



Office of Inspector General

Illinois Department of  
Healthcare and  
Family Services

2006 Annual Report

Rod R. Blagojevich  
Governor

John C. Allen, IV  
Inspector General



**Office of Inspector General**  
***Illinois Department of Healthcare and Family Services***

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Rod R. Blagojevich  
*Governor*

John C. Allen IV  
*Inspector General*

March 30, 2007

**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 2006. 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. As required by Public Act 88-554, this report also provides data on over-payment recoupments, fraud prevention savings, sanctions against providers, and investigation results. It is my hope that the 2006 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 2006**

***INTRODUCTION***

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). DPA became the Department of Healthcare and Family Services (HFS) on July 1, 2005.

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 HFS, 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 HFS's programs.

The OIG investigates possible fraud and abuse in programs administered by HFS 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 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 2006, the OIG had an authorized staffing of 209 employees, with 186 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.

The OIG continued fulfilling its mission during 2006, with John C. Allen IV serving as Inspector General. 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 All Kids.

## ***ENFORCEMENT ACTIVITIES***

### **Audit Initiatives**

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

During 2006, the OIG collected overpayments totaling \$29,670,258. 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 2006, OIG completed 806 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***

During 2006, the OIG conducted 566 desk audits. These audits identified overpayments totaling nearly \$1.8 million and are the product of routines performed by the Fraud Science Team (FST). Desk audits performed during 2006 focused on the following improprieties.

- Billing for transportation during the middle of an inpatient stay – This routine identifies payments made to transportation providers for trips occurring during the middle of an inpatient hospital stay.
- Duplicate transportation billing – This routine identifies instances where the transportation provider billed repeatedly for the same service or group of service yet did not provide these additional services.
- Billing for services after the recipient's date of death – This routine identifies paid services that were billed for dates of service occurring after the recipient's date of death.

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

The OIG analyzes a cross-section of providers each month to identify aberrant patterns that may be indicative of fraud or abuse. In May 2006, the OIG began invoking self-audits on providers that presented an excessive use of extended and comprehensive office visit codes. These self audits were performed in lieu of the previous practice of mailing letters to the providers, encouraging them to rethink their utilization of certain office visit codes. Twenty-two self audit requests were sent to providers from May through December 2006. The recoupment results from the self-audits remain pending at year-end.

Also new for 2006 was OIG's review of provider self disclosures. The disclosure documentation that was submitted by the provider to department is inspected by OIG staff and an analysis of the provider's paid claims data is performed to ensure that the provider has included all instances where a discrepancy may have existed. If other discrepant items are found, the OIG will initiate a desk audit to include the additional items and collect the proper overpayment. An analysis of the source of the errors and any billing error patterns is also completed and may be utilized to refine the audit process or included in a future FST data mining routine.

***Limited Number of Re-audits***

During 2006 the BMI audit group implemented the “One Re-Audit” policy. In 2005, BMI completed 392 re-audits compared to 332 that were completed in 2006. The number of multiple re-audits for 2007 is expected to decrease significantly as this new policy achieves its full effect. This new policy has resulted in the reduction of time to complete an audit and establish the overpayment. In addition, the time saved in not performing multiple re-audits will enable the OIG to conduct more audits each year.

Prior to the implementation of this policy, multiple re-audits were routine. It was not uncommon for a Medicaid provider to request as many as 6 or 7 re-audits when the provider disagreed with each audit finding. Under the new policy, it is made clear that to settle disputed findings, only one re-audit with an opportunity to provide additional material will be allowed prior to a hearing before an Administrative Law Judge.

***Collection Efforts***

The OIG decided to take a more pro-active approach in the collection of court ordered restitutions and audit overpayments. Over \$12 million in accounts receivable were no longer being actively collected thru established protocols. During 2006 the OIG revised these processes to include more aggressive follow-up and case closures.

***Court Ordered Restitution Cases***

The OIG Collections Unit performed a comprehensive review of Illinois Medicaid court ordered restitution cases and found 47 cases where entities were delinquent in repaying debts to HFS. The amount of delinquent overpayment is approximately \$6.8 million. The unit contacted the respective court to ensure HFS payment records were up to date before contacting these entities. For these 47 delinquent cases, the following actions have occurred:

- 8 cases have been or are in the process of being written off as bad debt
- 16 cases have been filed with the Office of the Comptroller for collection of any funds that go through their office
- 10 cases have been or are in the process of being referred to the Office of the Attorney General for assistance with collection
- 13 providers have been in contact with the OIG regarding their repayment arrangements.

***Delinquent Audit Debts***

The OIG Collections Unit stepped up its efforts to refer audit debts to the Office of the Comptroller and the Office of the Attorney General on a regular basis for assistance with collection. There are currently thirty-five entities that are delinquent in repayment of debt due to an audit. Of those 35 entities:

- 8 cases are currently with the Comptroller in an effort to collect (approximately \$1 million); if no funds are collected through the Comptroller the cases will be referred to the Office of the Attorney General for assistance with collection
- 27 cases have been referred on to the Attorney General for assistance with collection (approximately \$4.5 million)

### Client Prosecution Cases

The OIG Bureau of Investigations (BOI) referred 23 client fraud investigations to prosecutors during 2006. Seven investigations of particular interest are highlighted below.

- BOI investigated duplicate assistance and unreported income and asset allegations involving married clients using alias names and Social Security Numbers (SSN). While receiving Social Security Administration (SSA) benefits in two names, the husband also received public assistance in both names. In addition, he failed to report his wife's employment or her receipt of SSA retirement benefits in her alias name and SSN or their ownership of a rental building. The case was referred to the U.S. Attorney's Office for an \$83,896.07 overpayment (\$11,130.12 in grant, \$72,024.00 in food stamps and \$741.95 in medical). The investigation is to be included with the SSA investigation.
- In November 2005, BOI assisted a United States Department of Agriculture (USDA) Agent from their Office of Inspector General in Maryland on a possible Inter-State Duplicate Assistance case. The USDA agent stated that a warrant for the Illinois resident was initiated for Theft of Government Property and making False Statements. A \$28,090.00 Maryland overpayment occurred during the period of September 2001 through April 2003, which overlapped a \$3,669.00 Illinois overpayment. A BOI investigator further examined the circumstances in the case and identified an additional Illinois overpayment in the amount of \$9,891.00 for failure to report spousal income for the period of June 2004 through October 2005. The Illinois Assistance case was canceled effective November 2005 and the Illinois overpayment was established.

