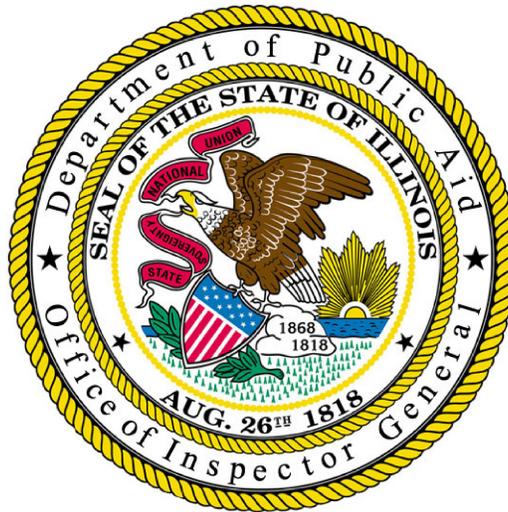


# Office of Inspector General

Illinois Department of Public Aid

## 2004 Annual Report



**Rod R. Blagojevich**  
Governor

**Wyona Johnson**  
Acting Inspector General

March 2005



## Office of Inspector General

### *Illinois Department of Public Aid*

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Rod R. Blagojevich  
*Governor*

Wyona Johnson  
*Acting Inspector General*

March 31, 2005

**To the Honorable Rod R. Blagojevich, Governor, and Members of the General Assembly:**

I am pleased to provide you with the Office of Inspector General's Annual Report for Calendar Year 2004. This report describes various activities that have occurred during the past year which have enhanced the integrity of the Illinois Medical Assistance Program and other programs of the Departments of Public Aid and Human Services.

This Office has achieved its accomplishments through the hard work of over two hundred staff throughout the state, along with the commitment and dedication of the Departments of Public Aid and Human Services. Through its efforts, the OIG has improved the fiscal integrity of both of these agencies.

As required by Public Act 88-554, this report provides data 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 investigations.

I hope the OIG's 2004 Annual Report is a valuable resource to you and your staff.

Sincerely,

Wyona Johnson  
Acting Inspector General

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**Office of Inspector General  
Illinois Department of Public Aid  
Annual Report  
Calendar Year 2004**

***BACKGROUND***

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). The position of Inspector General is appointed by and reports to the Executive Inspector General and requires confirmation by the Illinois State Senate. The OIG operates within DPA, but does so independently of the agency director. The OIG is fully committed to ensuring that department programs are administered with the highest degree of integrity.

Prior to 1994, the Division of Program Integrity (DPI) was responsible for many of the duties absorbed by the OIG. The most significant difference between the two entities lies in the OIG's statutory mandate "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct." This directive to first prevent fraud has enabled the OIG to greatly increase its impact on DPA's programs.

**Scope**

The OIG investigates possible fraud and abuse in programs administered by DPA and DPA legacy programs in the Department of Human Services (DHS). Acknowledging its mandate, the OIG has developed and enhanced a broad range of tools and techniques to prevent and fight fraud and abuse in Medicaid, KidCare, food stamps, cash assistance and child care. The OIG also has enforced the policies of DPA, DHS and the state of Illinois affecting clients, health care providers, vendors and employees.

**Staffing**

OIG staff members include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information specialists. During 2004, the OIG had an authorized staffing of 225 employees, with 204 employees being on-board at the close of the year. The majority of the staff is based in either Springfield or Chicago, with the remainder working out of field offices located throughout the state.

**Networking**

OIG staff have been active in the Association of Inspectors General, a national group supporting the work of IG's at local and state levels, and in the federal Centers for Medicare and Medicaid Services' Medicaid Fraud and Abuse Technical Advisory Group (TAG). The OIG staff also has been active in the National Welfare Fraud Directors Association, United Council on Welfare Fraud, National Health Care Anti-Fraud Association, Association of Certified Fraud Examiners, National Internal Affairs Investigators Association and the American Society for Industrial Security.

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*STATE / FEDERAL PARTNERSHIP***Medi-Medi Project**

OIG is now embarking on a new and innovative approach to fraud and overpayment detection. In 2004, OIG was granted the authority to access Illinois Medicare data and combine it with Medicaid data to enhance its fraud detection efforts. Illinois' national leadership in Medicaid program integrity and fraud detection resulted in an invitation from the federal government to participate in this collaborative effort. In the short time OIG's Fraud Science Team (FST) has had access to the data, it has identified several dozen new targets for investigation and audit. It also has identified powerful analyses that are expected to result in additional investigations, audits, and administrative actions.

The Illinois Medi-Medi Project is a collaborative effort between OIG, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMMS), and state and federal health care law enforcement partners. Under Medi-Medi, OIG and CMMS have obtained access to each other's data to perform fraud detection and prevention analyses and support law enforcement efforts, audit activities, and administrative actions. Illinois is one of several states asked to participate in Medi-Medi, and to our knowledge it is the only state actively using the data for advanced fraud detection. The project's steering committee, which is co-chaired by the Acting Inspector General and a representative from CMMS, consists of OIG's state and federal law enforcement partners, including the Illinois State Police Medicaid Fraud Control Unit, the Illinois Attorney General's Office, the Office of Inspector General for the U.S. Department of Health and Human Services, the Federal Bureau of Investigations, and the three U.S. Attorney Offices for Illinois. The steering committee works closely to provide input on data analysis, to select cases referred for investigation, to coordinate jointly performed investigations and to provide updates on Medi-Medi case investigations.

As its first analysis, FST used the Medicare data in combination with the Medicaid data to expand its Time Dependent Billing Routine. Data from both programs were matched and combined to provide a broader understanding of the billings of suspect practitioners. FST can now identify practitioners who bill in excess of a normal day across both programs, including those who bill for in excess of 24 hours a day. Based on the results from this routine, OIG made numerous referrals to the law enforcement members of the steering committee for investigation. By adding Medicare data, FST was able to identify providers who would not have been detected otherwise. FST will be modifying its existing routines and developing new ones to take advantage of the opportunity that access to the Medicare data provides. Several additional fraud detection analyses are planned for 2005.

Medi-Medi presents OIG and the rest of the Illinois health care law enforcement community with a significant opportunity to leverage and combine their respective datasets, information technology (IT) infrastructure and expertise in data analysis, IT and law enforcement. It provides the Illinois health care law enforcement community with a more comprehensive picture of providers' billing behavior and opportunity to identify, investigate, audit and prosecute significant health care fraud impacting both programs.

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## ***NEW INTEGRITY ACTIVITIES***

### **OIG Case Tracking System Implementation**

A centralized OIG Case Tracking System (CASE) implemented during December 2004, consolidated case management functions for all OIG investigative, audit and review activities. CASE replaced thirteen database systems that were previously used to track different types of OIG cases. In addition, it replaced numerous word processing documents and spreadsheet files that were also used to record activities.

