW). Formed in 1997, the group meets monthly and is co-chaired by the Deputy Medicaid Director and the Deputy IG for Operations. The group features a broad base of disciplines, including law and information systems, from DPA and OIG.

The MFPEW's most significant accomplishment has been the tracking of spiked payments to providers. Spiked payments are an attribute of providers who cheat the system then close their operations. Such behavior was observed in the case of Clin Path Lab. The lab had been billing the department routinely for a few thousand dollars each month through most of 1996. From November 1996 to late February 1997, Clin Path's billing accelerated dramatically with claims totaling \$1.3 million in less than four months.

**Significant accomplishment:
Tracking spiked payments.**

At the time, the department did not have an automated surveillance technique to detect such behavior. A claims processing staffer alerted the OIG when she called Clin Path to discuss the lab's high volume of rejected claims, and no one answered the phone. An immediate investigation found no lab at the location was on file. Payments were suspended, and the proprietors were convicted of fraud.

To prevent similar behavior in the future, the spiked payment report prompted the OIG to monitor a running 24 months of paid claims for earlier detection. Any dramatic increase or decrease in billings triggers human intervention by an OIG provider analyst. The result may be referrals for audit or investigation or even the suspension of payments pending the investigation.

In two years, the workgroup has put together a dramatic record. The other achievements are:

- Creating a systematic way to cross-check drugs billed by physicians against drugs billed by pharmacies for the same recipients.
- Correlating non-emergency medical transportation services to medical services provided the same day.
- Improving the monitoring of providers through on-site visits and better verifications of credentials, business addresses and service locations.
- Monitoring pharmacies, which consistently renew prescriptions early or have an unusual number of days supplied, inordinate cases of one-day supplies of drugs or multiple prescriptions for the same recipient on the same day with drugs from the same therapeutic class.
- Monitoring payments made to physicians for lab tests performed by independent labs.
- Monitoring providers with expired licenses.
- Strengthening medical vendor settlement agreements to ensure corrective actions needed to improve deficiencies.

- Recommending Diagnostic Related Group (DRG) 468 (Extensive Operating Procedures Unrelated to Principle Diagnosis) and DRG 477 (Non-Extensive Operating Procedures Unrelated to Principle Diagnosis) for pre-payment review based on research indicating suspicions of abuse.

Postmortem Payments

DPA has been challenged by delayed notification when clients die in long term care facilities. DHS local offices contend providers fail to give timely notice. Providers respond they have provided the notice, but local offices have not processed the death notification. In either case, the taxpayer loses because overpayments occur.

In 1997-98, the OIG examined the problem in a study of postmortem payments to long term care providers. The office reviewed 963 deaths reported in the fourth quarter of FY 1997. On average, the client's case record was not corrected for 171 days after the date of death. The study found more than \$1.1 million in erroneous payments by the department because it was unaware clients had died.¹ The vast majority of those overpayments were to nursing homes.

In 49 cases, the overpayments were to non-institutional providers. In those cases, further study found 116 services supposedly provided to clients after they died. Although the dollar amount was small (\$7,301) by comparison, nearly one-third of those services are likely to have been intentional provider fraud rather than inadvertent error.²

The Office of Auditor General also identified postmortem payments as a concern when it cited DPA for failure to record timely notifications. Its report said: "The Illinois Department of Public Aid could be quicker in stopping payments to nursing homes for long term care (LTC) after residents die or leave." The report recommended that DPA "continue its efforts to implement a system to detect an overpayment situation prior to payment." The agency accepted this finding.

At the request of DPA Director Ann Patla and with the concurrence of DHS Secretary Howard A. Peters III, the OIG chaired a workgroup with DMP and DHS's Division of Community Operations to identify why death notices and cancellations are not timely. The findings from that project are being reviewed by the workgroup at this writing.

