



Office of Inspector General

Illinois Department of
Healthcare and
Family Services

2005 Annual Report

Rod R. Blagojevich
Governor

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Office of Inspector General
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March 31, 2006

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

As Inspector General for the Illinois Department of Healthcare and Family Services, I am pleased to present you with the Annual Report for the Office of Inspector General (OIG) for Calendar Year 2005. The achievements described within this report are the results of the hard work and dedication of more than two hundred staff members as well as the commitment of Healthcare and Family Services and the Department of Human Services. Due to their efforts, the OIG has shown great progress in the pursuit of our mission.

This report describes a wide array of activities that the Office has undertaken over the past year to enhance the integrity of the programs operated by this Department and the Department of Human Services. Recently, Healthcare and Family Services has started operating two new programs: the Office of Energy Assistance and the Office of Healthcare Purchasing. The OIG looks forward to working with these new divisions.

As required by Public Act 88-554, this report provides data on over-payment recoupments, fraud prevention savings, sanctions against providers, and investigation results. It is my hope that the 2005 Annual Report provides you with valuable information.

Respectfully Submitted:

John C. Allen, IV
Inspector General
Healthcare and Family Services

Mission

The mission of the Office of Inspector General is to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in programs administered by Healthcare and Family Services and the Department of Human Services.

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**Office of Inspector General
Illinois Department of Healthcare and Family Services
Annual Report
Calendar Year 2005**

INTRODUCTION

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). Its mission is to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in programs administered by the Illinois Department of Healthcare and Family Services and the Department of Human Services (DHS). On July 1, 2005, DPA became the Department of Healthcare and Family Services (HFS).

The position of Inspector General is a four (4) year term appointed by the Governor of Illinois, reports to the Executive Inspector General (OEIG) and requires confirmation by the Illinois State Senate. While the OIG functionally operates as a separate division of HFS, it still maintains autonomy from the agency. 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 enables the OIG to greatly increase its impact on HFS' programs.

The OIG investigates possible fraud and abuse in programs administered by HFS 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. Also, the OIG enforces the policies of HFS, DHS, and the State of Illinois affecting clients, health care providers, vendors and employees.

OIG staff members include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information specialists. During 2005, the OIG had an authorized staffing of 209 employees. The majority of the staff operates in either Springfield or Chicago and the remainder working out of field offices located throughout the state.

The OIG began a new era of leadership during 2005, as John C. Allen, IV was appointed Inspector General on May 1, 2005 and subsequently confirmed by the Illinois Senate on October 26, 2005. Under Inspector General Allen's direction, the OIG plans to continue its current fraud fighting efforts and expand its integrity activities to include new HFS programs such as Governor Blagojevich's new All Kids program and the new Division of Group Health Purchasing.

ENFORCEMENT ACTIVITIES

Executive Inspector General

By Executive Order (Administrative Order #6 (2003)), agencies where the position of Inspector General is governed by statute, the inspectors general shall report to the Office of Executive Inspector General (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 HFS 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.

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 partnered on several investigations of alleged infractions by state employees.

Audit Initiatives

Recoupment of Overpayments

The Office of Inspector General is responsible for identifying and collecting overpayments. An overpayment occurs when medical services are authorized and paid through the Medicaid program when these charges were improper. During 2005, audit-related overpayments totaling \$18,469,301.37 were collected by the OIG. 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 the 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 utilized to conduct audits of long term care facilities. In 2005, the OIG completed 902 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. Providers often requested a reaudit, in order to submit additional documentation. Other completed audits move directly into recoupment or are contested by the provider and are settled in the administrative hearing process.

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. Providers are targeted for desk audits based on the improper billing practices noted during post-payment provider audits and fraud routine analyses.

During 2005, the OIG conducted 437 desk audits of fee-for-service claims paid to home health agencies, laboratories, hospitals and physicians. These desk audits identified overpayments totaling nearly \$6 million. Desk audits performed during 2005 focused on the following billing improprieties.

1. Hospitals improperly billing the global fee for x-ray services, although radiologists had separately billed for their professional fees. Since the radiologists had been paid

for their professional services, the hospital should have only billed for the technical service.

2. Home health agencies improperly billing for procedure codes that do not require prior approvals, when the services actually provided required prior approval.
3. Laboratories billing separately for laboratory tests provided during inpatient hospital stays. Since the Department makes all-inclusive payments to hospitals for inpatient stays, it was improper for the laboratories to bill separately for these services.
4. Physicians were paid more than the maximum allowed Department reimbursement for a particular psychiatrist procedure code due to an error in the Department's computer system. The edit in place failed to screen the maximum allowable rate for this particular procedure code. The OIG has worked with the Department to ensure the edit is now functioning properly.

Self Audits

Provider self audits are another OIG effort that efficiently identifies and recoups overpayments resulting from errors on certain types of claims without visiting the provider's physical location. The OIG's Fraud Science Team (FST) identifies target areas and conducts pilot reviews that determine the extent of billing errors for these targeted claims. FST then works with the Audit Section to conduct computerized self-audits, where providers are asked to conduct their own review and to submit disclosed overpayments.

During 2005, the OIG conducted self audits on claims paid to hospitals, pharmacies and physicians. These self audits resulted in identified overpayments of over \$1 million. For 2005, self audits were conducted on providers for the following identified billing improprieties:

1. Hospitals billing for certain Diagnosis Related Group claims
2. Laboratories billing for services but failing to report payments received from third party payors.

Client Prosecution Cases

The OIG Bureau of Investigation (BOI) had thirty-two client fraud cases accepted for prosecution during 2005. Three of these cases are highlighted below.

- ❖ An OIG investigator worked the Illinois portion of the case in which a mother and father are accused of murdering their daughter "Precious Doe" in the State of Missouri. The mother had collected food stamp benefits from Illinois from March 2004 through May 2005. The OIG investigator completed a prosecution investigation of the mother for applying for benefits in Illinois on March 1, 2004, for herself and four daughters, including the one that was murdered. The overpayment in Illinois was estimated at \$10,378.25, for the period of March 2004 through May 2005. The father's overpayment was estimated at \$565.00 during a 2-month overpayment period, March and April 2005.

At one point the authorities noted that they had looked into the murdered child being "Precious Doe" but had ceased the investigation because they were informed that the

child was receiving food stamp benefits in Illinois. The OIG investigator testified before the Grand Jury in Kane County, Illinois on July 22, 2005 that the child murdered in Missouri in 2001 continued to receive benefits in Illinois.

The mother was indicted on July 22, 2005, on 5 counts: 3 counts of Public Assistance Fraud (Classes 1, 2, and 3), 1 count of State Benefits Fraud, and 1 count of Perjury. The father was indicted on 3 counts: 1 count each of Public Assistance Fraud, State Benefits Fraud, and Perjury.