Although these previous systems provided basic monitoring capabilities for individual case types, they did not cross-reference other tracking systems to determine whether another OIG unit may have also investigated a particular person or entity for a different or related reason. The new CASE system will enable OIG staff to utilize information regarding previous or current cases pertaining to a particular person or entity in addition to the data they garner from their own fact-finding efforts. In addition, CASE will also interface with other DPA information systems and the Medical Data Warehouse.

It is important to note that the new automated CASE system is much more efficient than many of the manual processes it replaced. For example, CASE automatically generates letters that need to be mailed so that staff does not need to prepare them manually. These new efficiencies allows OIG staff to carry out their responsibility of preventing, detecting and eliminating fraud and abuse much more expediently. Staff can now use time previously spent on manual activities to complete more in-depth analyses and better target potential fraud and abuse cases.

Eventually, CASE will replace much of the paper documentation that has historically been utilized in the OIG. Documents will be scanned so that they will become part of the electronic case files. Also, as more cases are entered into the new system, staff will be able to look at past cases for analysis so that case selection parameters can be better refined. This ability will greatly assist OIG staff in their efforts to combat fraud and abuse in the future.

### **Alternate Payee Requirements**

Several new measures have been initiated during 2004 which should greatly reduce misspent or fraudulent Medicaid payments associated with alternate payees. An alternate payee is an individual or entity that is designated to receive payments for services provided to Medicaid clients on behalf of a provider. A joint effort between the OIG, Division of Medical Programs and the Office of General Counsel was undertaken because the Department currently has no authority to recover overpayments directly from alternate payees and limited authority to prohibit them from continuing to participate as alternate payees in the Medical Assistance Program. In order to remedy these regulatory shortcomings, the Department initiated administrative rule changes, drafted new legislation and began the steps to create a quarterly notification process to providers with alternate payees.

Administrative rule revision to 89 ILC 140.24 was introduced during 2004 as a stopgap measure to help combat inappropriate Medicaid payments to alternate payees. The revisions clearly limit the circumstances under which the Department may permit individual practitioners in the Medical Assistance Program to designate an alternate payee and describes who may serve as an alternate payee. The rule also prohibits the designation of a payee or alternate payee who appoints, employees or contracts with any person who is sanctioned in a state or federal

healthcare program. In addition, the rule requires alternate payees to accept and forward all remittance advices to the provider.

New legislation was drafted and will be introduced in 2005 to create specific jurisdiction for the Department to recover overpayments, and assess other sanctions, against those alternate payees that violate state rules or statutes. This legislative proposal would formalize the Department's relationship with alternate payees requiring the alternate payee to register with the Department as an alternate payee. The new legislation would also make the alternate payee jointly and severally liable with the vendor for any overpayments of monies. Moreover, it would grant the Department the authority to deny or cancel alternate payee registrations without cause. Finally, the new legislation would grant the Department the authority, after an opportunity for a hearing, to revoke an alternate payee from the Program, and to prohibit all owners, officers, and those individuals with management responsibility from participating in the Program.

In addition, the Department is planning to send individual practitioners, who utilize alternate payees, a quarterly ledger of payment activities. This ledger will provide the practitioner with summary information by payee on claims submitted and dollars paid.

### **New Transportation Provider Requirements**

A variety of new requirements geared toward combating fraud and abuse perpetrated by Medicaid transportation providers were implemented during 2004. These new requirements, which have resulted from the codification of components of the statute Public Act 92-0789, are extremely important because Medicaid non-emergency transportation (NET) had become a hotbed for potential fraud and abuse nationwide in recent years.

These new measures should significantly reduce fraud and abuse among NET providers in Illinois. New fraud prevention capabilities include criminal background checks that include mandatory fingerprinting of new NET providers. This requirement will make it significantly more difficult for unscrupulous providers who have past criminal histories to become enrolled in Illinois' Medicaid program.

A major fraud and abuse enforcement tool was also authorized as part of this legislation. Beginning January 1, 2005, newly enrolled NET providers in Illinois are now subject to a 180 day probationary period. This new capability will enable the Department to terminate newly enrolled NET providers without cause if they exhibit suspicious billing patterns within the probationary period.

Six new administrative rule amendments were codified during 2004. They primarily focused on NET providers, but also included several new measures that affect all providers. These six administrative rule amendments are discussed below.

#### 89 IAC 104.208

Under the amendment, the Department may terminate NET vendors from participation in the Medical Assistance Program prior to an evidentiary hearing but after reasonable notice and an opportunity to be heard.

#### 89 IAC 140.11

Under the amendment, the enrollment of NET vendors will be probationary for 180 days, during

which time the Department may terminate the NET vendors without cause and without a hearing. Upon termination, certain individual officers, individuals owning at least 5% of the entity, and those individuals with management responsibility will be barred from the Medicaid program.

In addition, the new rule requires all vendors whose ownership changes by 50% or more from the date of initial approval for enrollment in the program to submit a new application for enrollment. Finally, the amendment permits the Department to periodically re-enroll and dis-enroll classes of providers.

#### 89 IAC 140.13

The amendment expands the definition of “management responsibility” to include dispatchers and individuals in charge of day-to-day operations of NET vendors. The amendment also better defines the term “non-emergency transportation vendor” by indicating which types of providers are included in this term.

#### 89 IAC 140.19

The amendment accomplishes two purposes. First, if a vendor has been terminated from any medical assistance program (i.e. Illinois Medicaid, another state’s medical assistance program, or the Medicare program) based upon a healthcare related felony conviction, then the vendor shall be barred from the Illinois Medicaid program for five years or the length of the sentence, whichever is longer. Second, if a vendor has been terminated a second time from any medical assistance program based upon a healthcare related felony conviction, then the vendor shall be barred from the Illinois Medicaid program for life.

#### 89 IAC 140.498

The amendment provides that all NET vendors must, at their own cost, submit to a fingerprint based criminal background check as part of their enrollment and re-enrollment process. New applicants must submit to criminal background checks within 30 days of applying, while existing vendors who submit updated enrollment information must submit within 60 days of re-enrolling. Transportation providers enrolled as privately owned automobiles or government agencies are exempt from submitting to criminal background checks.

#### 89 IAC 140.491

The amendment accomplishes several purposes. First, the Department, or its authorized agents, shall refuse to accept prior and post approval requests, and shall terminate prior approvals for future dates, for specific NET vendors under a series of instances. Second, the amendment permits post approval requests from a NET vendor when a life threatening condition exists and there is no time to request a prior approval. Third, the amendment decreases the time (with limited exceptions), from 90 days to 15 work days, in which a NET vendor may request post approval for a service requiring prior approval.

### **BOI Surrogacy Project**

In 2004, the OIG Bureau of Investigations (BOI) undertook a pilot project involving two cases of surrogate births. A surrogate birth is a situation where a woman is paid to bear a child on behalf of another party. BOI decided to initially investigate the two cases based on referrals of possible fraudulent activity associated with the births.