Protecting Staff and Clients, Securing the Workplace

A total of 405 allegations that could reasonably be described as violent or potentially violent have been investigated since 1992. The complaints have ranged from verbal abuse to physical assault to an employee who solicited an undercover state police officer on state premises to murder her husband. In 1996, the OIG's research staff began studying the prevention and handling of workplace violence. The report, Maintaining a Safe

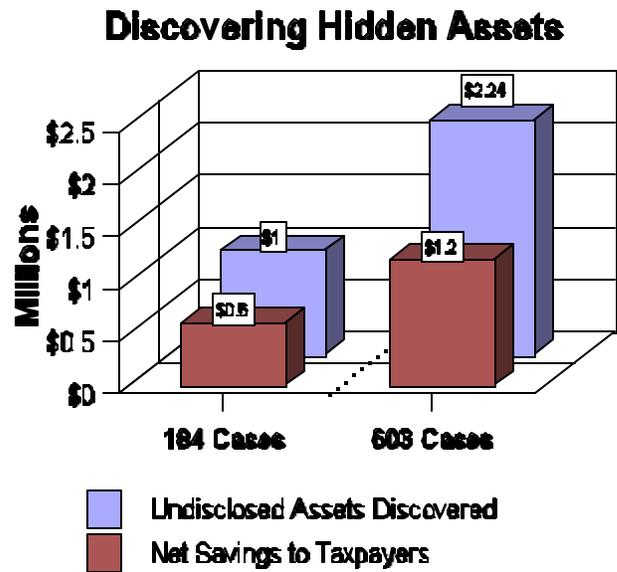
¹ In effect, these overpayments are interest-free loans to long-term care providers. Most are recovered through an automated reconciliation process.

² No automatic reconciliation and recovery occur for overpayments to non-institutional providers.

Workplace: Best Practices in Violence Prevention, could not have been more timely when it was issued in summer 1997.

On March 20, 1997, the value of this information was underscored when two explosive devices were discovered at the Sangamon County local office. Both devices were safely removed and dismantled with no injuries or property damage.

The OIG subsequently issued reports on the physical security of legacy DPA/DHS offices. These reports clearly supported increasing security at all facilities. In 1999, both agencies upgraded security standards and services and made dramatic changes in security management. Both departments now have full-time security coordinators to monitor workplace safety and require employees to wear photo identification badges at all times. Like most efforts, this task is a work in progress.



Discovering Hidden Assets in Long Term Care

The OIG completed the second phase of its research known as the Long Term Care Asset Discovery Initiative (LTC-ADI) in September 1999. This project originated with an OIG reviewer’s concern that the state was not doing enough to ensure that persons with excess assets were denied long term care benefits through Medicaid.

In 1996, the OIG worked with the then DPA Division of Field Operations to screen applicants more effectively. Out of 184 applications, the project discovered more than \$1 million in assets that should have been disclosed at intake. The savings were reduced to \$597,099 after allowable asset exemptions were applied.

To be sure the findings were valid, the OIG initiated a second review of 603 applications the next year. Nearly \$2.24 million in undisclosed assets were discovered, netting almost \$1.2 million in savings for taxpayers. Phase two of the project avoided \$3.32 in costs for every \$1 spent.

An estimated annual savings of about \$9 million could result if the LTC-ADI went statewide. The OIG has been discussing the next steps with DPA.

Targeting Welfare Fraud

The use of fictitious children is one of the most profitable ways to maximize fraudulent welfare benefits. Theresa Henderson was responsible for one of the most notorious cases in agency history. She created five separate assistance cases, using four false identities and creating 29 fictitious children in the process. Before she was sent to prison, she illicitly reaped more than \$366,000 in state and federal funds.

False identity cases, particularly for children, are the most difficult to identify prospectively. Many false identity cases involve twins or triplets. In two separate studies since 1997, the OIG examined 128 families with multiple children for whom there were no paid medical services for one or more children in a family.

OIG acts to stop false identity cases involving children.

The research, originally called Children-At-Risk Evaluation, is known as Project CARE. In the second phase of the project, 17 fictitious children were identified in six assistance cases. Altogether, 11 of the 82 cases were fraudulent and caused \$364,547 in overpayments. The fraud indicators in these cases were:

- No medical services for one or more children in a family.
- Non-standard birth certificates, such as those for a home birth.
- Questionable documents, such as baptismal certificates, in lieu of a birth certificate.