- ❖ A case involving a public assistance recipient was forwarded to the U.S. Attorney's Office for inclusion with a criminal case already pending against the client. The recipient and the recipient's spouse had been indicted on multiple counts due to Supplementary Security Income (SSI) and DHS fraud. This investigation included Department of Children and Family Services childcare and adoption fraud components. The investigation was worked with the U.S. Postal Service Inspection Service. OIG's investigation involved the recipient's use of an alias name to fraudulently receive public assistance and included a \$79,997.97 overpayment; \$15,625.00 in cash assistance, \$41,184.00 in food stamp benefits and \$23,188.97 in medical assistance. In addition, BOI is completing a child care investigation of the client and will pursue prosecution of that fraud component.
- ❖ A case involving identity theft was forwarded to the U.S. Attorney's Office for inclusion with a criminal case already pending against a public assistance recipient. The recipient fraudulently used the identity of an individual to apply for and receive Home Health Care payments. This investigation was also worked with the U.S. Postal Inspection Service. OIG's investigation involved the recipient's failure to report the income and the absence of various household members in the assistance unit. The case included a \$23,092.00 overpayment; \$6,435.00 in cash assistance and \$16,657.00 in food stamp benefits.

Food Stamp EBT Referrals and Disqualifications

The Food Stamp Fraud Unit (FSFU) reviews cases referred for suspected food stamp fraud. The cases are reviewed, evidence is compiled and then it is determined if sufficient evidence is available to prove the suspected violation. If so, the client is notified of the charges and is provided the opportunity to return a signed waiver admitting to the charge. If the client does not return the signed waiver, an Administrative Disqualification Hearing (ADH) is scheduled.

Since the inception of the program in 1999, FSFU has received 15,643 referrals from the USDA Food and Nutrition Services (FNS) and 329 referrals from field staff and hotline calls. According to FNS, Illinois is a leading state in the processing of food stamp fraud referrals. The positive disqualification decision rate from hearings is 96.35%.

In 2005, FSFU received a total of 4,948 referrals and participated in 2,808 ADHs. In addition, FSFU received 622-signed waivers and 26 prosecution cases that resulted in 1,229 clients being disqualified last year. The hearing decisions and signed waivers realized a cost savings to the State of Illinois of \$4,232,898 during 2005.

HFS Employee Investigations

The Bureau of Internal Affairs (BIA) conducted 136 employee and vendor investigations during 2005. Several of these cases are described below.

- It was reported that an employee's absence from the office June 7 through June 10, 2004 might have been taken under false pretenses. On June 7, 2004, a supervisor received a telephone call from a person who claimed to be a nurse calling to report that the employee would not be able to report to work that day as the employee sought treatment in the emergency room. It was ascertained that she falsified official forms and was absent when she purchased airline tickets on May 4, 2004, knowing that she did not have enough vacation time available for a four-day absence planned for the week of June 7th. The employee was not honest with management and used a premeditated scheme, arranging for her friend, a nurse, to contact her supervisor and provide false and misleading information that the employee was seeking medical treatment at the hospital ER during the time of her vacation to Florida. The employee lied to investigators during the investigation. This employee was issued a 15-day suspension.

Also, the investigation determined that a co-worker violated HFS policy by falsifying records and when she denied telling other co-workers of the vacationing employee's June 7-10, 2004 whereabouts. This employee was issued a Written Reprimand.

- Routine monthly monitoring of Internet usage, uncovered a user who had logged over 30 hours on the Internet that month. There was evidence that non-work related Web sites were accessed, including numerous pornographic sites. The investigation determined that the employee violated HFS policy when he accessed the Internet from his HFS computer to access Web sites for personal reasons. Several of these sites were hard-core pornography, including at least two Internet downloads of videos containing graphic sex acts. He admitted to viewing these videos and Web sites during work hours and claimed he had a pre-employment addiction to pornography. He resigned his position with HFS, effective close of business on January 19, 2005.
- BIA received information that an employee involved in a previous investigation was currently being investigated by the Illinois State Police for sexual assault of a minor child. A copy of the Information for Complaint from the Sangamon County Circuit Clerk's office on felony case revealed that the employee was charged with three counts of Criminal Sexual Assault. The complaint read that between June 13, 2000 and June 13, 2003, the employee committed acts of sexual penetration with a minor child who was his stepdaughter. On June 9, 2004, he was afforded the opportunity to submit a resignation, however, he declined and was suspended pending judicial verdict. On January 14, 2005, the employee pled guilty to one count of criminal sexual assault and was sentenced to 180 days incarceration to be served with 90 consecutive weekends in jail. He submitted his resignation from the Department, effective January 27, 2005.
- BIA received information that a temporary services employee alleged that a janitor and two co-workers sexually harassed her. BIA investigated this matter jointly with the Equal Employment Opportunity Office (EEO). The janitor allegedly approached the victim in the parking lot and engaged her in conversation and requested her personal

telephone number. The victim said she did not know the janitor and that the parking lot was empty at the time. She later said she felt intimidated by the situation and provided the janitor with a fictitious telephone number. On a later date, the janitor again approached the victim, and in this instance, questioned her why she provided a fictitious telephone number. She told the janitor that she was scared and uncomfortable with the situation. She also informed the janitor that she was not interested in being involved with him. The janitor then allegedly engaged the victim in conversations of a sexual nature to include repeated requests for sexual intercourse. The janitor detained the victim for approximately one hour before she insisted she had to leave.

Based upon the victim's statements and BIA's interview with the janitor, the allegations were substantiated. The cleaning company removed the janitor from working in any HFS facility in the future.

The victim also alleged that an employee made remarks to her about her sexual orientation on or about October 19, 2004. These remarks were made in the company of a third worker and stemmed from the victim sharing with them the initial parking lot incident with the janitor. The victim alleged that her co-worker, who was also aware of the parking lot incident with the janitor, had discussed her sexual orientation with co-workers. We determined that the co-worker violated HFS policy when he engaged in conversations regarding the sexual orientation of a fellow employee and made comments that were inappropriate for the workplace. This co-worker of the victim was issued a ten-day suspension, effective April 1, 2005.

- A DHS local office discovered a suspect case during a random review of cases opened and referred the matter to BIA. The complaint involved a DHS caseworker and the fact she may have serviced an application case for her sister, as a new out-of-district applicant. The evidence determined that the caseworker processed an assistance application for her sister as a new out-of-district applicant. The caseworker admitted that she intentionally failed to follow established office procedures in order to process her sister's application and to intentionally leaving off information on the application. BIA established that the case was totally ineligible at its inception. Therefore, the sister received total fraudulent benefit payments of \$6,573.

The caseworker used her position to fraudulently benefit her sister. The caseworker fulfilled the elements of the crime of Administrative Malfeasance, when she misappropriated, misused or unlawfully withheld available benefits for public aid purposes or converted to these benefits to the use of another (her sister). The sister and caseworker in the furtherance of their scheme to defraud the state of Illinois of \$6,573 fulfilled the elements of the crime of State Benefits Fraud. Two warrants were issued. The sister was arrested for State Benefits Fraud over \$300 and an arrest warrant for State Benefits Fraud and Administrative Malfeasance was issued for the caseworker.

- In May 2005, a child support client applicant alleged that someone at the child support hotline released confidential information about her child support case to the alleged father. She surmised this because within minutes of terminating her call with a female Hotline worker, she received a telephone call from the alleged father who berated her for contacting the agency to name him as an NCP. He also said that he had an inside contact

at the agency. When interviewed and shown a picture of the suspected worker, the victim also identified her as the same person who worked with her previously and had been fired for an internal theft. The investigator, along with a temporary services supervisor interviewed the Hotline worker. The worker admitted that she was a best friend with a female who happens to be the alleged father's sister. She also admitted that her cell phone records would probably show calls being made to the female in May, but denied that she had told the female about the victim's call into the Hotline regarding the alleged father. The worker admitted that she had a conversation with her friend regarding the questioning from her supervisors regarding the person's complaint, but again denied any direct contact with the alleged father.