In each case, client’s surrogate pregnancy expenses and births of the children were paid through

the Medical Assistance Program and the client also received payment from the biological parent(s). Investigations concluded that one client received a payment of almost twenty thousand dollars from the biological parents for having the fertilized egg from the biological mother implanted in her body. In the second case, the client was paid almost twenty-five thousand dollars in compensation for being a traditional surrogate.

The positive results of the pilot indicated that surrogate births present opportunities for clients to commit fraud. As a result, OIG decided to further analyze claims data to determine cases involving possible surrogates that should be investigated. In September 2004, BOI staff identified cases where Medicaid services were provided to the client for the birth of an infant, but there were no subsequent Medicaid charges for the infant after birth. Often times, it was found that the infant did not have a first name, but was rather listed as "girl", "boy", and "baby" and then the last name of the mother. Also it was surmised that if there was not a birth certificate for each baby listing the client's name, there was an increased probability that an adoption had taken place.

Fifteen potential surrogacy cases have been identified for further scrutiny. Six of these cases were selected in December 2004, and investigations have been initiated to determine whether the clients engaged in fraudulent activities.

### **Existing Provider Verification II**

The Existing Provider Verification (EPV) project utilized fraud detection routines in conjunction with field staff follow-up to combat fraudulent claims and billing errors from current NET providers. During Phase I, which was initiated in 2002, transportation services selected for review were identified through Fraud Science Team (FST) computerized fraud routines. These routines identified both NET services that occurred during in-patient hospital stays and NET services with no corresponding medical services. Phase I of this project resulted in the identification of over \$380,000 in overpayments to NET providers, the referral of sixteen providers to the Illinois State Police and the continued monitoring of two providers. EPV Phase I was completed during 2003.

EPV Phase II was initiated during July 2004. To establish the targets for this second phase of EPV, claims data was analyzed for all NET providers who were not reviewed in Phase I or currently under review under some other OIG program integrity effort. During Phase II, only cases involving NET services with no corresponding medical services were reviewed. Twenty-two cases were sent to the OIG's quality control review staff to verify the validity of the services billed. This verification is performed by making provider and client contacts and by reviewing medical records. Preliminary findings indicate over one-half of the twenty-two cases will be referred to the OIG's audit staff for further scrutiny. Also, one case has already been referred to the state police for investigation. Final results of these reviews will be available in 2005.

### **Family Health Plan Reviews**

To satisfy the federal requirements of the Medicaid Eligibility Quality Control (MEQC) program, the OIG received approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to conduct a review of Family Health Plan (FHP) cases. A FHP is any family medical program administered by the State. FHP cases consist of all

Medicaid cases except those eligible under the Aid to the Aged, Blind and Disabled (AABD) program. The goal of this review is to determine what, if any effect the following changes have had on the case and payment error rates for Medicaid:

- elimination of asset requirements
- increased standards for eligibility
- guaranteed Medicaid eligibility for persons under 19 for 12 continuous months
- reduction of pay stub requirements
- acceptance of declaration of childcare expenses
- additional programs (Family & Parent Assist)

These FHP reviews began in April 2004 and will continue through March 2005.

### ***ON-GOING INTEGRITY ACTIVITIES***

#### **Provider Audit Initiatives**

##### ***Recoupment of Overpayments***

During 2004, the OIG collected overpayments totaling \$24,379,022. The vast majority of this recoupment amount was identified through post-payment audits conducted of providers enrolled in the Medicaid program.

These audits were conducted by OIG Bureau of Medicaid Integrity (BMI) staff auditors and CPA firms which were contracted by the Department to conduct audits on its behalf. While staff auditors performed audits on all types of providers, CPA firms were only utilized to conduct audits of Long Term Care (LTC) facilities. In 2004, OIG completed 304 audits of various medical providers participating in the Medicaid Program. This total number of completed audits included desk audits and self audits, as well as traditional field audits where auditors physically visit the providers' facilities.

##### ***Desk Audits***

A desk audit is an in-house review where OIG staff audit a provider's paid Medicaid claims without actually visiting the provider's physical location. These providers were targeted based on the improper billing practices noted during post-payment provider audits and fraud routine analyses.

During 2004, FST conducted fraud routine analysis and identified potential overpayments to numerous laboratory providers. FST staff noted that duplicate payments for lab tests were sometimes made to both the non-salaried hospital based pathologists who billed the department for their professional component of the service, and the hospital laboratories which billed for the global service which included the pathologists' professional services. The analyses also identified situations where more than one laboratory had billed for the same tests provided to the same patients. By conducting desk audits, the OIG was able to recover the identified duplicate payments.

##### ***Self Audits***

The in-patient hospital self audit project is an ongoing OIG effort to efficiently identify and recoup overpayments resulting from coding errors on hospital inpatient claims. FST staff

identified target areas, conducted pilot reviews to determine the extent of billing errors for these targeted claims and worked with OIG's Audit Section to conduct computerized self audits. Hospitals were provided the opportunity to perform self audits, which greatly reduced the OIG's auditing effort while providing the hospitals with an opportunity to learn the reasons for and the sources of their coding errors. Hospitals that chose not to conduct a self audit were required to submit medical records for coding review and verification. Additionally, OIG conducted verification reviews of a portion of the self audits to ensure that the hospital self audits were performed accurately.

In 2004, FST initiated pilot reviews to determine the extent of billing errors for several new target groups. FST identified several of these target areas based on problem areas identified through national coding validation work performed by a coding vendor on contract with the Department. Random samples were selected for each group and reviewed to determine the extent of billing errors. Based on the finding of these reviews, OIG has asked 159 hospitals to conduct self audits of over 1,500 claims to determine whether they had billed correctly. OIG expects several million dollars to be identified and recouped through this next phase of the project.

#### **Out of State Pharmacy Project**

Implemented in December of 2003, this project was designed to determine if prescriptions dispensed by non-bordering out of state (NBOS) pharmacies were actually received by the recipient or if the recipient had received medications they did not need. Sixteen NBOS pharmacies were identified for this project. These pharmacies had paid claims totaling over \$200,000 during the calendar year of 2002.

Recipients receiving more than 80% of their prescriptions from a NBOS pharmacy were selected for review. Pharmacies which were already under investigation, certain specialty drugs, recipients receiving home health care services and recipients receiving less than 40 prescriptions during the year were excluded from review.

As of November 19, 2004, seven hundred sixteen reviews for this project were completed with approximately 19 errors identified. Preliminary findings do not indicate a pattern of fraud. Final analysis and results will be available in 2005.

#### **Long Term Care - Asset Discovery Investigations**

The Long Term Care-Asset Discovery Investigations (LTC-ADI) project began in 1996. LTC-ADI identified applicants for public assistance for Long Term Care expenses who either failed to disclose their assets or who had unallowable asset transfers. Due to the project's initial success, DPA initiated a second phase in 1997. The second phase identified undisclosed assets and unallowable asset transfers, but also utilized analyses of deterrence and error-prone profiling. Savings of \$2,288,097 were realized by the reduction of benefits or the withdrawal or denial of public assistance as a direct result of the investigation process.