The OIG has been working with DHS to develop more effective methods of referring cases with questionable documents for investigation. The office also has been reviewing how to monitor medical claims more effectively on an automated basis to identify suspect cases.

The OIG has been accumulating knowledge from the Fraud Prevention Investigations program to develop even more effective fraud-prone criteria for pre-eligibility investigations. These criteria will be used to target existing cases as well.

Related Fraud Prevention and Detection Efforts

In the last five years, the OIG has conducted, initiated or participated in other efforts to serve integrity and program staffs. These projects include:

- Fraud Science Team, which has developed or acquired state-of-the-art fraud detection routines to scrutinize medical claims before or shortly after payment.
- Data Warehouse, which will contain five years of claims history to improve fraud detection through complex data analyses.
- CS/SURS, which will move the current provider profiling system from a mainframe to a LAN-based, real-time system to improve analysis and link electronically every step of the review process.
- Recipient Services Verification Projects, which determine if clients received the services billed to Medicaid by physicians, non-emergency medical transportation companies and home health providers. In both projects, the vast majority of recipients did receive the service.
- Medicaid Client Satisfaction Surveys, conducted from 1996-1999, identified that most clients were satisfied with their health care providers and the services.
- Random Claims Sampling, which will examine the validity of medical claims not otherwise singled out by the Medicaid Management Information System. It is expected the sampling will deter false claims and expand understanding of Medicaid fraud.

- Commercial Code Review, which is expected to augment the department's existing pre-payment edits and reviews, avoiding the inappropriate expenditure of several million dollars annually.
- Recipient Eligibility Verification/Medical Electronic Data Interchange, which allows providers to verify eligibility electronically, reduce inappropriate use of the medical eligibility cards and improve future fraud and abuse safeguards.
- Electronic Fingerprinting, which ensures individuals do not have more than one active assistance case and that recipients are not fugitives or incarcerated by the Illinois Department of Corrections.
- Case Tracking, which will electronically update and transfer findings from review process to review process, linking information necessary for analysis, correspondence and final action.

INVESTIGATIONS

Partnering with Law Enforcement

The OIG is not a law enforcement agency. The office is statutorily authorized to conduct criminal investigations and work with state and federal law enforcement and prosecutors. The office has been active partners with law enforcement throughout the state. The examples are:

- Medicaid Fraud: The office participates in health care fraud task forces in the three federal districts in Illinois. The office has assigned a full-time investigator to the Medicaid Fraud Control Unit in Springfield and provides additional critical administrative support to state and federal investigators and prosecutors.
- Welfare Fraud: The office refers hundreds of welfare fraud cases to local prosecutors every year. Two full-time OIG investigators have been assigned to the State Financial Crimes Task Force. This task force is a multi-agency, white-collar investigative entity housed in FBI offices and commanded by the Illinois State Police.
- Internal Security: The office works closely with the Illinois State Police, Division of Internal Investigation on criminal allegations of employee or contractor misconduct. Since 1994, the office has investigated nearly 1,200 cases. The office also presents criminal cases to prosecutors.

Operation Talon

Federal law prohibit fugitives from receiving food stamp benefits. In 1997, the Office of Inspector General for the U.S. Department of Agriculture created Operation Talon to prevent fraud. Every month, DPA's OIG matches DHS food stamp clients against wanted persons files. Law enforcement agencies have apprehended 470 fugitives illegally receiving benefits. The operation has primarily targeted Cook County fugitives with felony charges ranging from possession and sale of drugs, attempted murder, child molestation and robbery.

Management Services of Illinois

On August 23, 1996, the U.S. Attorney, Central District of Illinois, announced the indictments of four central Illinois men and Management Services of Illinois, Inc. (MSI). The four were indicted for devising and participating in a scheme to defraud DPA of \$12.9 million. Charged were former DPA Senior Public Service

Administrator Curtis G. Fleming; William D. Ladd, Michael R. Martin and Ronald D. Lowder of MSI. Each defendant was charged with 16 counts of mail fraud, bribery, receiving a bribe, and misapplication of government property.