The worker denied that she previously worked with the victim. When questioned about why she left her previous employer, the temporary worker admitted that she was terminated because of her involvement in a theft scheme. She admitted that she only became aware of the theft near the end of the scheme when the company began its investigation. She admitted that she failed to place this information on her employment application with the temporary service.

Based upon her admission of misconduct that resulted in a termination from the previous employer and the fact she omitted this information from her employment application for temporary employment, the temporary services agency determined that the worker would be terminated immediately.

- Management reported that a SeniorCare client received a telephone call from a male subject who verified her SSN, date of birth and address, asking her if she lived alone. The caller told the client that he was offering "extra coverage" for SeniorCare and offered to drop off a package the next day. The client suspected a problem and declined the caller's offer. She notified the local police.

Initially, the SeniorCare client told the police that her caller ID identified the Health Benefits Hotline number. Suspecting that caller ID would not register our Hotline number because of the manner the system is configured, we tested Caller ID and discovered that the system pulls from a bank of unassigned numbers for outgoing calls and those numbers display on in-coming calls on the recipient's Caller ID. Further investigation revealed the incoming number came from a consulting company located in Ft. Worth, Texas. This company utilizes an almost identical approach to telemarketing solicitation as what the client reported.

The investigation determined that there was an attempted telemarketing scheme that resulted in at least three victims being identified. The scheme involved trying to obtain the victims' routing and account numbers from their checking accounts on the pretense of establishing their new prescription account number and a method of identifying each member. The scam resulted in a pre-authorization check being processed through each victim's bank in the amount of \$299 made payable to the company. The routing number was the same for all three victims' pre-authorization checks. This routing number belongs to an Internet bank located in Wilmington, Delaware. Two of the three victims were clients of HFS's SeniorCare program, however, at this time there is no evidence that the client database has been compromised. Investigators from other investigative

agencies indicated that there was no sign of state databases being compromised. There have been no other similar complaints to the OIG or the department.

The Federal Trade Commission has expressed an interest in pursuing the information contained within the OIG investigation and have requested a copy be forwarded to them, as has the U.S. Department of Health and Human Services. Copies of the Report of Investigation were forwarded to Attorney General's offices in Illinois, Texas and Kentucky.

The OIG has suspended the investigation, as there is no evidence at this time supporting HFS employee or contractor misconduct or involvement; however, the federal authorities have continued their investigation and dubbed the scammers "the 299 Gang."

- BIA received a report that a non-custodial parent came to the office and alleged that an employee was engaged in a conflict of interest with the NCP's ex-wife, who is a child support client. The investigation established that the employee violated HFS policies by having a personal relationship with a client. The employee initially denied the relationship, but when confronted with information that refuted his statements, the employee admitted having a personal relationship with the client and acknowledged taking recent action on her case. The worker was issued a seven-day suspension.
- An employee reported that a co-worker might have misused her computer privileges. A forensic examination of the hard drive and files associated with her assigned computer system was conducted to determine if there was any evidence of misuse. The investigation determined that the employee violated policy when she admitted that she used her state issued computer for her own personal use and forensic computer evidence supported that she used her computer system to create personal letters, access information on the Internet, perform on-line banking transactions, and perform email correspondence. She admitted that the 208 personal documents recovered from her computer were done for her benefit. The employee was issued a ten-day suspension.
- A supervisor observed a subordinate employee viewing his sister's case information on the Medicaid Management Information System (MMIS). The employee had no MMIS tasks assigned to him. The investigation determined that the employee violated policy when the employee admitted to accessing the Department's MMIS in order to secure confidential case information concerning his sister. It was also reported in a local newspaper article that he was arrested for Criminal Damage to a Vehicle. BIA obtained the police incident report regarding the arrest. In addition to the Criminal Damage to Vehicle, the employee was in possession of two unused hypodermic needles/syringes. When investigators spoke to the employee, he said he was chased by a dog and sought refuge on top of a vehicle, but fell on the vehicle in the process busting out the rear window.

However, in the police report the employee initially denied any knowledge of damage to the vehicle, but later admitted to it. As a result of the investigation and other issues regarding the employee's attendance and his performance, he was discharged for cause.

- A manager at the Illinois State Disbursement Unit (SDU) reported that a custodial parent's (CP) case had been credited with payments from three checks from the CP's personal checking accounts, all determined later to be closed accounts. The checks had been credited and paid to the client via direct deposit before the SDU had time to act and stop processing. The checks totaled \$5,500. The investigation determined that the client authored and presented for payment to the SDU three checks drawn on closed accounts. The total of \$5,500 was credited to the CP's existing child support case and electronically transferred to her debit card. She spent the entire amount of \$5,500 for miscellaneous purchases and for personal gain. Two more checks were presented but not credited by the SDU onto her child support case. One of these checks was determined to be a counterfeit check possessing the correct routing number, but a non-existing account number. Local police in the company of one of BIA's investigators arrested the CP. She is awaiting sentencing on the criminal charges.
- It was reported that an employee was suspected of falsifying official agency records. A child support client alerted the states attorney's office that child support documents she received in the mail contained signatures that were not penned by her. BIA substantiated the allegation and established that the employee violated multiple HFS policies when she knowingly and intentionally signed a custodial parent's name to official child support forms. The employee was issued a 7-day suspension.
- BIA discovered during an email review for another Internal Affairs case that there was evidence that two employees were engaged in an excessive amount of personal use of the Department's email system. There was also evidence that one of the employees may have released confidential case information to a person who was a former employee of the Department. The investigation determined that both employees used the Department's email system for personal use in violation of HFS policy. They not only sent personal email messages to one another, but also shared some of this information with a network of other employees within HFS and other individuals outside of the Department. One employee violated HFS policy when she accessed a Department database and printed forms containing confidential client information on a former employee. This employee was in violation of HFS policy when she engaged in and conducted outside business activities on state time, using state resources, using the Department's email system to communicate and plan her purchases of supplies, coordinate selling and plan trips in relation to her outside business endeavor. One employee was issued a 7-day suspension, and the other employee was issued a 10-day suspension. Three additional employees were counseled as a result of their email abuse.
- A Medicaid provider alleged that an employee was very impolite to him over the telephone, threatened his participation in the program and failed to send him a notification of intent to review letter. The complainant also alleged that when the employee arrived at his clinic, she continued to behave discourteously towards him and refused to show identification. The investigation determined that the employee violated HFS policy when she failed to prepare and send a required letter of introduction and confirmation of appointment to the provider before her appearance at his clinic. The employee further violated HFS policy when in an effort to conceal her failure to prepare and send the required letter, she created a false document and post dated the document as the purported mail date and then presented the letter to BIA knowing that the document

had never been created and mailed to the provider. The employee used agency computer equipment to create a false and misleading document and provided false and misleading information to BIA investigators. The employee was issued a 7-day suspension.

Computer Forensic Activities

The OIG has a significant role in investigating, monitoring and examining staff's computer activities of HFS resources to insure compliance with the Department's Computer Security and Internet Policy. This is accomplished by the following activities.

Computer Forensic Examinations

During 2005, BIA examined eight Agency computers in the course of conducting internal affairs investigations regarding violations of the Department's Computer Security and Internet Policy. Additionally, the OIG continues to work in partnership with the Office of Executive Inspector General (OEIG) in their collective efforts to combat abuse and misconduct involving state computer equipment in their respective areas of jurisdiction. BIA assisted the OEIG on several investigations of alleged computer infractions by state employees.