The results of Phase I and Phase II convinced DPA and DHS that LTC-ADI should be continued. Phase III of LTC-ADI was initiated during May 2003. The Department contracted with a private investigative firm to perform the asset discovery investigations. However, before the vendor completed any investigations, it notified the Department that they did not want to continue with the contract since the investigation process required additional expertise that it currently did not

possess. The OIG undertook the responsibility to complete the outstanding investigations. Temporary workers were hired and OIG reassigned staff from other areas to conduct the investigations. LTC-ADI Phase III ended in March 2004 with a generated savings of \$2,974,163.

OIG continues its aggressive and cost-effective approach to maintaining the integrity of Medicaid's Long Term Care expenditures. This approach included hiring of staff to work solely with the Long Term Care-Asset Discovery Investigations and modifications to the LTC-ADI investigation process. A new RFP was published and a contract was awarded September 22, 2004 to a Certified Public Accounting firm to conduct the Long Term Care-Asset Discovery Investigations.

LTC-ADI rollout was effective December 1, 2004. The rollout of specific counties and regions will be conducted on a monthly basis. The first phase of the rollout consisted of five counties (Will, Knox, Madison, St. Clair and Winnebago). Through the collaborative efforts of DPA and DHS, it is planned that the remainder of the state will be rolled out by April 2005.

#### **Medicaid Fraud Prevention Executive Workgroup (MFPEW)**

MFPEW is an executive-level oversight workgroup charged with ensuring that reasonable and prudent measures are being taken to deter and detect fraud and abuse within Illinois' Medical Assistance Program. In order to accomplish its mission, MFPEW members collaborate to develop innovative techniques that help the Department's computerized claims processing system prevent and detect improper Medicaid payments. The workgroup, which was created during 1997, is comprised of representatives from OIG, DMP and the Bureau of Information Systems. This cooperative effort provides a forum to address emerging issues associated with the dynamic nature of fraud.

The following is an update on projects that were advanced during 2004:

HICL Sequence Numbers - This edit identifies and prevents recipients from receiving the same drug in different strengths at the same time or two similar drugs within the same therapeutic drug class at the same time continues to prevent inappropriate medicines from being dispensed. One additional drug class was added during 2004 to supplement the seven drug classes implemented during 2003.

Prescribing Practitioner Survey – A survey was developed and sent to the Medicaid agencies in the states that participate in the National Association of Surveillance Officers (NASO) to identify best practices regarding prescribing practitioners. NASO is an organization of Medicaid officials that promote an awareness of fraud and abuse and the development of resources to identify such abuses. Information requested on the survey included:

- What types of provider information are maintained on non-Medicaid providers who prescribe to Medicaid recipients
- When the physician is required to submit this information
- Whether the agencies pay for the prescription if the physician has not submitted the required information
- Where the information is stored, e.g., provider database

- Whether a pharmaceutical claim can be rejected based on the above information
- Whether the state's system performs a cross-match with the federal DEA tape to ensure the accuracy of the prescribing practitioner's ID number

The information obtained from the survey is currently being analyzed. Follow-up interviews with specific states are planned. The goal is to enhance Illinois' system so it can better define the prescribers and analyze their prescribing patterns to Medicaid recipients.

Pharmacy and Durable Medical Equipment Analysis – A study is being conducted to identify duplicate payments when a pharmacy and a Durable Medical Equipment provider bill the Department for the same supply item. The focus of the study is on ostomy supplies, diabetic supplies and wound bandages.

Crosscheck on Radiology Services – Logic was developed which identifies incorrect radiology payment combinations among hospital outpatient facilities, emergency rooms and radiologists. The logic will be applied during 2005 and self-audits will be conducted to recover overpayments that have been made.

### **Fraud Prevention Investigations**

Fraud Prevention Investigations (FPI) program targets error-prone public assistance applications which contain suspicious information or meet special criteria for pre-eligibility investigations. The FPI program has provided an eight and one half year estimated average savings of \$11.41 for each \$1.00 spent by the state. FPI has also averaged a 64% denial, reduction or cancellation rate of benefits for the 26,202 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings has reached nearly \$55.6 million. The FPI program continues to prove its value to help ensure the integrity of public assistance programs in Illinois and to increase savings for the taxpayers of Illinois. Generating 4,400 investigations, the program identified 2,491 cases that led to reductions, denials or cancellations in fiscal year 2004. BOI calculated an estimated net savings for 2004 of more than \$6.2 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps.

### **New Provider Verification**

Since June 2001, the OIG has conducted pre-enrollment site visits of non-emergency transportation (NET) and Durable Medical Equipment (DME) entities, which have applied to become Medicaid providers. The visits were initiated so that the legitimacy of these businesses could be verified prior to their enrollment as providers. During the visits, the reviewers confirmed the business' location and existence, verified information provided on the enrollment application, inquired about ownership information and licenses, checked for Medicare program sanctions and assessed the business' ability to serve Medicaid clients.

As of December 31, 2004, a total of 733 (422 NET and 311 DME) site visits have been completed to date. Approximately 10% of the applicants were not enrolled into the program due to one or more of the following reasons: incomplete enrollment packages, non-operational businesses, businesses did not respond to contact by the department to establish on-site visits, businesses requested withdrawals from the program or businesses applied for the wrong provider type.

During 2004, the OIG's quality control reviewers performed site visits for 97 NET providers and 100 DME providers. Approximately 89% of the 197 site visits resulted in the providers being enrolled in the Medicaid program, with 8% of those providers newly enrolled being referred for claims monitoring. The remaining 11% of entities visited were not enrolled because either the businesses were not operational, the provider applications were incomplete or the businesses failed to contact the OIG representative within the specified time frame.

### **New Provider Monitoring**

In December 2001, the OIG Provider Analysis Unit (PAU) began monitoring the billing activity for any NET or DME provider identified through the New Provider Verification enrollment process as having questionable activity (for example, a DME provider that has not yet acquired inventory by the date of enrollment). This monitoring is designed to quickly identify potential fraud and abuse in the provider's billing patterns. Over the last three years, a total of one hundred and twenty-two providers have been referred for monitoring.

During 2004, as a result of these ongoing monitoring activities, twelve cases were referred back to BMI for a second site visit or phone call, and one case was referred to the Illinois State Police. In addition, eleven new NET and two new DME providers were assigned to PAU for monitoring.

### **KidCare Program Integrity Plan**

The OIG finalized the FY02 KidCare Negative Case Action Report in June 2004. This review consisted of verifying the validity of negative actions (terminated or denied) taken by the Central KidCare Unit (CKU). The reviews were desk file and system reviews only. No collateral contacts, employer or client, were made to complete the reviews. When adequate documentation was unavailable to determine the validity of the negative action, the case was dropped with no further action.

The OIG also reviewed the cases to determine if the Single Filing Unit Policy used by the CKU had any impact on the eligibility of children. This policy combines all household income to determine eligibility for medical programs instead of applying the agency's standard Medicaid eligibility determination process, which separates children and stepparents from the entire family unit prior to progressing to KidCare Share, Premium or Rebate.