Martin and Lowder were convicted of mail fraud and bribery. Ladd was found guilty of money laundering. Fleming pleaded guilty to mail fraud and cooperated with prosecutors against the other defendants. All received prison sentences. MSI was ordered to forfeit a parcel of real estate.

MSI was under contract to provide third-party liability insurance information to DPA. In December 1993, MSI's contract was amended to include a more favorable payment system for the firm. In the year prior to the amendment, MSI submitted vouchers and invoices totaling about \$417,080. In the year after the amendment, MSI's invoices and vouchers rose to more than \$11.26 million.

It was further established that between January-May 1994, MSI fraudulently received \$4.55 million for work it had already performed and for which it had already been paid under its previous contract.

On September 2, 1997, a DPA Public Service Administrator resigned after admitting she was aware of employee misconduct and bribery by Fleming, but failed to report the misconduct.

The investigation was led by the U.S. Attorney, Central District of Illinois, with assistance from the FBI, IRS, Illinois State Police and the OIG. The investigation was officially concluded December 21, 1998.

Other Examples of Misconduct

- A joint investigation between the Illinois State Police and the OIG determined a Family Support Specialist I defrauded DPA of \$18,541.73 over six years. The employee pled guilty to public assistance fraud on September 2, 1994, and was sentenced to 30 months' felony probation and 10 months' community service. On October 28, 1994, the employee resigned in lieu of discharge. The total amount of \$18,541.73 was recovered from the employee through an offset.
- An investigation determined a Method and Procedures Advisor II lived with a client, helped the client qualify for unauthorized public aid and intentionally defrauded DPA of more than \$24,000. The employee resigned and in February 1994, pled guilty in Sangamon County Circuit Court to official misconduct. The employee was sentenced to 30 months' probation and ordered to pay restitution of \$17,770 to DPA. The OIG had previously collected \$6,258 from the employee, which brought the total amount recovered to \$24,028.
- On June 6, 1995, a male client attacked and stabbed two male clients in the Sangamon County local office before being shot in the abdomen by a security officer. Neither client was severely wounded, and the subject recovered from his gunshot wound. The subject was charged with two counts of attempted murder. On October 30, 1995, the subject pled guilty but mentally ill to two counts of aggravated

- battery. On December 29, 1995, he was sentenced to five years in prison with the stipulation he be transferred to the Department of Mental Health and Developmental Disabilities for treatment.
- A Property Consultant at the Madison County local office sold confidential client data to a private investigative agency in Florissant, Missouri, to help the investigative agency locate people residing in Illinois and surrounding states. The Illinois State Police and the OIG conducted the investigation, resulting in the employee's resignation on March 12, 1996, and criminal charges of bribery and official misconduct. The employee admitted he accessed client computer files, printed copies, sold the copies to the Florissant firm, which then sold the documents to another firm. He admitted to accessing and selling documents from 1990-1996 for thousands of dollars. During the course of the investigation, Illinois State Police and OIG investigators recovered thousands of DPA documents from two Missouri firms. On September 16, 1996, the subject pled guilty to official misconduct and received a two-year court ordered probation.
 - After an extensive investigation with the Inspector General's Office of the U.S. Department of Health and Human Services, it was determined that a former Income Maintenance Specialist I devised an elaborate scheme in which she defrauded DPA and the Social Security Administration. She left DPA in June 1995, and started drawing her state retirement. In August 1971, she had submitted an application for a Social Security card using an assumed name. This is the same year she began her employment with the state of Illinois. The fraud started in 1972 when she used the assumed name and her second Social Security number to qualify for public assistance. From 1978 (the earliest fiscal records available for reconstruction) until May 1996, she received \$33,233 in public aid to which she was not entitled. This case was referred to the U.S. Attorney. The subject agreed to serve four months' confinement and make full restitution to the state of Illinois and \$81,328 to the Social Security Administration for SSI benefits.
 - An anonymous tip on January 12, 1998, led the OIG to an Executive II who falsified her daughter's summer employment records at DPA. The letter alleged that the employee's daughter worked at O'Hare Airport at the same time. The employee was responsible for payroll and other personnel matters in the Chicago office of the Division of Child Support Enforcement. The OIG determined that the employee misappropriated \$5,695.91 in payroll funds to her daughter in 1996 and 1997. The employee admitted her misconduct to the OIG and resigned her position with DPA, effective May 4, 1998. The money was recovered from her retirement, sick leave and vacation payout. She pled guilty to one count of felony theft and official misconduct on May 4, 1999, and was sentenced to 13 months' probation. The employee's daughter pleaded guilty to misdemeanor theft and was sentenced to a one-year conditional discharge. A DPA employee was suspended for 12 days for her failure to notify the department that state funds were being misappropriated by her supervisor.
 - A DHS Office Administrator III resigned June 16, 1998, during an Illinois State Police and OIG investigation. Investigators proved he used the state computer system to create 493 fraudulent assistance checks totaling \$325,973 from 1993-1998. The checks were mailed to family and friends for his personal gain. On November 16, 1998, he pled guilty in Sangamon County to one count of felony theft