The subject was arrested in Illinois on April 25, 2006 and taken to federal court where she posted bond. On July 6, 2006, the subject pled guilty in U.S. District Court in Maryland, to one count of embezzlement. She received a sentence of 24 months probation, 100 hours community service, \$25.00 assessment fee, and restitution for in the amount of \$28,090.00 to the USDA.

- On June 10, 2005, a BOI investigator received a fraud referral from a Detective with the Peoria Police Department. The Detective stated that on June 8, 2005, as part of a drug investigation, the Peoria Police Department executed a search warrant at a private home in Peoria. The Detective stated that at the home police seized over \$120,000.00 in cash. The Detective also stated that as a result of evidence found in the home, police were also subsequently able to seize over \$70,000.00 in bank accounts belonging to the subjects.

A subsequent investigation conducted by the BOI investigator found that the subject had concealed her household's assets (bank accounts and stock accounts) from the Department of Human Services in order to fraudulently receive public assistance benefits. The concealment of her household's assets allowed her to fraudulently receive a total of \$21,857.00 in public assistance benefits for the period of July 1998 through July 2005.

As a result of this investigation, on November 10, 2005, the subject was indicted (Peoria County Court 05-CF-1273) on one count of State Benefits Fraud (Class 3 Felony). On June 5, 2006, the subject plead guilty to that charge and on July 27, 2006, she was sentenced to 30 months of probation. As conditions to her probation, she was ordered to

serve 180 days in the Peoria County Jail (day for day applies) and pay restitution to the Department of Human Services in the amount of \$21,857.00.

As of December 19, 2006, the subject completed her jail time by serving 90 days in the Peoria County Jail and paid \$18,678.81 in restitution. She remains on probation at this time.

- A BOI investigation revealed that a Saline County resident received Supplemental Security Income (SSI), Medicaid and food stamps for a disabled child who was not in her custody. The case was referred to the U.S. Attorney in Benton, IL and the subject was indicted on one count of mail fraud and three counts of making false statements. She pled guilty in U.S. District Court – Southern District of Illinois to all four counts on January 23, 2006 and was sentenced on May 3, 2006 to 16 months incarceration and ordered to pay restitution of \$38,101.00 including \$7,827.00 in food stamp overpayment.
- A public assistance recipient allegedly failed to report her marriage and her husband's income to DHS while receiving Medicaid and food stamps in St. Clair County. She also applied for and received federal disaster relief claiming losses related to hurricane damage in Louisiana while she was a resident of Illinois. The BOI investigation revealed that she was married and failed to report her spouse's income while receiving public assistance. The case was sent to the U.S. Attorney for the Southern District of Illinois. The subject was charged by a federal grand jury on 13 counts of fraud against several agencies on June 22, 2006. She pled guilty on October 6, 2006 and was sentenced on 01/17/2007 to four years in federal prison and ordered to pay restitution to several agencies, including \$4,659.00 in food stamp overpayment and \$278.00 in Medicaid.
- A recipient allegedly resided with her husband who had employment income that she did not report to DHS while she received food stamps, SSI and Medicaid in St. Clair County. The BOI investigation discovered that she received a total food stamp overpayment of \$20,652.00 from September 2001 through February 2006 and an overpayment of \$33,252.00 in SSI benefits. That information was presented to the U.S. Attorney–Southern District of Illinois on September 13, 2006 and remains there awaiting indictment.
- The Special Agent in Charge (SAC), Oklahoma DHS, Office of Inspector General, requested assistance concerning an Illinois recipient's benefits from August 1, 2006 through September 11, 2006. The Illinois recipient also had an active case in Oklahoma. There were felony warrants issued in Washita County, Oklahoma for the subject and her boyfriend for child stealing. A BOI investigator was assigned the case. The SAC was contacted and he requested all transactions made with the subject's LINK card. The OIG's Central Verification Unit monitored the subject's LINK card and the SAC was notified when the card was used. On September 13, 2006, the United States Marshall Service went to the subject's Illinois employer, and arrested the subject and her boyfriend. The missing child was located in Illinois and all the subjects were extradited to Washita County, Oklahoma. The child was returned to the custodial parent and the Illinois public assistance case was canceled.

**Multiple Assistance and Impersonation Project**

In June 2004, BOI noted an increase in the number of referrals involving possible multiple assistance and impersonation. Multiple assistance allegations involve clients receiving more than one public assistance case in Illinois, typically using alias names and Social Security Numbers. Impersonation cases involve allegations of someone receiving benefits in a citizen's name, date of birth and/or SSN and no other Illinois public assistance case had been linked to the client. Investigators were assigned to assist in the investigations and preparation of criminal cases. Contact was made with the Illinois Secretary of State who agreed to provide BOI with photographs of state driver's licenses and identification cards due to the criminal nature of the investigations.

A continuation of the project was initiated in November 2006. A total of 28 cases were opened (8 multiple assistance and 20 impersonation referrals). As of December 31, 2006, 5 impersonation cases have been completed; all unfounded. Four cases had the incorrect Social Security numbers due to a glitch BOI discovered in the DHS programmatic cross match with the Social Security Administration. In the fifth case, it was determined that the local office added a child to the wrong case resulting in an agency error, which caused an overpayment of \$212.00. The bureau continues to examine the remaining cases.

During 2006, in conjunction with a referral from the Social Security Administration, an overpayment of \$64,676.65 was referred for criminal prosecution to the Cook County State's Attorney's Office and two cases were referred to the Bureau of Collections with overpayments of \$10,554.00. In addition, a spin-off Child Care case resulted in a Child Care overpayment of \$1,264.92. In 2006, a total of \$76,495.57 was identified in overpayments. Additionally, the bureau learned in November of 2006 that a case referred to the U.S. Attorney's Office in 2005, resulted in the client pleading guilty to Theft of Government Funds and ordered to pay restitution of \$70,330.00.