Results of these negative eligibility reviews, which were conducted on 230 cases, identified four error cases resulting in an error rate of 1.74%. Only one case was identified as having been denied by the CKU using the single filing policy that would have been eligible under the standard Medicaid eligibility determination process.

The KidCare Program was relatively new at the time of these reviews. The OIG considers the results of these reviews to be acceptable and will continue to monitor this program to ensure medical coverage to eligible children.

BMI also finalized the client satisfaction surveys for both the active and negative surveys that were conducted in conjunction with the eligibility reviews. Valuable comments were collected that will be provided to the Bureau of KidCare. Preliminary findings indicate that most clients were satisfied overall.

### **School Based Health Services**

In 2004, the OIG finalized the report for the technical assistance reviews of School Based Health Services (SBHS). The intent of this review was to identify discrepancies which would make a claim ineligible for reimbursement and educate Local Education Agencies (LEAs) by providing resources to help prevent discrepancies from occurring in the future.

Ninety-two percent (92%) of the LEAs were represented by nine billing agents for the fee for service portion of the claims. The OIG manually selected an LEA provider for each billing agent with ten recipients for each provider. The reviews included pending claims for dates of service provided between July 1, 2001 and December 31, 2001. In addition to reviewing services listed on the Individualized Education Plan (IEP) and their respective service logs, this review consisted of substantiating services by viewing practitioner notes and practitioner credential criteria.

For purposes of this review, all errors were identified within a claim, resulting in a total of 3028 errors for 1837 claims. The review identified the need to improve LEA provider's understanding of and compliance with policy when submitting claims for reimbursement. Corrective action measures taken by the Department were: clarifying policy in the SBHS handbook, creating suggested standard forms, providing training sessions to LEA providers throughout the state summarizing errors discovered and offering additional resources to aid in program compliance.

### **Client Satisfaction Surveys**

Client Satisfaction Surveys monitor the integrity of Medicaid in Illinois by measuring client satisfaction with medical services administered through fee for service. The surveys measure quality, access, utilization and fraud by contacting a sample of clients receiving Medicaid. The survey questions are based on a nationally recognized instrument, the Consumer Assessment of Health Plans Survey. Surveys were administered by the OIG's quality control field staff and were conducted either face to face or by telephone.

A total of 669 surveys were conducted in 2004 for the reporting period of April through September 2003. Findings for this period include:

- Most people were satisfied with the quality of care received,
- Most people did not experience difficulty scheduling doctor's appointments,
- Very few people noticed fraudulent activities, and
- Over half of the people had received services during the past several months.

OIG will continue to monitor client satisfaction by conducting surveys.

### **MEDI Safeguards**

The claim submission component of the Department's Medical Electronic Data Interchange (MEDI) system was implemented during 2004. Through MEDI, Medicaid providers and their authorized designees can now check Medicaid eligibility, submit claims electronically and follow-up on claim status via the Internet. While having the capability to accept electronic claims greatly increased the efficiency of claims processing, it also posed new risks to the Department as unscrupulous individuals would technically have the ability to quickly submit fraudulent claims for large dollar amounts via the Internet. In order to deal with this threat, the OIG worked with Division of Medical Programs and Office of Information Services to develop

new safeguards to greatly reduce the possibility of MEDI billing fraud. These new requirements are in addition to the standard procedures for submitting transactions to the State.

Before a person can be authenticated in the MEDI system, he/she is required to first obtain a digital certificate from the Illinois Department of Central Management Services. During the digital certification process, a person is authenticated against his/her driver's license information on file with the State. The person's identifying information must identically match the data on the driver's license record to be issued a digital certificate.

Next, the person must be authenticated by DPA and authorized for access to an application in the MEDI system. This process involves registering users and capturing their identifying information. Although MEDI allows certain designated individuals, such as billing agents or employees of providers, to access the system in addition to providers themselves, new safeguards require that the enrolled provider or the provider's administrator through MEDI must grant specific authority to employees and the provider's associates.

These controls will benefit both providers and the Department by ensuring that only authorized entities or persons can submit claims via the Internet. These pro-active measures should reduce the possibility of electronic billing fraud, while allowing providers to utilize technological advances that streamline the Medicaid claims submittal process.

### **Surveillance Utilization Review Subsystem (SURS) Advances**

SURS is an exception processing system that generates a comprehensive statistical profile of health care services and utilization patterns. The statistical analysis assists to identify instances of potential provider fraud and abuse of the program, to monitor those recipients whose medical services have been restricted due to over-utilization and to identify potential defects in level of care or quality of service.

The following advances were made in SURS during 2004:

Enhanced Targeting – The flexibility of the PC based CS SURS software product used by the OIG provided additional targeting ability for recipients who potentially over utilize or abuse medical services. Specifically, the restriction rate for recipients has increased from less than 50% to approximately 75% of all recipients selected for utilization review. Drug and substance abuse and constant hospitalizations representing poor quality of care have been identified by CS SURS.

Monthly Production Enhancements – Features added to the provider monthly exception reports include the ability to identify providers when a large increase or decrease occurs in payments or services provided. The revised monthly reports also identify providers with patterns of providing unusually high amounts of services on specific days of the week. The above features are good indicators of potential fraud or abuse and are targets for review.

Episode of Care – The Episode of Care feature in CS SURS provides the ability to identify potential quality of care issues. An Episode of Care is a compilation of all services that pertain to a particular illness or injury. The following Episode of Care runs have been developed:

--Hospital Dialysis Routine – An Episode of Care run was developed that identifies in-patient recipients who received multiple dialysis treatments from one or more physicians on the same date of service.

--Multiple Glasses and Exams in a 12-Month Period – An Episode of Care run was developed that identifies recipients who received more than two pairs of glasses or eye exams within a 12-month period. This run is being modified to carve out classes of recipients who are more likely to need multiple optical services.

Home Health Visits 60 Days after Hospital Discharge – A run was developed which identifies recipients that were discharged from an in-patient hospital setting and subsequently received home health services 60 days after their in-patient stay without prior approval. The results of this run will be used in desk audits to recoup inappropriate billings.

### **Data Warehouse**

OIG continues to utilize the Medical Data Warehouse to respond to data requests from various federal and state agencies. Users have ‘finger-tip’ access to a broad range of data which include: over 8 ½ years of paid claim data, 3 years of rejected claim data, provider and payee enrollment information, recipient eligibility information, and various types of reference data. The ability to receive on-line real-time responses to data inquiries has significantly improved OIG’s fraud and abuse detection efforts.

OIG has taken full advantage of this tremendous resource on a daily basis. Two additional data warehouse routines developed in 2004 have enhanced the Department’s ability to conduct provider analysis and hospital audits. These reports are:

Ping Pong Report – This report allows the end user to enter prompted information and identify situations where recipients have apparently gone from one provider to another to receive the same services. The results may be indicative of a recipient who is doctor shopping, or providers billing for services not rendered.