Internet Monitoring

Specialized Internet monitoring software allows the OIG to continuously monitor Agency employees' and contractors' usage of the Internet on a monthly basis. The software determines the total length of time spent accessing the Internet, addresses of sites visited, general categories of sites accessed and demographic patterns of usage. As the result of such monitoring, forty-two employees and contractors were identified as participating in questionable Internet activity during 2005. Several of the more egregious users were referred for investigation while less severe infractions were referred to the employee's division for administrative handling.

Email Monitoring

In July 2005, the OIG assumed the responsibility of monitoring all email sent to, and received from, sources outside of the Department. Specialized email monitoring software allows BIA to monitor the number of incoming messages, the number of outgoing messages, and the size of the email. As a result of this monitoring, the OIG discovered several employees sending and receiving pornographic images. Additionally, BIA examined the internal email of thirty-five employees suspected of misusing the Department's email system.

PREVENTION ACTIVITIES

Fraud Prevention Investigations

The goal of the Fraud Prevention Investigation (FPI) Program is to prevent ineligible persons from receiving public assistance benefits which otherwise would have been inappropriately issued. The program targets public assistance applications containing suspicious information or meeting special criteria for pre-eligibility investigation. When DHS local office staff makes a referral, the referral is reviewed by the OIG Bureau of Investigations (BOI), and sent to a vendor for investigation. When the vendor completes the investigation, a summary report is sent to BOI for review. BOI then makes a recommendation to approve, deny or cancel an applicant's case to the DHS local office.

Since fiscal year 1996, the program's savings have reached \$67.5 million. Over these past ten years, the program has realized an average savings of \$12.01 for every \$1 spent on administration of the program. If this program had not been in place, these assistance benefits most likely would have been issued to individuals who were not eligible to receive them.

During calendar year 2005, the FPI program generated 3,355 investigations of which 2,166, or 65%, resulted in cancellation, denial or reduction in benefits. The savings for calendar year 2005 calculates to more than \$5.9 million for all assistance programs, including Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps.

Since inception, the FPI program has only operated in Cook County. On December 13, 2005, the OIG issued a new Request for Proposal (RFP) to expand the program beyond Cook County to the Metro East (Madison and St. Clair counties) region of Illinois. An analysis of applications for benefits indicated that the OIG should strive to expand FPI into other regions of the state. The Metro East area was selected as the first region for expansion because that area has the largest number of clients in the state after Cook County.

Long Term Care—Asset Discovery Investigations

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program targets error-prone long term care applications. In partnership with OIG, the DHS local throughout the state participate in this effort. LTC-ADI evaluates those containing questionable information or meeting special criteria for pre-eligibility investigations. The program's goal is to prevent ineligible persons from receiving long term care benefits, thereby saving tax dollars and making funds available to qualified applicants who meet the eligibility requirement based upon Medicaid standards. The investigations, which are completed by a vendor on contract with the department, uncover undisclosed assets and unallowable asset transfers.

The OIG accepted 368 LTC-ADI cases for investigation during calendar year 2005. The savings realized in 2005 for not providing public assistance benefits to ineligible persons due to LTC-ADI was \$7.5 million. For every \$1 spent on administration of the LTC-ADI program, \$12.45 of savings was realized.

Medicaid Fraud Prevention Executive Workgroup (MFPEW) Activities

Senior staff members from the Division of Medical Programs (DMP) and the OIG conferred on September 23, 1996, to discuss initiatives to prevent and detect inappropriate payments that are processed through the Medicaid Management Information System (MMIS). The immediate objective identified by this group was the creation of an executive-level oversight workgroup to ensure that reasonable and prudent measures are being taken to deter and detect fraud and abuse within Medicaid. On January 23, 1997, the director of the Department of Public Aid approved the creation of the Medicaid Fraud Prevention Executive Workgroup (MFPEW). The first meeting was held in May 1997.

MFPEW develops measures consistent with the provision of quality health care to combat fraud and abuse in the Medical Assistance Program. The workgroup has a broad base of disciplines from DMP and the OIG and includes Office of Information Systems staff. This cross-section of HFS collaborates to develop new fraud prevention methods and ensure the effectiveness of the MMIS system in preventing and detecting improper payments.

During the past nine and one-half years, the workgroup has researched and supported issues to strengthen the Department's stance against potential fraud and abuse. These issues have resulted in on-site provider reviews, report recommendations, MMIS edit changes or proposals, policy changes and the development of profiling criteria. MFPEW understands that the nature of fraud is constantly changing. To meet this challenge, the Department recognizes it must evolve with the dynamic nature of fraud. MFPEW is committed to researching emerging issues, such as fraud committed through the electronic interchange of data, and developing edits, policies or routines to prevent fraud within Medicaid. MFPEW is prepared to proactively meet the challenge of fraud control.

Pharmacy Analysis

MFPEW has spent a considerable amount of time evaluating and analyzing existing edits in the Department's pharmaceutical program. The following are several pharmacy initiatives that have been studied through MFPEW during 2005:

Out-of-State Prescription Evaluation--MFPEW identified that the Department paid almost \$55 million to out-of-state pharmacies in CY02. With the growing usage of mail-order pharmacies, MFPEW wanted to ensure the following:

- Clients were receiving the proper medication prescribed by their physician
- Clients did not continue to receive medications in the mail after the prescription expired or was discontinued
- Clients actually received the medications being billed by the mail-order pharmacies

To address these issues, BMI conducted an Out-of-State Pharmacy Pilot that targeted non-bordering pharmacies that were paid more than \$200,000. A total of sixteen mail-order pharmacies were reviewed. The study included phone interviews with recipients, prescribers and pharmacies.

The results of the study indicated that 97.3% of the services provided were validated. The Pilot did identify a few isolated instances where the practitioner did not prescribe the medication billed to the Department or where the pharmacy continued to send the medication to the recipient after they were notified to stop. A pattern was not present with any of the instances identified.

Pharmacy Bill Splitting Issue--An audit of a long-term care (LTC) provider identified the practice of dispensing maintenance medications on a weekly basis to LTC recipients rather than monthly. This practice resulted in three additional dispensing fees paid to the LTC pharmacy. Data analysis was completed to determine if this was a widespread practice among LTCs, and did not identify any other instances where this practice occurred. MFPEW concluded that no major system changes were warranted. OIG will periodically target this issue to ensure pharmacy bill splitting does not occur in the future.

Compound Drugs--A study of compound drugs was initiated during 2005 to identify the existence of prescriptions that are inappropriately billed as a compound drug. Four specific areas are being evaluated:

- Prescriptions billed as compounds that are comprised of a syringe and one ingredient or a pre-filled syringe billed as a compound

- Prescriptions billed as compounds that are comprised of a syringe, needle and one ingredient
- Prescriptions billed as compounds that contain a syringe and are billed within the LTC setting
- Duplicate prescriptions that result from being billed as a compound and a non-compound

It is anticipated that this study will conclude in calendar year 2006 and the results may lead to system changes to address any vulnerabilities identified.