and one count of computer fraud. He was sentenced to six years in prison and ordered to make restitution of \$265,000 on December 21, 1998.

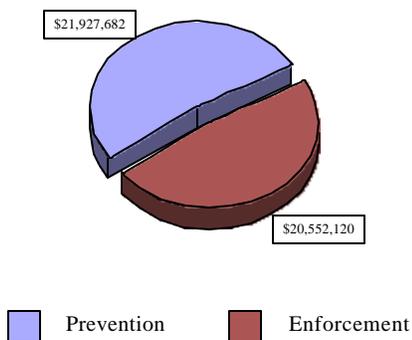
- In March and April 1998, several thefts of DPA equipment and personal items from employees occurred in the Bloom and Harris buildings in Springfield. Burglaries and attempted burglaries of vending machines also occurred in both buildings.. The value of the items stolen and the damage to property totaled \$21,767.54. An OIG investigation narrowed the list of possible suspects to an employee of a security agency with officers in both buildings. Working with security agency management and the Illinois State Police, the suspect, a contractual security officer, was interviewed and confessed to the thefts and burglaries. The investigation found he had also stolen equipment, valued at \$14,000, from the Illinois Department of Commerce and Community Affairs. On December 31, 1998, he pled guilty to four counts of theft and was sentenced to 18 months' probation. He was ordered to serve 120 days in jail. A judgment of \$15,461 was entered for DPA. The security agency has made restitution to DPA according to the provisions of its contract.
- In October 1998, a check for \$2,783 payable to DPA was discovered missing. The check was mailed to the Division of Child Support Enforcement in Chicago, but never received. The OIG learned this check and others were missing from the Chicago mail room. An investigation by the U.S. Postal Inspector, Illinois State Police and the OIG determined an Office Coordinator working in the mail room removed valuable items from the mail. The Office Coordinator resigned on June 22, 1999, and waived all reinstatement rights. A criminal investigation continues, and criminal charges are pending.

CONCLUSION

Like other IG's, much of our efforts focus on enforcement activities. But we also place a significant emphasis on prevention. We have worked to establish a cost effective balance between enforcement and prevention. The \$18.4 million budgeted in FY 99 for the OIG returned approximately \$42.5 million in collections and cost avoidance as shown in the chart below.