**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 Electronic Benefits Transfer (EBT) Program in 1999, SFU has received 24,757 referrals from the USDA Food and Nutrition Services (FNS) and 353 referrals from field staff and hotline calls. According to the Chief of Program Operations Section for the USDA, FNS Midwest Region, Illinois is the most active State in the Midwest Region in pursuing clients suspected of EBT fraud.

*“FNS MWRO holds Illinois up as a model of a successful EBT client integrity project. We commend you and your staff for your commitment and ongoing efforts to improve the integrity of the Food Stamp Program by ensuring that clients are held accountable for the proper use of Food Stamp benefits.*

*Tim English, Regional Director, Food Stamp Program  
Food & Nutrition Services, Midwest Regional Office*

In 2006, FSFU received a total of 7,840 referrals, participated in 1,017 ADHs and received 727 (71.5%) positive hearing decisions. In addition, FSFU processed 390 signed waivers and 32 prosecution cases. FSFU efforts resulted in the disqualification of 1,149 clients during 2006 and a cost savings to the State of Illinois of \$3,050,577.

### **HFS Employee Investigations**

The OIG Bureau of Internal Affairs (BIA) conducted 149 employee and vendor investigations during 2006. Several of these cases are described below.

- An employee in the Bureau of Collections reportedly provided false and misleading information to the Department regarding his jury duty responsibilities for three days in August 2005. The investigation, completed in 2006, determined the employee violated multiple policies when he failed to accurately report his whereabouts and failed to inform his immediate supervisor or designated alternate within one hour of the start of the work shift to report his absence and reasons for absence. Even though the employee claimed he was in his office working there are no office computer, fax or telephone records to support his claim. Further, the county Jury Commission had no record of him serving on a jury on the dates in question. He was issued a seven-day paper suspension.
- The Office of the Secretary of State contacted the Office of Inspector General to report one of the undercover plates assigned to an OIG vehicle was checked by a police officer in suburban Chicago. The vehicle was assigned to an employee in the Office of Inspector General at the time of the plate inquiry. The investigation disclosed multiple policy violations, including time abuse, travel regulations, creating false or misleading records, and failed to cooperate with the Internal Affairs investigation. He was issued a 15-day suspension.
- It was reported to Internal Affairs that a Family Support Specialist was using state resources and time for personal business. The situation involved a civil matter and the employee had been using the State's computer; fax machine and stationery to prepare documents related to the civil matter. The investigation determined that she used the HFS email system for personal use and also shared some of this information with a network of other employees within HFS. She also abused time by using regular work hours to correspond to a network on the Agency's email system. The employee submitted travel vouchers for reimbursement of mileage expenses that contained entries that were not consistent with known mapping resources for distances between destinations. She had received excess reimbursements of more than \$6,300.00. These claims contained false and misleading information. These actions resulted in the

employee receiving a 21-day suspension. The Agency has initiated action to recover the excessive travel reimbursement from the employee.

- During the course of conducting the aforementioned investigation, investigators discovered that travel vouchers submitted by another employee might contain billing for mileage in excess of the correct number of miles for various trips she had taken. We identified what appeared to be \$2,951.02 in excess mileage charges for the period reviewed. We found the employee had made a \$540 reimbursement to the Agency based on the result of an investigation by the Office of Executive Inspector General (OEIG). An overpayment still existed in the amount of \$2,411.02. The employee was issued a 21-day suspension and voluntarily made full restitution to the Agency for the remaining amount of excess mileage charges.
- In October 1999, it was reported to Internal Affairs that a Childcare Initiative (CCI) Subsidy Specialist was suspected of updating her sister's childcare case with false information. During the investigation, it became apparent that the worker's fraudulent activities were more widespread than originally reported. She was discharged from CCI following the referral to our office. The investigation established that this former worker updated her sister's childcare case with false information and created false information on eight additional childcare cases thereby causing the Department to generate at least \$55,157 in misappropriated payments to her and others. We also determined the former worker used a sophisticated paper scheme of non-existent employers, some fictitious residential and business addresses, P.O. Boxes and Postal Mailing Boxes, false employers statements and earnings stubs, and fabricated social security numbers associated with the majority of providers and clients. In some cases, the addresses for clients and providers were interchanged and repeated while in other cases, identical addresses and P.O. Boxes for clients and providers were utilized to facilitate the fraud. In September 2003 she was indicted by the Cook County Grand Jury for Theft over \$100,000. We estimated that the exact amount of lost funds in the scheme was in excess of \$300,000. In early 2006, the OIG learned that on December 19, 2005, she pled guilty on one count of Theft over \$100,000. She was sentenced to four years of probation, fined \$479, and ordered to make restitution to the Department of Human Services in the amount of \$101,000.
- In November 2005, an incident occurred between two employees within the Office of Inspector General, which involved physical contact. The investigation, completed in 2006, substantiated the physical contact wherein one of the employees was injured. The employee who grabbed the other employee was cited for multiple policy violations and was discharged for cause. Upon appeal the discharge was reversed and the employee reinstated. The employee was issued a 45-day suspension in lieu of the discharge.
- In August 2005, staff from the Illinois State Disbursement Unit (SDU), reported that a Custodial Parent's case had been credited with payments from checks from her own personal checking accounts, all determined later to be closed accounts. The checks had been credited and paid via direct deposit before the SDU had time to stop the processing of the payments. The investigation determined that the woman authored and presented for payment to the SDU two checks drawn on a closed account in a total amount of \$3,500. She also authored and presented for payment to the SDU another closed account check from a credit union in the amount of \$2,000. The total of \$5,500 was credited to

the custodial parent's existing child support case and electronically transferred to her *Comerica* debit card (EPPICard). She spent the entire amount of \$5,500 for miscellaneous purchases and for personal gain. Several other checks were presented and determined as a counterfeit check possessing the correct routing number, but a non-existing account number. In September 2005, Lovington police in the company of one of our investigators who had investigated the case arrested the woman. In April 2006, the woman appeared in court where the judge sentenced her to 30 months incarceration in the Department of Corrections, one-year term of mandatory supervision after her release, and ordered her to make restitution to the state in the amount of \$5,500. The restitution has been paid.