Smoking Deterrent Agents

MFPEW has been studying potential edit solutions to address the overuse of smoking deterrent agents in the Medical Assistance Program. The Department has developed a Duration of Therapy edit based on recommendations established by the Food and Drug Administration (FDA). The purpose of this edit is to limit clients to receipt of a fixed number of days of smoking deterrent products. Once this window has been exhausted, then the recipients will not be able to obtain additional products for the balance of the year. The success of this edit will allow the Department to expand the Duration of Therapy edit to other pharmaceuticals that have specific time frames regarding the use of their product.

Non-Emergency Transportation (NET) Provider Re-enrollment

As of September 1, 2005, the OIG began conducting criminal background checks and on-site visits for approximately 510 non-emergency transportation (NET) providers re-enrolling with the department. Excluded from this process are government entities and newly enrolled providers that had already submitted fingerprints for criminal background checks. In addition, providers already subjected to a site visit within the last two years (September 1, 2003 to August 31, 2005) will not have another site visit conducted, but will have a criminal background check completed.

As of December 31, 2005, the OIG had received approximately 66 referrals, re-enrolled 9 providers and returned 4 applications due to non-compliance with fingerprinting, incorrect information on provider applications or an unreported reorganization.

Client Eligibility Reviews

In October 2005, the OIG began conducting client eligibility reviews of long term care (LTC) cases that had been approved within the last 90 days. This initiative, entitled Changes Affect Recipient Eligibility (CARE), involves contacting the client or authorized representative approximately 90 days following the DHS local office interview for LTC applicants.

During the application process for LTC, the applicant is informed that all changes (financial or non-financial) must be reported to the Department in a timely manner. Often applicants are overwhelmed with the responsibilities of placing a loved one in a long term care facility and do not remember to report the changes. After the patient is placed in the nursing facility and the family member or authorized representative has access to the patient's records, there may be changes to the client's financial and non-financial status. The purpose of this pilot is to identify the changes that had taken place and had not been reported since the date of application approval.

This review promotes oversight to an area of Medicaid that not only has a history of being error-prone, but an area that represents a significant portion of all Medicaid expenditures. Nearly six months of data is being collected with the results being available by August 1, 2006.

Also during 2005, the OIG began conducting an Income Verification Review (IVR) of Family Health Plans (Title XIX only). The purpose of this review is to determine if using one pay stub is truly representative of 30 days income.

In an effort to further streamline the application process and assist families in applying for medical benefits, beginning in January 1, 2004 the requirement of using only one pay stub to determine eligibility for all Family Health Plans was implemented. The IVR will provide insight as to whether one pay stub is truly representative of 30 days income, if families determined eligible for Medicaid using one pay stub are truly eligible, if more than one pay stub is being provided and/or used in eligibility determinations and if collateral sources are being utilized to determine whether the income source provided is questionable. Beginning in Federal Fiscal Year 2001, area of income has been the leading contributor to the case error rate for Medicaid.

Reviews will begin in January 2006 and will continue for approximately six months. Results will be available during 2007.

Family Health Plan Reviews

In April 2004, as part of the federally mandated Medicaid Eligibility Quality Control (MEQC) review process, the OIG implemented Family Health Plan Reviews to provide insight into the effects of changes within certain Medicaid eligibility policies. Over the previous six years, the Department has been revising eligibility standards to expand Medicaid coverage for more children and families in Illinois.

During 2005, OIG completed an analysis of 772 cases for the review period of April 2004 through September 2004. The analysis revealed an accuracy rate of 92.4% in eligibility determinations and 97.3% payment accuracy. Upon completion of the analysis for the final six months (October 2004 through March 2005) of data, the OIG will provide recommendations for improvement of the already commendable accuracy rates.

PERM

Illinois is one of 17 states selected by the U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (HHS CMS) to participate in the first year of the mandated Payment Error Reduction Measurement (PERM) program. HHS CMS is measuring the extent of improper payments in every state Medicaid program across the next three federal fiscal years and on an ongoing basis thereafter. The purpose of this effort is to enable HHS CMS to:

- ◆ Comply with the federal Improper Payment Information Act, which requires federal agencies to estimate improper payments in their program, develop a national improper payment amount and rate for Medicaid, and report those figures to OMB and Congress
- ◆ Produce and publish state-level corresponding improper payment estimates

OIG has been closely monitoring PERM and related developments for several years and will be the state's liaison to HHS CMS and its contractors for this project. The PERM review will be a significant effort for OIG and HFS, as it requires states to provide data files and an extensive amount of billing policy documentation in a short time frame. It also requires extensive review and collaboration with HHS CMS' statistical, documentation, and medical review contractors. The federal contractors are designing the sample, obtaining information on Medicaid policies, and performing the medical review based on their interpretation of HFS policy. In future years, PERM will include a review of managed care capitation payments, Children's Health Insurance Programs, and eligibility verification. It is possible states may be asked to perform extensive recipient eligibility reviews on behalf of CMS, in addition to those now required under Medicaid Eligibility Quality Control.

Illinois was the first state to perform a Medicaid payment accuracy review. This landmark review, the Payment Accuracy Review (PAR), served as a model for subsequent reviews performed by other states. Illinois has continued its tradition of measurement in recent years with the Random Claims Sampling project. This project ensures that all Medicaid claims submitted for payment in Illinois have a chance of being reviewed. A report outlining the findings of this project will be published during 2006.

New Regulatory Measures

Legislation was initiated and signed into law by Governor Blagojevich during 2005, which should greatly reduce improper or fraudulent Medicaid payments associated with alternate payees. Alternate payees are individuals or entities that are designated to receive payments on behalf of a provider for services provided to Medicaid clients. This legislation was spearheaded by the OIG because the Department had 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, Public Act 94-265 became effective on January 1, 2006.

This new law created specific jurisdiction for the Department to recover overpayments, and assess other sanctions, against those alternate payees that violate state rules or statutes. Public Act 94-265 formalized the Department's relationship with alternate payees, requiring the alternate payee to register with the Department. The new law also made the alternate payee jointly and severally liable with the vendor for any overpayments of monies. Moreover, it granted the Department the authority to deny or cancel alternate payee registrations without cause. Finally, the new law granted 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.

Public Act 94-265 has prompted the OIG to review administrative rules to determine what changes are needed to implement the requirements of the statute. As a result, twenty-two administrative rules will require change and five new rule sections have been drafted. Enactment of these rule amendments will be pursued in early 2006.

COOPERATIVE EFFORTS

Medi Medi

The OIG co-chairs the Medi Medi project, a collaborative effort with HHS CMS and state and federal law enforcement partners that uses data from both the Medicaid and Medicare programs to identify fraud and overpayments. The Illinois project is unique because the OIG, with its expertise healthcare fraud detection, is an equal partner in the project and is actively using combined Medicaid and Medicare data for fraud detection and case development.

The project has achieved significant results. OIG and the Medicare Program Safeguard Contractor (PSC) working on behalf of HHS CMS have identified dozens of cases that are now under investigation or facing a federal or state administration action as a result of the project. Discussions are underway for both OIG and the PSC to perform joint audits and other reviews to establish the extent of improper billing against both programs and take appropriate actions.

During the past year OIG took a first step in the development of a joint audit methodology by collaborating with the Office of Audit Services within the U.S. Department of Health and Human Services' Office of Inspector General (HHS OIG) to review several providers who were not initially referred to law enforcement for investigation. The Medi Medi project provided us with an opportunity to assess the providers' billings at a global level by examining the providers' claims from both programs. This opportunity was not available to the OIG previously and provides us with invaluable insights not only on the specific cases under review but also on the elements that will be needed for future joint audits. HFS OIG and HHS OIG identified several targets based on provider-specific data analyses and developed a review that would rapidly identify the extent of the providers' billing problems. HHS OIG auditors visited each of these providers at their location, interviewed them or their staff, and performed a review of the providers' records. As part of the provider-specific data analysis, HFS OIG also identified whether the targeted providers had questionable operations registered to receive payments on their behalf.