FY 99 Fiscal Impact

\$42.5 million in Savings and Collections



- Prevention Activities:

- Recipient Restrictions
- Fraud Prevention Investigations
- Long Term Care Asset Discovery Initiative
- Medicaid Fraud Prevention Workgroup
- Fraud Science Team
- Payment Accuracy Review Measurement

- Enforcement Activities:

- Provider Audits
- Client Fraud Investigations
- HMO Marketing Misconduct
- Provider Sanctions
- Medicaid Quality Control Reviews
- Food Stamp Disqualifications
- Physician Peer Reviews
- Internal Investigations

The OIG consists of more than 300 employees from a variety of disciplines, all of whom are dedicated to a single purpose: improving the safety and integrity of the programs and staffs at DPA and DHS. The IG believes their labors have established a record of success and achievement. The accomplishments have been possible because of the partnerships that have been created and nurtured over many years. Nothing the OIG does can be successful in the long term without close collaboration with various divisions, particularly the Division of Medical Programs, and all of DPA and DHS. Those two agencies' cooperation and dedication to program integrity are an integral component of our achievements.

LISTING OF OIG PUBLISHED REPORTS

OIG Published Reports

Title of Report	Date of Report	Description
<i>Non-Emergency Medical Transportation Reviews: Focusing on Compliance</i>	December 1999	A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation.
<i>Project Care: Exploring Methods to Proactively Identify Fraud</i>	December 1999	Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.
<i>Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments</i>	December 1999	Recommended methods by which non-institutional post mortem payments could be identified more quickly.
<i>Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century</i>	September 1999	Verified the cost-effectiveness of searching for assets of LTC applicants.
<i>Recipient Services Verification Project: RSVP II-Home Health Care</i>	August 1999	Confirmed receipt by clients of home health care services.
<i>Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues</i>	June 1999	Validated the effectiveness of the project's error-prone criteria and processes.
<i>Fraud Prevention Investigations: FY98 Cost/Benefit Analysis</i>	December 1998	Identified an estimated \$4 million in net savings with a benefit of \$14.25 for every dollar spent.
<i>Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices</i>	October 1998	Examined weaknesses in the security of the agencies and proposes several recommendations for improvement.

Title of Report	Date of Report	Description
<i>Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement</i>	August 1998	First ever such study in the nation. Identified that the department accurately expends 95.28%, plus or minus 2.31%, of total dollars paid.
<i>Medicaid Client Satisfaction Survey: October 1996-September 1997</i>	July 1998	Measured client satisfaction with quality and access in both fee-for-service and managed care.
<i>Postmortem Medicaid Payments: Identifying Inappropriate Provider Payments on Behalf of Deceased Clients</i>	April 1998	Confirmed that LTC client cases were not being canceled timely resulting in overpayments to nursing homes and made several recommendations for improvement.
<i>Fraud Prevention Investigations: FY97 Cost/Benefit Analysis</i>	February 1998	Identified an estimated \$3.63 million in net savings with a benefit of \$13.02 for every dollar spent.
<i>Medical Transportation: A Study of Payment and Monitoring Practices</i>	December 1997	Identified policy changes and monitoring strategies.
<i>Funeral and Burial: A Review of Claims Processing Issues</i>	October 1997	Examined policies and procedures of the Department of Human Services in paying for client funeral and burial and made recommendations for improvement.
<i>Maintaining A Safe Workplace: Best Practices in Violence Prevention</i>	June 1997	Identified best practices available to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors.
<i>Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings</i>	May 1997	Recommended a thorough assessment of software systems for prospective review of billings which have the potential to save the State millions.

Title of Report	Date of Report	Description
<i>Fraud Science Team Development Initiative Proposal</i>	April 1997	Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments.
<i>Medicaid Client Satisfaction Survey: April 1996-September 1996</i>	April 1997	Measured client satisfaction with quality and access in both fee-for-services and managed care.
<i>Prior Approval Study</i>	May 1996	Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature.
<i>Clozaril Report</i>	February 1996	Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement.
<i>Hospital Inpatient Project Summary Report</i>	April 1994	Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.

STATISTICAL TABLES

Aggregate Provider Billing and Payment Information

This table reflects aggregate provider billing and payment information, reported as required by Public Act 88-554. The appendices that follow the statistical tables show the data by provider type and at various earnings or payment levels. The data are by provider type because the rates of payment vary considerably among types.

The number and amount of paid claims include payments made through the automated claims processing system and the Public Aid Accounting System (PAAS).