- Monthly Internet email review uncovered evidence that a PA Family Support Specialist 1 was engaged in an excessive amount of personal use of GroupWise email by sending over 540 email within the month. The employee sent personal email messages to a network of other individuals outside of the Agency. He admitted that the subject content of the personal email was not appropriate for the workplace. He also used regular work hours to correspond with a network of others using the Agency's email system that was not work-related. He was issued a 10-day suspension.
- In 2006, staff from the Office of Labor Relations requested that Internal Affairs initiate a review of an Office Clerk's GroupWise email. Labor Relations had information that the woman was using the Department email for personal use and had generated numerous emails in the brief time she had been employed by the agency. She had worked for only three weeks. The majority of her email contained non-work-related material, some of which contained profanity. The employee resigned her position during her interview with Internal Affairs.
- A Medical Programs contractor reported that a Pharmacist Consultant, who was working for a downstate major retail pharmacy and also works out of the Belleville DCSE office processed a Refill-Too-Soon request for Accu-Check Test Strips that was called in by the pharmacy in March 2006. This order was approved. However, the consultant who was then working at the pharmacy in question requested an override for an excess quantity on the Accu-Check Test Strips. The complainant said that she called the woman personally and verbally denied the request as well as reminded her of the Pharmacy Unit's policy regarding such requests of test strips. Our contractor later checked the database and found that the woman "intentionally" had entered an override of "Refill-Too-Soon" from her assigned downstate work location in order to allow the billing to go through for the excess quantity that Consulting Staff had originally denied. In May 2006, the woman was terminated as a contractor.
- Monthly Internet monitoring review uncovered evidence that a DCSE Executive 1 was engaged in personal use of the Internet. The investigation determined that the man used the HFS Internet system for personal use when he admitted that the subject content of the Internet use was not work-related and was not appropriate for the workplace. He also utilized regular work hours to use the Agency's Internet system. He admitted to and recovered evidence substantiates the content of the Internet use was not work-related and he misused the Department's equipment and resources to view pornography. He was issued a 7-day suspension.

- The Division of Personnel and Labor Relations faxed Internal Affairs a sexual harassment allegation from a female employee in the Division of Finance. A male employee allegedly made inappropriate remarks to a female co-worker. She told her supervisor about the comment. The preponderance of evidence supported the allegations that the male employee violated Agency policies when he made a sexually suggestive comment to a female co-worker. The male employee's vagueness or limited recollection, lack of detail, coupled with his evasive answers and his acknowledgment that he would/could make such a comment reflected negatively upon his credibility. The comments as alleged by the victim were confirmed by another employee's recollection of events. The male employee was issued a five-day paper suspension.
- An email purported to be authored by a human resource specialist with Affiliated Computer Services, Inc. (ACS), claimed that ACS has been engaging in "ghost payrolling" by billing the Department for employees who have left ACS. ACS is the Department's contractor for the State Disbursement Unit (SDU). During the course of this investigation a referral was received that alleged ACS was wrongfully splitting SDU disbursements and over-billing the state of Illinois. Our investigation determined that on August 6, 2005, an email was sent from a Hotmail account to the Governor's office and the Ethics Officer for ACS. According to the complaint, the ghost payroll was reimbursed by HFS. One of the principals in the investigation attributed the email to a former employee of ACS who left the company on poor terms. Our review of the contract between HFS and ACS, our review of invoices and our interview with ACS' contractor monitor revealed that ACS was paid solely based upon the number of disbursement transactions completed. The allegation that ACS staff engaged in a practice of split billing was sustained. A review conducted by ACS auditors established that two ACS employees knowingly split SDU payments to increase their own pay-for-performance earnings. ACS discharged the employees, both of whom refused to be interviewed by Internal Affairs. ACS disciplined a third employee, who allegedly did not profit from his actions. This employee later resigned from ACS when Internal Affairs investigators attempted to compel him to produce documents he claimed he possessed that mitigated his behavior. Based upon ACS' corporate internal audit department's review, ACS projected that an overpayment of \$81,025 existed. We asked ACS to produce the records and documents that were used to arrive at this figure.

With the assistance of staff from the Bureau of Medicaid Integrity and the Bureau of Information Technology, ACS' records were examined. The documentation ACS initially shared (nineteen boxes of documents) did not provide sufficient information about the study they performed or their projection estimates for their entire process to be understood. After several interviews with ACS audit staff, additional documentation was provided to the OIG. ACS staff appeared to be forthright and responsive in providing requested information. While information provided by ACS could not always be independently verified, it did seem to be consistent with the contract monitor's understanding of the program and its operation.

Our review discovered a fourth employee who had approximately ten questionable split payments; however, ACS indicated this employee's pay was not affected by the extent to which the employee split transactions. Based upon the information we requested and

reviewed, we were able to develop a more direct and accurate loss projection. Our analysis of the available information resulted in an overpayment figure of \$92,031.

Changes at the SDU to prevent future occurrences of inappropriate split disbursements have been instituted. The changes include no longer basing incentive pay on the number of disbursements, making changes in the business rules on splitting payments and last, both DCSE and ACS establishing a quality assurance process to examine daily multiple disbursement to payment ratio.

ACS terminated two employees for splitting transactions, and a third employee of ACS who was initially disciplined by ACS resigned in May 2006, during our investigation. DCSE has implemented procedures to recoup \$92,031 in the overpayment to ACS.

- The Illinois State Police, Division of Internal Investigation reported that an HFS Office Coordinator failed to record all of his convictions on his Request For Release of Information, CMS 284. The employee said that in February 2003 he was working at a Speedway gas station and management accused him of voiding items from the cash register and taking money from the cash register. He said that none of the video camera's tapes showed him taking money from the cash register. He was allowed to quit his job. Approximately two to three months later, theft charges were filed. The man entered into a plea bargain for retail theft and received two years probation and agreed to pay approximately \$700.00 in restitution and fines. The employee also admitted that he was arrested by the Springfield Police Department and charged with forgery. He was currently on a recognizance bond and claimed that in July 2005, while he had been Treasurer at a local community services home, he wrote three unauthorized checks totaling approximately \$500.00. The case was still open and being litigated. The man claimed he did not report this incident on his employment application because he had not been convicted of the alleged offense.

In addition, the employee acknowledged that in approximately August 1985 the Illinois State Police arrested him for selling two ounces of marijuana to an undercover officer. He pled guilty and received 18 months conditional discharge, 30 days in jail and paid approximately \$700.00 in fines and restitution. He said that he didn't disclose this on his employment application because his attorney had told him that these records were sealed and/or expunged.