In the Fall of 2005, HHS CMS hired a new PSC for the contracting region that includes Illinois. This change has had a significant impact on the project, as new agreements must be developed and signed, workflow procedures are being revised, the PSC's Medicare database is under development, and connectivity between the Department's and PSC's systems has to be established. Once these and other start up activities are completed, new fraud detection routines can be run and additional cases will be identified. At this time OIG is working closely with the PSC on existing cases and the development of new detection areas for later in 2006.

Prosecutions

The OIG provides support to State and Federal law enforcement agencies in the prosecution of providers, alternate payees, and individuals whose actions under the Medicaid program violate Federal and State statutes. The Office provided assistance on these cases by performing data research, providing program related documentation and arranging department program expert witnesses.

The OIG worked with both State and Federal prosecutors and law enforcement officials in this effort. Prosecutors generally handled the legal enforcement of our statutes as a criminal or civil prosecution. Qui tam, or whistleblower cases, are often handled as multi-state jurisdiction prosecutions. Several of the prosecutions completed during 2005 are described below.

- Bridgett Beard, owner of A. J. Transportation Services, Inc., a non-emergency transportation provider, was convicted of Vendor Fraud in May 2005. The indictment alleged the billing of false claims to the Department. Beard was sentenced to five years probation and ordered to pay \$36,000.00 in restitution to the State of Illinois.
- Sherrie Renken, a non-emergency transportation provider, was convicted of two counts of Mail Fraud in December 2005. Ms. Renken was sentenced to 18 months in a Federal penitentiary, three years probation and ordered to pay restitution to the State in the amount of \$75,052.07. The mail fraud was based upon false claims being submitted under the Medicaid program.
- Mercy Awosika, part owner of a non-emergency transportation provider known as Clacom Cambulance Corporation, was convicted in May 2005 of Vendor Fraud. Awosika was sentenced to 2 years probation and ordered to pay \$46,000.00 in restitution to the Department. The fraud was based upon false claims being submitted under the Medicaid program.
- David Rommel, DDS was convicted of nine counts of Mail Fraud and one count of Health Care Fraud in November 2005. This dentist was sentenced to 63 months in a Federal Penitentiary, three years probation and ordered to pay the Department \$827,106.75 in restitution. Rommel was convicted of causing false billings to the Department and performing unneeded dental work on the healthy teeth of Medicaid recipients.
- Eddie Spencer, owner of a non-emergency transportation provider named Spencer's Transportation, pled guilty to one count of Vendor Fraud. Spencer was sentenced to six months probation and ordered to pay restitution of \$26,500.00. The fraud was based upon false claims being submitted under the Medicaid program.
- In January 2005, Rhonda Washington pled guilty to Vendor Fraud and was sentenced to four years probation, 180 days in Cook County Jail and \$1,000,000.00 restitution to be paid at the rate of \$250,000.00 per year of probation. Washington operated alternate payee entities Optimum Healthlinks, Inc. and Omega Development.
- Dr. Soo Tong Park entered a plea of guilty in January 2005 to one count of Vendor Fraud. Dr. Park was sentenced to two years probation and ordered to surrender his medical license. In addition, a civil judgment of \$1,876,633.00 was entered in favor of HFS. Dr. Park was a physician who had filed false claims under the Medicaid program.
- In September 2005, a qui tam action was settled with King Pharmaceuticals, Inc. in the U.S. District Court for the Eastern District of Pennsylvania for the period of 1994 through 2002. King is a manufacturer of various pharmaceuticals and a distributor via several subsidiaries. The action alleged that King knowingly failed to collect and analyze pricing information to determine the most accurate average manufacturers' price. King agreed to pay the amount of \$124,057,318 to the United States and the affected states. The State of Illinois' share was \$1,308,717.

- A qui tam action was settled with Serono, SA Inc. in the U.S. District Court for the Districts of Massachusetts, Maryland and Connecticut during 2005. Serono is the manufacturer of Serostim, described as an AIDS wasting drug. The action alleged that Serono knowingly used false data with the government to influence off-label use of the drug. Serono agreed to pay the amount of \$567,065,000, of which \$9,996,896 is the Illinois portion.
- Between September 1, 1997 and September 19, 2003, Rush University Medical Center submitted claims for physician professional services, hospital outpatient and hospital inpatient services for Medicare and Medicaid patients participating in clinical trials for which some or all of the services were not reimbursable as routine care costs, as defined by the National Coverage Decision on Clinical Trials. As a result of this conduct, Rush submitted or caused to be submitted unallowable claims for payment to the Medicare Program and the Medicaid Program. Rush disclosed the Covered Conduct voluntarily to the Department of Justice. In December, 2005, Rush agreed to pay \$1,004,940 to settle this action, with \$52,666 being paid to the State of Illinois.
- From 1991 through 2004, Gambro Healthcare, Inc. caused claims to be provided to both Medicare and Medicaid for the purpose of maximizing payments to Gambro in excess of established reimbursement rates. Gambro is a durable medical equipment prosthetics orthotics and supply company. A relator filed a qui tam suit in April 2001, against Gambro and various subsidiaries. In June of 2005, a Gambro subsidiary pled guilty to one count of Health Care Fraud, and Gambro agreed to compensate the United States government by a total of \$308,390,672. The State of Illinois' share of this settlement was \$564,928.

Illinois Healthy Women

In June 2003, the Department's Bureau of Contract Management (BCM) was awarded approval by the HHS CMS to implement the Family Planning Expansion Initiative. This initiative was implemented on April 1, 2004 as the Illinois Healthy Women (IHW) program and provides family planning/birth control and related reproductive health care for women between the ages of 19 and 44 when they lose their Medicaid benefits. Approval of the initiative was contingent upon compliance with Special Terms and Conditions, including a requirement to conduct customer satisfaction surveys.

The OIG provided assistance to BCM by conducting 253 client satisfaction surveys of clients who had utilized IHW services and 53 client satisfaction surveys of clients who had not utilized the services of the program. The 253 IHW surveys contained 25 questions which were categorized into 5 areas: quality, access, referrals, utilization and demographics. The overall results of the 253 surveys reveal a 92.24% satisfaction with quality, a 63.32% satisfaction with access and a 69.88% satisfaction with referrals to services. Of the clients surveyed, 80% stated they plan to continue utilizing IHW services. Demographics of those surveyed revealed 69% were between the ages of 19-30 with an average of 1.6 children.

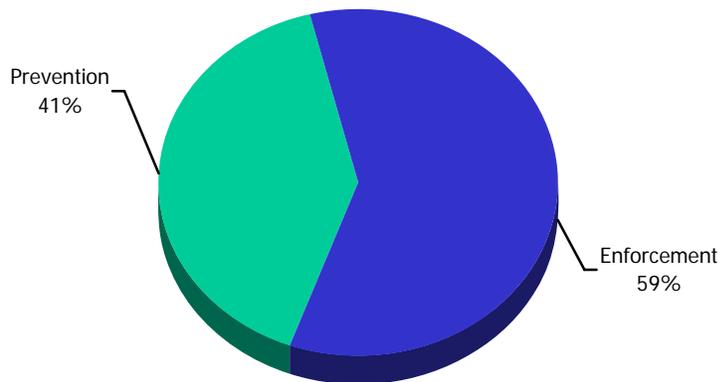
Results of the 53 surveys with no IHW services utilized revealed the majority of clients have not used IHW services because they are using a Medicaid card.