Aggregate Provider Billing and Payment Information

	CY 1999
Number of Providers	58,791
Amount Billed	\$10,656,009,212
Number of Paid Claims	58,321,377
Amount Paid	\$7,457,996,266

Audits of Medical Providers

The OIG initiates medical audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Medical audits generally cover an eighteen-month period and are conducted on institutional and non-institutional providers.

Once a provider is selected for an audit, the provider is contacted and records are reviewed onsite by the audit staff. Providers with identified overpayments are asked to either repay the liability, present documentation to dispute the findings or request an administrative hearing. Audits are considered completed upon receipt of the provider's payment, negotiating a settlement agreement or receiving the final decision of the Director.

The provider may repay the department by check or by a credit against billings, in either monthly installments or a single payment. Because providers are allowed to make payments in installments, collections vary and the amount reported will often cover audits closed in previous quarters. Collections generally result from audits completed in prior periods.

Note: Collection amounts are taken from a new source effective July 1, 1999; Bureau of Fiscal Operation's Public Aid Accounting System (PAAS).

Collection of Overpayments

	CY 1999
Audits	306
Collections	\$9,012,784

Collection of Restitutions

Monies collected are from fraud convictions, provider criminal investigations and civil settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or in installment payments. Restitutions vary considerably from one year to the next. They are dependent on when cases are settled and the amounts that are ordered to be restored.

Collections of Restitutions

	CY 1999
Amount Collected Provider	\$515,397
Client	\$14,155

Refill Too Soon

This table summarizes the Refill Too Soon (RTS) program, reported as required by Public Act 88-554. The program is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the time period covered by a previously paid prescription claim. The estimated savings represents the maximum amount the department could save as a result of the RTS edits. Once payment for a prescription is rejected, the prescription is probably resubmitted later, after the first prescriptions expires. The estimated savings shown in this table represents the value of all rejected prescriptions, but the true savings are probably less.

Refill Too Soon Program

	CY 1999
Total Number of Scripts	20,804,882
Amount Payable	\$799,116,489
Scripts Not Subject to RTS	1,414,059
Amount Payable	\$38,242,344
Scripts Subject to RTS	19,390,823
Amount Payable	\$760,874,145
Number of Scripts	838,954
Estimated Savings	\$38,703,673

Provider Sanctions

The OIG acts as the department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the twelve months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

Provider Sanctions

	CY 1999
Hearings Initiated	
Termination	41
Suspension	8
Denied Application	5
Recoupment	45
Termination/Recoupment	12
Decertification	3
LTC/Hospital Assessment	0
Child Support Sanctions	65
Total	179
Providers Sanctioned	
Termination	36
Voluntary Withdrawal	12
Suspension	7
Denied Application	3
Recoupment	59
Termination/Recoupment	2
Decertification	0
LTC/Hospital Assessment	0
Child Support Sanctions	39
Other P.A. 88-554 Sanctions	0
Total	158
Cost Savings	\$636,448
Cost Avoidance	\$50,026

Client Eligibility Investigations

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. The results of the investigations are provided to caseworkers to calculate the overpayments. Cases with large overpayments or aggravated circumstances are prepared for criminal prosecution and presented to State's Attorneys or the U.S. Attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits. Clients who intentionally violate food stamp program regulations are disqualified from the program twelve months for the first violation, twenty-four months for the second violation, permanently for a third violation and ten years for receiving duplicate assistance.

Client Eligibility Investigations

	CY 1999
Investigations Completed	936
Estimated Overpayments	
Grant and Food Stamps	\$2,621,219
Medical	\$213,066
Types of Allegations	
Employment	17%
Family Composition	28%
Residence	4%
Interstate Benefits	3%
Other Income	11%
Assets	6%
Multiple Grants	1%
Other	30%
Total	100%
Food Stamp Disqualifications	939

Child Care Investigations

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented, or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care at inappropriate rates. The results are provided to the Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to State’s Attorneys or the U.S. Attorney.