Near the conclusion of the interview, we confronted the employee with the fact that he had three separate counts of felony forgery charges, the amount of the forgery was \$1,000 (not \$500), and questioned the credibility of his statement that his previous drug conviction had been expunged as the state police do not forward this data unless it exists on a person's criminal history. We also obtained information that the employee, who was a non-certified employee, was going to be discharged non-certified, as he had released confidential client information to an unauthorized individual. When confronted, the man elected to resign his position with DCSE immediately with no reinstatement rights and agreed to not seek or accept future state employment.

- While conducting an investigation on an unrelated matter, BIA discovered in an email that appeared to document an incident wherein a Public Service Administrator researched

and released client-related information in KIDS on behalf of a co-worker, who requested the information for personal reasons. He was interviewed and admitted receiving the email request and forwarding the requested information to the co-worker. The employee was issued a 7-day suspension.

- The Illinois State Police, Division of Internal Investigation reported that a HFS Reproduction Service Technician 1 failed to record all past convictions on his Illinois Request For Release of Information Form. The man failed to disclose his full criminal history dating back to 1978. This included his guilty plea to Retail Theft Under \$150.00 and Resisting a Peace Officer, Delivery of Cocaine in 1979, and in 1986 when he was convicted of Driving Under the Influence and lost his drivers license for two years in 1989 for refusing to submit to the breathalyzer. The employee was issued a 1-day suspension.
- In a case first reported in June 2005, a Human Services Caseworker may have serviced an application case for her sister as a new out-of-district applicant. The evidence determined that worker processed an assistance application for her sister as a new out-of-district applicant. We established that the case was totally ineligible at its inception. Therefore, the client received total fraudulent benefit payments of \$6,573 for the twelve-month period from December 2003 through November 2004. In June 2005, investigators from Internal Affairs met with a McLean County ASA to present our case. Two warrants were issued and the client was arrested at the McLean County Sheriff's Office for State Benefits Fraud over \$300 and an arrest warrant for State Benefits Fraud and Administrative Malfeasance was issued for her sister. In September 2006, the client pursuant to a plea agreement pled guilty to Attempted State Benefits Fraud Over \$300. She was sentenced to 24 months Conditional Discharge, ordered to pay \$20 to the Crime Victims Compensation fund and to make restitution to the Department of Human Services in the amount of \$6,573 to be paid by May 31, 2008. The client was discharged from her position at the McLean County Sheriffs Department on August 5, 2005.

Also in September 2006, the DHS caseworker pursuant to a plea agreement pled guilty to the charge of Administrative Malfeasance. She was sentenced to 24 months Conditional Discharge, given a \$300 fine, order to pay \$200 to the Public Defender Reimbursement fund, \$32 to the Victim Compensation fund and \$10 for the Drug Court fee. She was discharged from her position as a caseworker at DHS in November 2006.

- The monthly Internet email monitoring report for May 2006 revealed that an individual logged 495 out-going email for the period in review. This person was one of the top five Internet email producers. The report revealed that nearly every email subject line appeared to be non-work related. The investigation determined that a Public Service Administrator used the HFS Internet computer system for personal use during regular work hours. She used the Agency's computer network and software to communicate with her friends and relatives. She was issued a 7-day suspension.

### **Security Activities**

On Sunday evening, March 12, 2006, the city of Springfield was struck by two tornadoes that did millions of dollars of widespread damage. Large power outages took place and significant property damage occurred throughout Springfield. The morning following the tornadoes, the

Inspector General and several BIA staff visited all HFS facilities in Springfield and assessed each building's security risk. While many HFS facilities were without power, most were operational the following day.

The OIG, through the BIA, continues to be proactive in the areas of safety and security of HFS staff, contractors, customers and other visitors. During 2006, these activities included: planning for participation in the State of Illinois Emergency Operations Center whenever it is activated in response to a situation; recommending an upgrade to the existing Hirsch Keyless Entry System to make it easier for the technology currently used by other state agencies to be shared; coordinating the updates of the on-site emergency procedure manuals; and overseeing the annual storm and fire drills for all of the locations under the control of HFS.

Additionally, BIA continues to respond on an almost daily basis to incidents that pose a possible threat to the safety of staff and visitors. These vary from a loud and abusive customer, to threats of great bodily harm made by non-custodial parents and unhappy Medicaid recipients to the personal domestic issues of staff members. Each situation is somewhat unique and requires an immediate response.

#### **New Activities Associated with the Office of Energy Assistance**

On July 1, 2004, the Office of Energy Assistance (OEA) was moved from the Department of Commerce and Economic Opportunity to HFS. In 2005, OIG staff held internal discussions regarding the need for program integrity activities of the Office of Inspector General tailored for the specialized program requirements of OEA. In January 2006, staff from the OIG, including the Bureau of Investigations and Bureau of Internal Affairs, received a series of training and familiarization sessions with OEA staff. The goal of the sessions was to provide OIG personnel with a broad-based understanding of the program and its components. Selected personnel within the OIG were also provided computer access to the Weatherization and Low Income Home Energy Assistance Program (LIHEAP) programs to facilitate program oversight and further insight into how the programs are structured.

Approximately 35 local community action agencies throughout the state administer LIHEAP to eligible low-income households to pay for winter energy services. LIHEAP includes a one-time benefit for energy bills, emergency assistance in the event of disconnection and assistance for reconnection.

In the process of our new initiative with the OEA, we have been able to nurture a cooperative partnership in which the OIG and OEA staff is able to exchange ideas and work together to facilitate the program integrity mission of the OIG as it pertains to Weatherization and LIHEAP. The OIG is exploring new methods and procedures to improve upon program integrity activities for the OEA initiative.

In 2006, the OIG began developing a statewide quality control (QC) program designed to verify the eligibility requirements (income, household size, fuel type and geographic location) of the one-time annual benefit portion of LIHEAP. The OIG will administer the QC program in 2007.