Hospital Outpatient Stratified Sampling – This report will allow the end user to enter sampling criteria for an outpatient hospital audit to identify the different stratum of outpatient services billed and paid to specific hospitals. Because the Department’s payments for outpatient services can vary widely, OIG performs stratified random sampling of hospitals outpatient services to ensure a proper representation of services is reviewed in the audit. Once the auditors review the records in the sample and determine the within-sample dollars paid in error, the system extrapolates these audit results from the sample to the universe of all services paid within the stratum to arrive an overall payment error amount for that stratum. To produce an overall payment error amount for the hospital, the system combines the calculated error amounts for each of the strata taking into consideration the frequency of occurrence of these services in the universe.

### **Random Claims Sampling**

Illinois was the first state to measure the dollars lost to fraud, abuse, and billing errors in the Medicaid Program. OIG’s 1998 Payment Accuracy Review (PAR) was widely cited in the trade press and was followed by other pioneering state efforts. In 2002 OIG initiated the Random Claims Sampling (RCS) project, an ongoing measurement effort similar to PAR that provides

OIG with intelligence on the extent and nature of Medicaid payment accuracy problems.

In the summer of 2004, the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services released draft rules for a nationally-required Medicaid payment accuracy measurement system, the Payment Error Reduction Measurement (PERM) project. While HHS/CMS is reconsidering the design of PERM in light of the public comments received, PERM is expected to result in changes in how OIG performs payment accuracy measurement. The extent and nature of such changes are unclear at this time, but could be significant.

OIG is preparing for a likely transition to PERM by conducting pilot reviews of services previously excluded from RCS and PAR. These pilot reviews will help OIG develop its procedures for obtaining the information needed to review these services. These pilots will also help OIG become highly familiar with these services and skilled in their review and assessment.

## **Internal Affairs**

### ***DHS Employee Investigations***

Since 1997, the DPA OIG has overseen the integrity functions for DHS in the former programs administered by DPA. OIG's governing statute, Public Act 88-554, provides for this DHS oversight at the request of the DHS Secretary. OIG's Bureau of Internal Affairs (BoIA) has conducted hundreds of employee and contractor misconduct investigations that resulted in convictions, discharges, resignations and suspensions. BoIA also performed investigations of DHS childcare contractors and funeral home operators that intentionally sought to defraud the state of Illinois. Since 1997, BoIA has also conducted hundreds of threat assessments involving DHS local office clients.

During this past year, OIG participated in several meetings with representatives of DHS and the Office of Executive Inspector General (OEIG) regarding the potential transition of DHS investigations from the OIG to the OEIG. The Executive Inspector General was already responsible by statute for the integrity oversight of the remaining two-thirds of DHS staff. In order to simplify misconduct reporting requirements for DHS staff and to prevent duplicative investigations, the OEIG proposed consolidation of all DHS employee misconduct investigations under the OEIG.

In September 2004, DHS Secretary Carol L. Adams, Ph.D., asked that the DPA OIG assist DHS in a more limited nature by continuing to only conduct investigations of alleged fraud and intentional program violations perpetrated by DHS clients and providers. Effective October 18, 2004, the OEIG assumed the integrity related functions for those DHS employees and contractors that previously fell under the jurisdiction of OIG.

### ***Internal Investigations***

In 2004, the following major cases were investigated by BoIA.

--An anonymous complaint alleged a manager was conducting herself in an unethical manner. The allegations ranged from failure to sign in/out timely on time sheets to failure to enter correct arrival times on sign in sheets. She also left during normal business hours to conduct personal errands.

The manager's son was the office janitor, but on multiple occasions the manager cleaned the

office during normal business hours. The manager's husband, who was also a manager in another office, assumed janitorial duties during his regularly scheduled work hours. The manager had also approved a new janitorial contract for her daughter.

The investigation substantiated that both employees violated numerous policies, engaging in an ongoing pattern of misconduct for years.

Prior to his investigatory interview with BoIA, the husband abruptly resigned his position. During her Internal Affairs interview conducted jointly with an investigator from the OEIG, the female manager resigned her position as well.

During the course of this investigation, Internal Affairs obtained information that the manager's supervisor may have breached the confidentiality of our internal investigation by discussing certain aspects of the case with the manager under investigation. A supplemental investigation determined that the supervisor discussed aspects of the case with the subject and documented that discussion with email. The supervisor was cited for nonfeasance by failing to exercise proper judgment in having discussions and written email communications with the subject of an internal investigation. She was suspended and was allowed to retire.

--An anonymous complaint alleged that an employee fraudulently received childcare assistance. The complaint alleged that the employee held full time employment with DPA and worked a second job. The employee received childcare assistance from the DHS and reported only her employment with the secondary employer. She also identified her mother as her daycare attendant while her children were allegedly actually staying with another daycare provider.

BoIA determined that the employee drew childcare benefits from October 1999 through November 2001 and failed to report her earnings from the state of Illinois. She was ineligible for all childcare subsidized monies that were paid by the state to her designated provider on her behalf. Preliminary analysis indicated that she might have defrauded the state's childcare assistance program in excess of \$8,000. The results of our investigation were turned over to the Illinois State Police, Division of Internal Investigation. A Cook County Grand Jury indicted the employee on five counts of Forgery, one count of Deceptive Practice and one count of State Benefits Fraud and was subsequently convicted and was sentenced to 24 months probation, fined and ordered to make restitution in the amount of \$8,200. She paid \$5,000 in a lump sum with the remainder to be paid in \$134 monthly increments. Upon conviction, the employee was allowed to resign her position with DPA where she had been on suspension pending the judicial verdict.

--A male employee, who worked on a Hotline as a Spanish speaking facilitator, had been sexually harassing female clients who had called in for assistance. BoIA interviewed victims who lived in the Chicago area. Officials had transcripts made of Spanish speaking overhearers from the Hotline in which the employee was heard making sexually inappropriate comments in Spanish to several clients. Based upon these results, the employee was interviewed and confronted with the evidence. He resigned his position effective immediately with no reinstatement rights and an agreement to not seek or accept future employment with the state of Illinois.

--During OIG's routine Internet monitoring, an employee was identified as having spent in excess of 35 hours on the Internet in a single month. Some of the sites were also identified as

being graphically pornographic in nature. The employee's computer was seized and a computer forensic examination was conducted on the local hard drive. As a result of the examination, over 430 pornographic images and evidence of other personal searches were obtained where he had surfed non-work related Web sites during his regular work hours.

An interview was scheduled and conducted with the employee. During the course of his interview, the employee resigned his position with DPA, waived any reinstatement rights and agreed to not seek or accept future employment with the state of Illinois.

--BoIA received a complaint from a female client that when she visited with her bi-lingual caseworker at the office, he inappropriately made verbal requests and initiated physical contact of a sexual nature. Because the complaint was criminal in nature, BoIA turned the case over to the Illinois State Police. OIG assisted the state police in their case investigation until criminal charges were formally filed. The state police arrested the employee at the local office. He was then placed on suspension pending judicial verdict.