FISCAL IMPACT

Calendar Year Savings

During Calendar Year 2005, the OIG realized a savings of approximately \$46.6 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize these savings. The exact dollar amount associated with each prevention and enforcement activity can be found in the *2005 OIG Savings and Cost Avoidance Tables* portion of this report on the page numbers indicated in parentheses next to the activities listed below. Please note that this is the first year for savings due to global settlements to be included in this chart.

CY05 Savings



Total = \$46,589,612



Prevention Activities:

- Client Medical Abuse (*refer to page 27*)
- Fraud Prevention Investigations (*refer to page 25*)
- Food Stamp Fraud: Disqualifications/Cost Avoidance (*refer to page 24*)
- Long Term Care—Asset Discovery Investigations (*refer to page 26*)

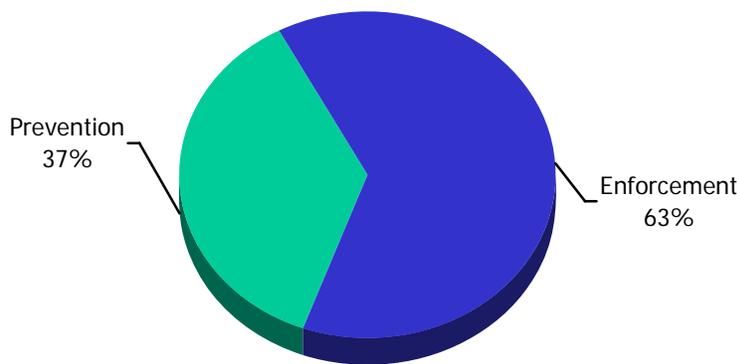
Enforcement Activities:

- Medical Provider Audits (*refer to page 21*)
- Client Eligibility (*refer to page 23*)
- Sanctions (*refer to page 22*)
- Food Stamp Fraud: Overpayments (*refer to page 24*)
- Restitution (*refer to page 21*)
- Global Settlements (*refer to page 21*)
- Child Care (*refer to page 24*)

Fiscal Year Savings

During Fiscal Year 2005, the OIG realized a savings of approximately \$43.6 million through collections and cost avoidances. This savings was more than double the OIG FY2005 budget of \$19.7 million. Please note that this is the first year for savings due to global settlements to be included in this chart. In addition, it should be noted that Long Term Care—Asset Discovery Investigations were only conducted during seven months of FY05, while they were performed during the entire twelve months of CY05.

FY05 Savings



Total = \$43,629,231

Prevention Activities:

- Client Medical Abuse
- Fraud Prevention Investigations
- Food Stamp Fraud: Disqualifications/Cost Avoidance
- Long Term Care—Asset Discovery Investigations

Enforcement Activities:

- Medical Provider Audits
- Client Eligibility
- Sanctions
- Food Stamp Fraud: Overpayments
- Restitution
- Global Settlements
- Child Care



CONCLUSION

During 2005, the OIG has moved forward 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 OIG has continued to strive to fulfill its mandate of preventing and detecting fraud and abuse in HFS programs. The dividends have been better prevention methods, faster and broader detection strategies and increased financial recoveries.

2005 OIG SAVINGS AND COST AVOIDANCE TABLES

Medical Provider Audits

The OIG initiates provider audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Audits cover either an 18 or 24-month audit period and are conducted on both institutional and non-institutional providers. The OIG conducts field audits, desk audits and self audits of providers. When a provider is selected for a field audit, the provider is contacted, and records are reviewed onsite by the audit staff. When the OIG performs desk audits of providers, claim information is reviewed without having an auditor physically visit the providers' facilities. Self audits allow an opportunity for providers to review their own records and report billing irregularities.

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 HFS 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. As a consequence, collections generally result from audits completed in prior periods.

Medical Provider Audits

Type of Audit	# Recoupments Established	Total Dollars Established
Field	320	\$28,997,097
Desk	255	
Self	75	

Medical Provider Collections

Monies collected are from fraud convictions, provider criminal investigations, civil settlements and global 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.

Medical Provider Collections

Type of Collection	# Cases	Total Dollars Collected
Provider Audits	645	\$21,395,513
Restitution	34	
Global Settlements	6	

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.

Sanctions

Hearings Initiated	# Cases
Termination	11
Termination/Recoupment	7
Recoupment	10
Suspension	2
Denied Application	4
LTC/Hospital Assessment	0
Decertification	16
Child Support License Sanctions	137

Final Decision	# Cases	Total Medical Provider Sanction Dollars
Termination	6	Cost Avoidance: \$2,721,858 Cost Savings: \$180,092
Termination/Recoupment	5	
Recoupment	5	
Suspension	2	
Voluntary Withdrawal	9	
Settlement	14	
Denied Application	3	
Reinstatement	7	
Barment	9	
Child Support License Sanctions	90	

Medical Provider Analysis: Narrative Review Committee

The OIG's Surveillance Utilization Review exception processing system routinely targets and identifies provider billing and payment patterns that exceed established norms for their peer group, e.g., pediatricians, pharmacies, laboratories. This information is analyzed and presented on a monthly basis to the Narrative Review Committee (NRC). The NRC is comprised of representatives from the OIG, Division of Medical Programs, Illinois State Police Medicaid Fraud Control Unit (MFCU), Department of Public Health and other agencies as required. The NRC discusses each case and recommends whether the provider should be audited, reviewed for quality of care, referred for criminal investigation, receive a letter regarding committee's concerns such as over utilization of specific procedure codes, or excluded from further scrutiny at that time.

Medical Provider Analysis: Narrative Review Committee

Outcomes	# Cases
Cases Reviewed	922
Recommendations to Provider	39
Refer for Audit	172
Refer for Quality of Care Review	245
Refer for MFCU Investigation	5
No Further Action at This Time	461

Law Enforcement

The OIG is mandated to report all cases of potential Medicaid fraud to the Illinois State Police Medicaid Fraud Control Unit (MFCU). Along with reporting the occurrence of the fraud, the OIG also provides data and data analysis support to MFCU, and other law enforcement entities such as HHS OIG, U.S. Attorney, Illinois Attorney General and the FBI to support its criminal investigations.

Law Enforcement

Enforcement Activities	# Cases
Referrals to Law Enforcement	57
Law Enforcement Data Requests	142

Client Eligibility

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. Investigation results are provided to DHS caseworkers to calculate the recoupment of overpayments. In cases with large overpayments or aggravated circumstances, the OIG 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.

Client Eligibility

Enforcement Activities	# Cases	Total Overpayments Established
Investigations Completed	890	\$2,241,328
Founded	505	
Unfounded	385	
Convictions	44	

Type of Investigations	Percent
Absent Children	17%
Absent Grantee	1%
Assets	5%
Duplicate Assistance	2%
Employment	16%
Family Comp/RR In Home	21%
Family Composition	10%
Food Stamp Trafficking	5%
Impersonation	1%
Interstate Duplicate Assistance	8%
Other Income	7%
Residence Verification	6%
Third Party Liability	1%

Food Stamp Fraud

Clients who intentionally violate the food stamp program are disqualified from the food stamp program for a period of 12 months for the first offense; 24 months for the second offense; permanently for the third offense; and ten years for receiving duplicate assistance and/or trafficking. Note: Cost avoidance is calculated as the average amount of food stamp issuances made during the overpayment period times the length of the disqualification period.