## ***PREVENTION ACTIVITIES***

### **Fraud Prevention Investigations**

The purpose of the Fraud Prevention Investigation (FPI) program is to conduct timely field investigations to verify applicant information and to detect and prevent the incorrect issuance of financial, medical or food stamp assistance benefits, as authorized by state statute (305 ILCS 5/8A 12, Sec. 8A 12 Early Fraud Prevention and Detection Programs). The applicant may be referred to the FPI program if there are reasonable grounds to question the accuracy of any statements, documents, or other representations made at the time of application. FPI is a frontline program that allows DHS caseworkers to utilize a resource that would otherwise not be available to them.

The investigations are conducted prior to establishing an applicant's eligibility for assistance. The FPI program's goal is to prevent ineligible persons from receiving welfare benefits, thereby saving tax dollars. The program targets error-prone public assistance applications containing suspicious information or meeting special criteria for pre-eligibility investigation. If a caseworker suspects that the applicant has made a misrepresentation, some of the possible areas used to select cases for investigation include the following: household composition, residence, financial management/child support and contradictory information.

The department contracts with a vendor to complete these investigations. Once a referral is made to the FPI program, the vendor must complete an investigation within five (5) business days for all Food Stamp only cases and eight (8) business days for all other categories of assistance. The investigation usually requires a home visit to the applicant's address to confirm residency, household composition or assets. The investigation may also involve contacts with landlords and neighbors to verify information. When the vendor completes the investigation, a summary report of the investigative findings is sent to the OIG. The investigation report will address the specific information reported in the referral from DHS. The summary report along with the OIG's recommendation is sent to the caseworker for their review and a determination of the applicant's eligibility for assistance is made.

In 2006, the FPI program expanded to include the four DHS local offices in the Metro East counties of Madison and St. Clair. Prior to that, the program was only operational in the nineteen Cook County DHS local offices. Since fiscal year 1996, the program's total gross savings have reached \$74.5 million (\$30.5 million - Medicaid / \$44.0 million - TANF and Food Stamps). Over these past eleven fiscal years, the program has realized an average savings of \$12.12 for every \$1 spent on administration of the program. If this program had not been in place, the assistance benefits most likely would have been issued to individuals who were not eligible.

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

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program targets error-prone long term care Medicaid applications. In partnership with OIG, the DHS local offices throughout the state participate in this effort. LTC-ADI evaluates Medicaid applications 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 on Medicaid standards. The investigations, which are completed by

a vendor on contract with the department, uncover undisclosed assets and unallowable asset transfers.

Early in 2006, LTC-ADI identified a problem regarding a method used to determine fair market value of farmland. Health Care and Family Services Medicaid Eligibility Policy requires that asset transfers be verified in order to determine the amount received for the asset; the fair market value of the asset and whether the money received had been spent. Policy guidelines available to DHS personnel describe fair market value as the value of the asset on the open market at the time of the transfer. The use of a property tax bill had been a long-standing practice of the department for fair market valuation. Research revealed that farmland is not assessed using the same calculation method as residential or commercial property, therefore the tax bill would not be an appropriate document to use to determine fair market value. An alternative method of valuation using a comparable sales approach has been adopted by LTC-ADI and based upon a recommendation from an agency attorney, that information has been forwarded to HFS, Bureau of Medicaid Eligibility Policy for clarification. A single case in Clark County resulted in an unallowable transfer that rendered 33 months of ineligibility and producing a cost savings to Illinois taxpayers in the amount of \$269,215.50 as opposed to \$50,640.00 using the property tax bill.

In an effort to increase the number of referrals made by the DHS local offices for the LTC-ADI program, the LTC-ADI staff attended several monthly Regional DHS meetings in 2006. The LTC-ADI presentation provided an overview of the program including; review of the referral process, insight into the contractor's investigations, summary of recommendations and information on appeal representation.

Additionally, the LTC-ADI staff began conducting training sessions for DHS local office staff in 2006. The training sessions are geared to educate the local office staff on the referral process and provide assistance for a clearer understanding of the recommendation packet. The LTC-ADI involvement in the appeal process is also reviewed.

The efforts of the LTC-ADI staff in 2006 proved beneficial in increasing the number of referrals accepted for investigation. The OIG accepted 526 referrals for investigation during the 2006 calendar year, up from 368 in 2005. The gross savings realized in 2006 for not providing public assistance to ineligible persons due to LTC-ADI was \$13,823,847. For every \$1 spent on administration costs relevant to the LTC-ADI program, \$16.18 of savings was realized.

### **Random Claims Sampling**

The Random Claims Sampling (RCS) project is a specialized measurement effort OIG undertook to gauge the extent of errors in the Medical Assistance Program. Unlike other measurement efforts, RCS' focus is the identification of new problem areas. As a consequence, we did not attempt to provide a broad, comprehensive view of the Medicaid program. By design, the project excludes services from certain problem areas that OIG is devoting an enormous amount of resources to, including medical transportation and long term care services. The reason for these exclusions is that OIG is well aware of these problems and is attempted to identify new areas of concern that warrant increased scrutiny and aggressive action.

Under RCS, a stratified random sample of 420 services from Medicaid and Children's Health Insurance Program providers that were adjudicated between July 2002 and July 2004 were

selected for review. This universe excluded services for managed care encounters or capitation payments, long-term care services, Cook County owned providers, transportation services, providers in programs administered by agencies other than HFS, services billed on behalf of Medicare eligible recipients, services rejected by the Department's edits or audits, and services billed at zero dollars.

Through the review, the OIG determined that for the selected services, the Department paid 96.7% of its sampled services accurately, plus or minus 4% with 95% confidence. We found very little variation in the error rate across the groups we examined.

OIG decided to discontinue RCS once the federal government formalized its plans for measuring Medicaid payment accuracy nationally through its Payment Error Rate Measurement Program, or PERM.

### **PERM**

During the past decade, states and now the federal government have conducted measurement effort to determine the accuracy of Medicaid payments. Illinois was the first state to perform such a study, and several other states also undertook their own measurement efforts. The U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (HHS CMS) is now measuring the accuracy Medicaid payments across all states during the next three years through its Payment Error Rate Measurement Project, or PERM.