After a mistrial, he was subsequently re-tried and found guilty of a misdemeanor battery charge and sentenced to ten days in the Cook County Jail and one-year Conditional Discharge. The employee resigned his position from DPA.

--An employee was investigated for conducting secondary employment during his regular work hours for DPA. BoIA reviewed his telephone records, Internet usage, his network personal drive, and his Agency GroupWise email. The evidence supported the allegation that the employee was conducting his real estate business using state equipment and resources.

An in-depth analysis of six months of telephone detail records revealed that a vast majority of his telephone calls were made to real estate interests or to tenants of the employee's rental properties (some were receiving Section 8 entitlement monies from the federal government). Very few calls could be attributed as DPA related business. Investigations identified several properties based on the employee's computer forensic examination and confirmed that he had used his Department computer to draft real estate documents.

After an investigatory interview was scheduled with the employee, he submitted a letter requesting that his resignation date be changed from December 20, 2004, to close of business November 1, 2004. Management accepted this request.

--BoIA received an anonymous referral alleging that an employee was grossly abusing time by operating her own personal business during her regularly scheduled work time at DPA. The employee allegedly left her work site to conduct her personal business and failed to notify her supervisor or the Department when she was gone.

A routine inspection of the employee's laptop computer revealed that she had personal documents from her private business. A forensic examination of the laptop disclosed other incriminating evidence of misuse, including evidence that she had used the Internet to search for contacts at a singles online "dating" club. Surveillance determined that on several workdays she did not report to her office work site, she was not on travel status, nor did she use Available Benefit Time.

During the employee's interview with BoIA, she was offered an opportunity to resign, but she declined. However, later in the month she submitted her resignation for retirement.

***Executive Inspector General***

By executive order, agencies under the Governor's Office where the position of Inspector General is governed by statute, the inspectors general shall report to the OEIG. OIG has worked in partnership with the OEIG in collective efforts to combat waste, corruption, fraud, conflicts of interest or abuse in their respective areas of jurisdiction. The DPA Acting Inspector General functions as the Department's liaison to the OEIG and participates in round-table discussions regarding integrity oversight functions and best practices to combat employee and contractor misconduct.

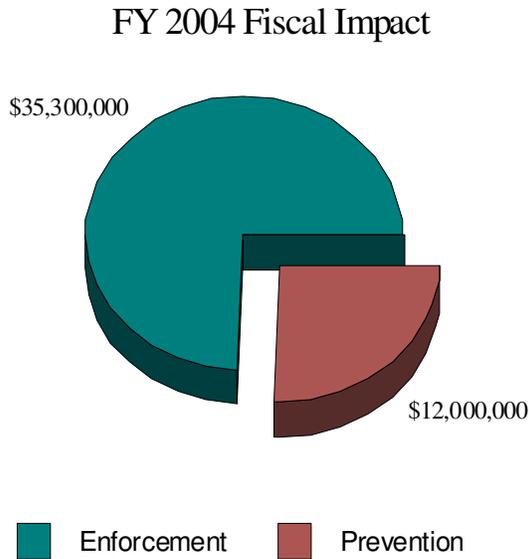
In an effort to assist the OEIG with its establishment of a downstate investigative unit, OIG provided available space in one of its downstate facilities to temporarily accommodate OEIG staff until such time that a permanent location could be established.

Several years ago, the OIG developed computer forensics capability for monitoring employee abuse of personal computers, e-mail and the Internet. Using this technology, the OIG and the OEIG have worked in partnership on several investigations of alleged infractions by state employees.

Prior to the October 18, 2004 transition of DHS integrity cases to the OEIG, investigators from both the OEIG and the OIG worked jointly on several DHS investigations involving employee and contractor misconduct.

**FISCAL IMPACT**

During Fiscal Year 2004, the OIG realized a savings of approximately \$47.3 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings. This savings was more than double the OIG FY2004 budget of \$21.3 million.



Prevention Activities:

- Recipient Restrictions
- Fraud Prevention Investigations
- FS Disqualifications/Cost Avoidance
- Medicaid Fraud Prevention Executive Workgroup
- Fraud Science Team
- Payment Accuracy Review Measurement
- Long Term Care—Asset Discovery Investigations

Enforcement Activities:

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

**CONCLUSION**

In the ten years since its creation, the OIG has moved forward aggressively on numerous fronts to expand the depth and breath of its program integrity mission. By relying on the hard work of OIG staff, cooperation with various government agencies and deployment of new technology and scientific methods, the standard for program integrity has been raised in Medicaid and other social services. The dividends have been better prevention methods, faster and broader detection tools and increased financial recoveries. Through its efforts, the OIG has succeeded in raising awareness of the importance of program integrity among clients, providers and the citizens of Illinois.

*OIG Published Reports*

<b>Title</b>	<b>Date</b>	<b>Description</b>
<i>School Based Health Services Technical Assistance Report</i>	August 2004	Identified the need to improve LEA providers' understanding of and compliance with policy when submitting claims for reimbursement.
<i>Fraud Prevention Investigations: FY02 Cost Benefit Analysis</i>	September 2002	Identified \$9.8 million in net savings with a benefit of \$12.31 for every dollar spent.
<i>Fraud Prevention Investigations: FY01 Cost Benefit Analysis</i>	September 2001	Identified an estimated \$8.6 million in annual net savings for 2001, boosting the total estimated savings to \$31.4 million since FPI began in 1996.
<i>Child Support Emergency Checks</i>	June 2001	An OIG-initiated study determined that 99.9% percent of the nearly \$14 million in emergency child support checks were either legitimate or never cashed. Of the 0.1% of the checks that remain unresolved, four have been confirmed as fraudulent.
<i>Fraud Prevention Investigations: FY00 Cost/Benefit Analysis</i>	November 2000	The program was expanded to all 23 local DHS offices in Cook County. It identified an estimated \$8.7 million in net savings, with a benefit of \$11.60 for every dollar spent. Since it's inception in 1996, the program's estimated net savings have been nearly \$23 million.
<i>Fraud Prevention Investigations: FY99 Cost/Benefit Analysis</i>	March 2000	Identified \$4.5 million in annual net savings with a benefit of \$12.12 for every dollar spent.
<i>Death Notification Project: Identifying the Cause of Delay in Notification</i>	February 2000	Evaluated whether nursing homes or DHS local offices are responsible for case cancellations due to death. The workgroup found that neither party is completely accountable, and made recommendations for improvement in the notification process. The workgroup also proposed increased monitoring of the 26 nursing home's identified as having the highest incidences of overpayments due to late notice of death.
<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.

Title	Date	Description
<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 21<sup>st</sup> 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.
<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.

<b>Title</b>	<b>Date</b>	<b>Description</b>
<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.
<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.

Most of these reports are available on our web site at [www.state.il.us/agency/oig](http://www.state.il.us/agency/oig). They can also be obtained by contacting the Inspector Generals office, Illinois Department of Public Aid at 217-524-7658.