Food Stamp Fraud

Enforcement Activities	# Cases	Total Dollars Established
Reviews Completed	2,903	Cost Avoidance: \$4,232,898 Food Stamp Overpayments: \$1,087,680
Pending Administrative Disqualification Hearing	5,944	
Disqualifications	1,229	
Unsubstantiated	3,851	

Child Care

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 of these OIG investigations 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, or to DHS Bureau of Collections for possible civil litigation.

Child Care

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	6	\$27,401
Founded	6	
Unfounded	0	
Convictions	0	

Client Medical Card Misuse

The OIG conducts investigations when clients or vendors are suspected of misuse or misrepresentations concerning the medical programs. Client fraud occurs when clients are suspected of misusing their medical cards or their cards are used improperly without their knowledge. Typical examples include loaning their medical card to ineligible persons, visiting multiple doctors during a short time period for the same condition, obtaining fraudulent prescriptions, selling prescription drugs or supplies, or using emergency room services inappropriately.

Provider fraud occurs when claims are made for care not provided or for care at inappropriate rates. Depending on the results of the investigation, the case may be referred for a physician or pharmacy restriction or a policy letter may be sent to the client. The case may also be forwarded to another bureau or agency for some other administrative or criminal action.

Client Medical Card Misuse

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	92	\$36,649
Founded	48	
Founded In-Part	15	
Unfounded	29	

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 a ten-year estimated average savings of \$12.01 for each \$1.00 spent by the state. FPI has averaged a 65% denial, reduction or cancellation rate of benefits for the 30,152 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings has reached nearly \$61.9 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. During calendar year 2005, the program generated 3,355 investigations, of which, 2,166 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated net savings for calendar year 2005 of more than \$5.4 million for all assistance programs: Medicaid, Temporary Assistance for

Needy Families (TANF) and Food Stamps. The FPI contract was cancelled in October 2005, and a new Request For Proposal (RFP) was issued on December 13, 2005, to expand the program beyond Cook County to the Metro East (Madison and St. Clair counties) region of Illinois.

Fraud Prevention Investigations

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	3,355	\$5,928,666
Denied Eligibility	393	
Reduced Benefits	1,673	
Cases Canceled	100	
Approved	1,189	

Long Term Care-Asset Discovery Investigations

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program targets error-prone long-term care applications, which contain questionable information or meet the special criteria for pre-eligibility investigations. In partnership with the OIG, DHS local offices throughout the state participate in the effort. The program's goal is to prevent ineligible persons from receiving long term care benefits due to diverting or not disclosing assets, thereby saving tax dollars and making funds available to qualified applicants who meet the eligibility requirement based upon Medicaid standards.

Long Term Care Asset-Discovery Investigations

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	368	\$7,472,839
Approved		
Impose Sanction Period/Group Care Spenddown	71	
Impose Sanction Period/Regular Group Care Credit	30	
No Sanction Period/Group Care Spenddown	112	
No Sanction Period/Regular Group Care Credit	37	
Denied		
Client Requested Application be Withdrawn	32	
Client Refused to Cooperate/Failed to Provide Verifications	86	

Client Medical Abuse

The OIG investigates allegations of abuse of the Medical Assistance Programs by clients. Abusive clients may be placed in the Recipient Restriction Program (RRP). After reviews by staff and medical consultants, clients whose medical services indicate abuse 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.

Client Medical Abuse

12 Month Restrictions	# Clients	Total Cost Avoidance Client Medical Abuse
Clients Restricted as of 12/31/2004	452	\$1,301,337
Client Reviews Completed	917	
New Restrictions	234	
Released or Canceled Restrictions	157	
Converted to 24 Month Restrictions	121	
No Restrictions	405	
Clients Restricted as of 12/31/2005	408	
24 Month Restrictions	# Clients	
Clients Restricted as of 12/31/2004	330	
Client Reviews Completed	278	
New Restrictions	121	
Re-Restrictions	26	
Released or Canceled Restrictions	130	
Clients Restricted as of 12/31/2005	347	

Internal Investigations

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its security oversight. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses and contract violations.

Internal Investigations

Enforcement Activities	# Cases
Investigations Completed	136
Substantiated	89
Unsubstantiated	47

Types of Allegations Investigated	Percent
Non-Criminal (Work Rules)	66.3%
Discourteous Treatment of Others	5.1%
Failing to Follow Instructions	3.7%
Negligence in Performing Duties	4.8%
Engaging in Business with a Client	0.3%
Incompatible Outside Interests	3.2%
Falsification of Records	1.8%
Sexual Harassment	0.9%
Release of Confidential Agency Records	1.8%
Misuse of Computer	5.1%
Work Place Violence	16.0%
Other Work Rule Violations	23.6%
Criminal (Work Rules)	28.3%
Theft or Misuse of State Property	2.9%
Misappropriation of State Funds	0.8%
Commission of or Conviction of a Crime	2.0%
Criminal Code ILCS 720	19.7%
Other	2.9%
Security Issue, Contract Violation	4.8%
Special Project, Background Check, Assist other Agencies	0.6%

Internal investigations often reveal violations of work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension or reprimand. The outcomes for the internal investigations completed during 2005 are listed below.

Misconduct Outcomes	# Actions
Misconduct Identified	71
Employee	60
Vendor	7
Other	4
Misconduct Resolutions	71
Discharge	5
Resignation	8
Suspension	14
Other, such as reprimands	19
Referred to Other Sources for Resolution	10
Administrative Action Pending at Year End	8
No Action Taken by Agency	7

APPENDIX A—OIG PUBLISHED REPORTS

Title	Date	Description
New Provider Verification Report April 2001 to September 2003	October 2005	Provided oversight to the enrollment of 288 non-emergency transportation and 212 durable medical equipment providers by scrutinizing applications and performing on-site visits.
Medicaid Eligibility Quality Control Report FFY02	April 2005	Cited a case error rate of 14.62% and a payment error rate of 3.06% for the Medicaid (Title XIX) population.
Illinois Healthy Women Survey Report 1 st Quarter 2005	April 2005	Conducted 253 surveys on women enrolled into the newly implemented IHW program who had utilized services and 53 surveys on those who had not.
<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 its 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.

Title	Date	Description
<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.
<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.

Title	Date	Description
<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.
<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.

Title	Date	Description
<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. They can also be obtained by contacting the Inspector General's office, Illinois Department of Healthcare and Family Services at 217-785-7030

APPENDIX B--REFILL TOO SOON DATA

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
CY2005*

Total Number of Scripts	44,811,490	
Amount Payable		\$2,298,502,501
Scripts Not Subject to RTS	102,718	
Amount Payable		\$7,360,464
Scripts Subject to RTS	44,708,772	
Amount Payable		\$2,291,142,037
Number of Scripts		2,127,228
Estimated Savings		\$124,647,168

APPENDIX C - 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 <http://www.state.il.us/agency/oig> under the heading of Calendar Year 2005 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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