Child Care Investigations

	CY 1999
Investigations Completed	97
Overpayment Identified	\$203,741

Client/Vendor Prosecutions

The OIG conducts investigations that because of the egregious of the crime on large financial loss are referred to a States Attorney or U.S. Attorney for criminal prosecution. These cases may involve multiple cases with false identities, failure to report income, long term fraud involving the circumstances of the client and other instances that have resulted in large overpayments to undeserving individuals.

Client/Vendor Prosecutions

Prosecution	CY 1999
Accepted for Overpayment on Cases	73 \$832,429
Convictions Restitutions Ordered	75 \$712,707
Acquittals	0

Medical Abuse Investigations

The OIG investigates allegations of abuse of the Medical Assistance Program by clients and vendors. Abusing clients may be placed in the Recipient Restriction (RRP) program. The recipient restriction process generally begins with computer selections of clients whose medical service utilization indicates abuse. After reviews by staff and medical consultants, clients are restricted to a primary care physician, pharmacy, or clinic for twelve months on the first offense and twenty-four months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider (except in emergencies). As an alternative to RRP, abusing clients may choose to enroll in an HMO. Cost avoidance is calculated by comparing the funds expended on behalf of the client before restriction to post restriction expenditures. It does not include the cost avoidance amounts for clients opting for HMO enrollment to avoid restriction. Cost avoidance dollars are estimated and based on the number of recipients restricted or locked-in at the end of the calendar year.

Medical Abuse Investigations

	CY 1999
Medical Overutilization	
Recipient Reviews Completed - 12 & 24 Months	4,112
Additional Recipients Restrictions - 12 & 24 Months	719
Recipients Locked-In at End of Year - 12 Months (a)	1,234
Recipients Locked-In at End of Year - 24 Months (b)	871
Recipients opting for HMO enrollment to avoid	259
Cost Avoidance	\$17,976,700
Recipients Restricted	2,105
Medical Abuse	
Substantiated	190
Unsubstantiated	226
Total	416

HMO Marketer Investigations

The OIG monitors marketing practices to ensure that clients have the opportunity to make an informed choice when enrolling with an HMO and to prevent HMOs from avoiding the sickest clients. The Bureau of Managed Care maintains a toll free complaint hotline from which the majority of referrals are received. Marketers found guilty of misconduct are removed from the Department’s HMO Marketer Register, which lists HMO marketers from whom the Department will accept enrollments.

HMO Marketer Investigations

	CY 1999
Types of Allegations	
Fraud	179
Misrepresentation	39
Unethical Practices/Other	30
	248
Findings	
Substantiated	126
Unsubstantiated	33
Unable to Determine	89
Total	248

Internal Investigations

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its oversight of security matters. The investigators are not sworn, do not carry firearms and do not have arrest powers. The types of investigations include, criminal and non-criminal work rule violations, public assistance fraud offenses, criminal code offenses and contract violations. Investigations often reveal violations of several work rules or criminal statutes. A single investigation may cite several employees or vendors. Discipline noted is generally from a different time frame than the investigations completed.

Internal Investigations

	CY 1999
Investigations Completed	
Substantiated	140
Unsubstantiated	59
Total	199
Types of Allegations	
Non-Criminal (Work Rules)	
Discourteous Treatment of Others	12%
Failing to Follow Instructions	1%
Negligence in Performing Duties	5%
Engaging in Business with a Client	0%
Incompatible Outside Interests	5%
Sexual Harassment	3%
Release of Confidential Agency Records	3%
Misuse of Computer System	4%
Falsification of Records	8%
Other Work Rule Violations	1%
Work Place Violence	16%
Criminal (Work Rules)	
Misappropriations of State Funds	2%
Attempted Fraud or Theft	0%
Commission of or Conviction of a Crime	6%
Other	1%
Public Assistance Fraud Offenses ILCS Chapter	7%
Criminal Code Offenses ILCS Chapter 720	25%
Contract Violations	1%
Total	100%
Misconduct Cited	
Employees	75
Vendors	7
Total	82
Levels of Employee Discipline	
Discharged	14
Resigned	7
Suspensions	10
Other, such as reprimands	25
No Action Taken	16
Total	72

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