Illinois was selected among the first wave of states to participate in the PERM. OIG is serving as the liaison to the Department on this effort. In this role we are working with HHS CMS and its contractors to obtain the necessary claims data to support HHS CMS' sampling efforts, provide quarterly updates on the Department's billing and payment policies for all Medicaid provider types, coordinate in-depth training to HHS CMS contract reviewers on the Department's policy, billing, and payment policies, and provide logistical support to those contractors. Once the review is completed and findings are issued, OIG will work with HHS CMS and the Department to identify any corrective actions that are warranted based on the review.

### **MFPEW Activities**

The Medicaid Fraud Prevention Executive Workgroup (MFPEW) is an executive-level oversight workgroup that ensures that reasonable and prudent measures are being taken to deter and detect fraud and abuse within HFS Medical Assistance Programs. The workgroup has a broad base of disciplines from the Division of Medical Programs, Office of Information Systems, and the OIG. 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 ten 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. MFPEW is prepared to proactively meet the challenge of fraud control. During 2006, the following issues were addressed:

***Duration of Therapy Edit***

A Duration of Therapy edit was developed to identify instances where recipients received medication beyond a medically acceptable period of time. The edit will capture a specific recipient's use of medications that have an established duration of therapy and will reject pharmaceutical claims submitted beyond the proper duration of therapy. HFS will benefit from this edit by cost avoiding millions of dollars through improper dispensing of pharmaceuticals with an established duration of therapy.

***DEA File***

OIG worked with staff from the Drug Enforcement Administration (DEA) Drug Diversion Office to gain access to the DEA Registration database. This database is updated weekly and provides a listing of all-active and retired DEA numbers nationwide.

The immediate benefit that HFS will recognize through the incorporation of this database will be the rejection of pharmaceutical claims submitted with a retired DEA number. HFS will also benefit from the active listing of DEA number database by improving the integrity of the prescribing information submitted on pharmaceutical claims.

It is anticipated that OIG will test the databases during 2007 and seek to migrate the databases to the front-end of the claims processing system.

***Psychotherapy / Day Training***

In 2006, OIG built upon its long-standing efforts to improve the fiscal integrity of psychotherapy, day training, and related services. OIG staff performed a three-prong analysis to identify improvements in how HFS pays for psychotherapy services. First, we analyzed claims for group psychotherapy for calendar year 2004 dates of service and identified that the Department paid over \$14 million for over half a million services billed using CPT code 90853 (group psychotherapy - not multi-family group). Next, to better understand how other states pay for psychotherapy services, OIG prepared a survey and disseminated it to other state program integrity offices through the National Association of SURS Officials. Finally, we reviewed published studies and other payer's guidelines on group therapy size and consulted with physician experts to identify a recommended group size and related requirements.

Based on this research the MFPEW developed a report for the Medicaid Director that identified a number of the Department's vulnerabilities in this area and identified recommendations to strengthen the Department's billing and payment policies. The recommendations include:

- Limit the group size
- Limit the maximum number of sessions during the year
- Limit the number of sessions allowed weekly
- Restrict the location where group therapy is rendered
- Require the physician who leads the sessions to personally conduct the entire session
- Limit the reimbursement of psychiatric services only to those patients that have been diagnosed with a psychiatric illness or condition

- Require group content and methods to be clinically appropriate for individual participants

The Department has committed to implement the recommendations suggested by MFPEW. The Division of Medical Program (DMP) staff are currently drafting the provider handbook and other policy changes outlined in the document.

In addition to this policy work, OIG has continued its analytical efforts in this area, identifying and addressing a large number of psychotherapy, day training, and related provider cases. This continues to be a major area of both concern and activity for OIG, its law enforcement partners, and DMP.

### ***Optical Prescriptions Review***

It was determined that a review of the Department's optical prescription process was prudent based on a concern that the number of eyeglasses dispensed to adults had increased drastically. The OIG performed an analysis of eyeglass data for the time period January 1, 2003 through December 31, 2005 to determine if adult recipients received two or more pairs of glasses within a 365-day period of time. The OIG also evaluated the number of prior approvals that were granted for any recipient who received three or more pair of glasses within the 365-day window to ensure that HFS policy was properly being followed.

The Handbook for Providers of Optometric Services, Chapter O-200, Section O-212.7 states that:

“Eyeglasses for adults are generally provided only once per year. However, a second pair of eyeglasses may be provided in the same year if the eyeglasses are lost or are broken beyond repair. If a third pair of eyeglasses or lenses is needed within the same year for any reason, prior approval is required.”

A total of 376,020 adult recipients received 551,007 pair of glasses during the three-year period under review. Analysis indicated that 3,547 (0.94%) recipients received two pair of glasses during the review period and 993 (0.26%) recipients received three to five pair of glasses during the same time period. No recipients received more than five pair of glasses during any of the 365-day periods. One prior approval was granted during the review period.

The Medicaid Fraud Prevention Executive Workgroup recommended that no policy changes be made due to the low volume of recipients receiving three or more pair of glasses in a year.

### **NET / DME Provider Re-enrollment**

As of September 1, 2005 the OIG began conducting criminal background checks and on-site visits for non-emergency transportation (NET) providers re-enrolling with the department. Government entities and newly enrolled providers that had already submitted fingerprints for criminal background checks were excluded from this process. Providers subjected to a site visit within the last two years were not required to undergo another site visit but were required to have a criminal background check completed.

As of December 31, 2006, the OIG had received 225 NET renewal cases for review. Two hundred and six (206) companies successfully passed the criminal background checks and/or site visits and were re-enrolled. 13 applications were returned due to the various reasons: (3)- non-compliance with fingerprinting requirement, (4)- incomplete or incorrect information on application, (2)- unable to contact the provider, (2)- provider requested withdrawal, (1)- provider did not report reorganization of business and (1)- provider out of business. One application was denied re-enrollment due to a Class X Felony discovered through the criminal background check process. Five applications were still pending at the end of the year. Beginning in April 2006, the OIG began accepting durable medical equipment (DME) provider re-enrollment applications for on-site visits. As of December 31, 2006, 26 DME referrals had been received and all were re-enrolled.

### **Changes Affect Recipient Eligibility (CARE)**

In April 2005, as part of the federally mandated Medicaid Eligibility Quality Control (MEQC) review process, the OIG implemented the Changes Affect Recipient Eligibility (CARE) project to identify unreported changes made to the client's situation within 90 days of approval for long term care assistance and what effect (if any) those changes had on eligibility.