*STATISTICAL TABLES***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 cover either an 18 or 24 month audit period and are conducted on institutional and non-institutional providers. When 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, a negotiated settlement or the DPA Director's final decision. The provider may repay the department by check or by a credit against future 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 periods. Collections generally result from audits completed in prior periods.

Collection of Overpayments  
CY 2004

Audits	304
Collections	\$24,379,022.00

**Collection of Provider and/or Client 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 by installments, and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

Collection of Provider and/or Client Restitutions  
CY 2004

Amount Collected	\$434,570.76
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**Refill Too Soon**

This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid claim. The estimated savings represents the maximum amount the Department could save as a result of RTS edits. Once payment for a prescription is rejected, the prescription is probably resubmitted later, after the first prescription 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  
CY2004

Total Number of Scripts	41,707,795
Amount Payable	\$2,205,353,985
Scripts Not Subject to RTS	98,051
Amount Payable	\$8,156,130
Scripts Subject to RTS	41,609,744
Amount Payable	\$2,197,197,855
Number of Scripts	1,895,476
Estimated Savings	\$116,982,905

### 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 12 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 2004

Hearings Initiated	
Termination	23
Suspension	1
Denied Application	2
Recoupment	10
Termination/Recoupment	5
Decertification	7
LTC/Hospital Assessment	1
Child Support Sanctions	107
Total	156
Providers Sanctioned	
Termination	6
Voluntary Withdrawal	5
Suspension	2
Denied Application	2
Recoupment	4
Termination/Recoupment	2
Decertification	0
Child Support Sanctions	41
Negotiated Settlements	9
Other P.A. 88-554 Sanctions	0
Total	71
Cost Savings	\$38,041.42
Cost Avoidance	\$39,205.52

### Client Eligibility Investigations

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public aid. Investigation results are provided to caseworkers to calculate the overpayments. Cases with large overpayments or aggravated circumstances are prepared for criminal prosecution and presented to a state's attorney or a 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 for 12 months for the first violation, 24 months for the second violation, permanently for a third violation and 10 years for receiving duplicate assistance.

#### Client Eligibility Investigations CY 2004

Investigations Completed	1,056
Estimated Overpayments	
Grant and Food Stamps	\$2,284,364
Medical*	\$30,963
Types of Allegations	
Employment	14%
Family Composition	23%
Residence	10%
Interstate Benefits	3%
Other Income	7%
Assets	6%
Multiple Grants	1%
Other	36%
Total	100%
Food Stamp Disqualifications	888

\*NOTE: Includes Medical overpayments from Client Eligibility Investigations and Medical Investigations

### 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 DHS' Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. attorney.

#### Child Care Investigations CY 2004

Investigations Completed	28
Overpayment Identified	\$229,099
Prosecution	
Accepted for Prosecution	1
Overpayment on Cases	\$13,336
Convictions	1
Restitutions Ordered	\$13,336

### Client Prosecutions

The OIG conducts welfare fraud investigations involving large financial losses. Substantiated cases are referred to a State's Attorney or U.S. Attorney for criminal prosecution, or to the Illinois Department of Human Services, Bureau of Collections for possible civil litigation. 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 Prosecutions CY 2004

Prosecution	
Accepted for Prosecution	42
Overpayment on Cases	\$386,290
Convictions	33
Restitutions Ordered	\$267,518
Acquittals	0

### Medical Abuse Investigations

The OIG investigates allegations of abuse of the Medical Assistance Program by clients. Abusive clients may be placed in the Recipient Restriction Program (RRP). The restriction process begins with a computer selection of clients whose medical services indicate abuse. After reviews by staff and medical consultants, clients are restricted to a primary care physician, pharmacy, or clinic for 12 months on the first offense and 24 months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider, except in emergencies. Prior to November 1, 2004, abuse clients could choose to enroll in an HMO as an alternative to RRP. An administrative rule change has removed this HMO option.

#### Medical Abuse Investigations CY 2004

Medical Overutilization	
12 Months	
Recipient Reviews Completed	1,882
Recipients Restricted for 12 months as of 12/31/03	418
Recipient Restrictions Added	456
*Recipient Restrictions Released and Canceled	476
Recipients Restricted for 12 months as of 12/31/04	398
24 Months	
Recipient Re-evaluations Completed	563
Recipients Restricted for 24 months as of 12/31/03	296
Recipient Restrictions Added	202
*Recipient Restrictions Released and Canceled	53
Recipients Restricted for 24 months as of 12/31/04	445
Recipients opting for an HMO instead of restriction as of 12/31/03	31
**Recipients opting for an HMO instead of restriction as of 12/31/04	61
Cost Avoidance for 2004	\$1,328,003

\*Releases are a result of: program compliance, cancellation of Medicaid eligibility, death of recipient, or opting to select an HMO (prior to 11/1/04).

\*\*Any abusive client who chose to enroll in an HMO prior to 11/01/04 was allowed to remain in the HMO.

**HMO Marketer Investigations**

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

HMO Marketer Investigations  
CY 2004

Types of Allegations	
Fraud	0
Misrepresentation	0
Unethical Practices/Other	1
Total	1
Findings	
Substantiated	0
Unsubstantiated	1
Unable to Determine	0
Total	1

## Internal Investigations

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its security oversight. The investigators are not sworn, do not carry firearms and do not have arrest powers. Investigations include criminal and non-criminal work-rule violations, public aid fraud, 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. Resolutions may include resignation, dismissal, suspension or a reprimand.

### Internal Investigations CY 2004

Investigations Completed	
Substantiated	114
Unsubstantiated	53
Total	167
Types of Allegations	
Non-Criminal (Work Rules)	
Discourteous Treatment of Others	16.9%
Failing to Follow Instructions	1.1%
Negligence in Performing Duties	16.1%
Engaging in Business with a Client	.4%
Incompatible Outside Interests	3.8%
Sexual Harassment	.7%
Release of Confidential Agency Records	1.9%
Misuse of Computer System	3.5%
Falsification of Records	3.0%
Other Work Rule Violations	14.5%
Work Place Violence	7.7%
Criminal (Work Rules)	
Misappropriations of State Funds	.4%
Attempted Fraud or Theft	1.8%
Commission of or Conviction of a Crime	2.0%
Other	.1%
Public Assistance Fraud Offenses ILCS Chapter 305	3.2%
Criminal Code Offenses ILCS Chapter 720	18.2%
Contract Violations, Security Issues	2.7%
Special Projects, Background Checks, Assist other Agencies	2.0%
Total	100.0%
Misconduct Cited	
Employees	41
Vendors	6
Total	47
Resolutions	
Discharged	6
Resigned	9
Suspensions	6
Other, such as reprimands	13
Administrative Action Pending at Year End	8
No Action Taken	2
Total	36

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***APPENDIX - AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION***

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed at [www.state.il.us/agency/oig](http://www.state.il.us/agency/oig) under the heading of Calendar Year 2004 Annual Report/Data. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type.

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