During 2006, reviews were completed on 467 cases for the review period of April 2005 through September 2005. There were a total of 178 (38.12%) cases with unreported changes. Of these 178 cases with unreported changes, 87 (48.88%) had changes that impacted the eligibility of the case and 91 (51.12%) had changes that did not impact eligibility. More than one change was discovered in 43.68% of the 87 cases. The majority of the primary changes occurred within the area of bank accounts/cash on hand. The second highest number of primary changes occurred within the area of third party liabilities.

Throughout the reviews, the Illinois Department of Human Services (IDHS) was notified of the individual case findings. Those requiring corrective action were monitored for completion. A summary of findings was submitted to the Centers for Medicare and Medicaid Services as required. Additionally the OIG will recommend needed program improvements based on the review findings.

### **New Regulatory Bills**

The OIG promulgated new legislation in 2006 which permits the Department to seek termination of providers from the Medical Assistance Program who have been convicted of murder or a Class X felony. Prior to the passage of this legislation, terminations based on convictions were limited to convictions of program-related health care felonies. Legislation was also promulgated which allows for the Department to temporarily withhold Medicaid payments to a provider, upon receipt of reliable evidence that the payments made may have involved fraud or willful misrepresentation. Rules are currently being proposed to implement these provisions.

In addition, rules were adopted in 2006 to implement the statutory language, which enables the Department to administratively hold accountable the alternate payees of providers in the Medical Assistance Program. The statutes and rules formalize the Department's relationship with alternate payees by requiring alternate payees to register with the Department. The Department may deny, cancel or revoke participation in the Medical Assistance Program of alternate payees

and the alternate payees are jointly and severally liable with the providers for overpayments made pursuant to the alternate payee agreement.

### ***COOPERATIVE EFFORTS***

#### **Medi Medi**

The national Medi Medi project is an effort to combine claims data from Medicaid and Medicare to fraud, refer cases for law enforcement and auditing, and develop prevention strategies. OIG participates in the Illinois Medi Medi project as an active collaborator in the data mining effort. This effort began in 2004 with combined fraud detection and case development between the OIG and Medicare's Program Safeguard Contractor.

In late 2005, CMS changed contractors and mutual access to data was postponed until appropriate federal regulatory filings and contractual agreement were executed. Much of 2006 was devoted to re-establishing the infrastructure OIG had with the first contractor. However, the project has continued to successfully supported law enforcement and audit efforts on the cases identified in 2005 and have provided OIG with no-cost access to valuable software and hardware that could not be obtained otherwise. In addition, the project has identified several new areas of interest for 2006/2007. One of significant interest is an effort to use new and previous unavailable data sources to aid in our continuing efforts to identify psychotherapy and day training abuse.

#### **OIG / DOR State Income Tax Initiative**

The Illinois Department of Revenue (DOR) Professional License Unit refers matters to the OIG Bureau of Administrative Litigation (BAL) for suspension of providers from participation in the medical assistance program based upon 305 ILCS 5/5-16.6, which requires that providers be in compliance with State Income Tax requirements. A Notice of Intent to Suspend and Right to Hearing is then prepared for service upon the provider.

There is currently no automated process between DOR and HFS to establish whether a delinquent taxpayer is a Medicaid provider. As a result, DOR only referred one case in calendar year 2005 and 12 cases in CY2006.

During 2006, OIG and DOR personnel discussed the requirement to further expand these cases to all types of providers by using provider and taxpayer database information. An inter-agency agreement has been drafted to enable HFS to periodically create an electronic file of providers in the HFS Medical Assistance Program. DOR will process this file against their tax database to identify non-tax compliant providers. This effort should significantly increase the number of cases referred to OIG. The result would benefit both Departments, and create a much smoother process of identification and enforcement.

#### **NPI**

OIG co-authored a National Provider Identifier White Paper that represented the opinions of over 45 state Medicaid program integrity units. The White Paper was submitted on behalf of the National Association of Surveillance Officials (NASO) to the National Coordinator for Medicaid Safeguards at the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (HHS CMS). The White Paper assessed the impact of the implementation of

the NPI number on Medicaid fraud and abuse prevention activities. Following are the key recommendations presented in the White Paper:

- Require all providers to obtain a unique NPI per location so that the focus of identifying and sanctioning potential fraud and abuse cases will be conducted in an efficient and effective manner.
- Provide intelligence within the NPI that will identify covered organizational healthcare providers and their locations.
- HHS CMS should expand the information that is captured to validate the provider's identity and cross-match that information against national databases.

### **Region V Pilot with State of Indiana**

Illinois and Indiana began a pilot in 2006 to test the concept of sharing program integrity information with border-states on providers when a review has been completed. This pilot holds promise to identify providers that are or may attempt to commit the same or similar type of fraud scheme in a border-state. The use of this data knowledge will provide an early intervention strike against would-be perpetrators. Initial testing of this pilot will occur in 2007 to validate the processes that have been developed to date. It is anticipated that this program will be expanded to other border-states upon the successful completion of the Illinois/Indiana pilot.

### **Joint Terrorism Task Force**

In 2006, the Joint Terrorism Task Force (JTTF), a federal anti-terrorism task force, determined that the subjects of several of their investigations were recipients of public assistance benefits in Illinois. Based on information obtained through JTTF investigations, the JTTF believed that these subjects had either failed to report, or under reported, their assets and/or income to the Department of Human Services (DHS) in order to fraudulently receive public assistance benefits. As a result, in October of 2006, the Bureau of Investigations was contacted and an investigator assigned. The Bureau of Investigations has opened five joint investigations with JTTF, and anticipates others.

### **Criminal Prosecutions**

The OIG provides support to State and Federal law enforcement agencies in the prosecution of providers, alternate payees, and individuals who 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 2006 are described below.

Omnicare, Inc. - A qui tam action resulted regarding the improper switching of drugs Ranitidine, Fluoxetine, and Buspirone from April 1, 2000 through December 31, 2005. Omnicare, Inc. paid the United States and participating states \$49.5 million as the settlement amount. The participating states (43 States) will be paid the sum of \$19, 858,782.63. The State of Illinois' share of the settlement is \$2,568,762.08, after relators fee of \$396,194.16 is deducted. Omnicare

entered into a Corporate Integrity Agreement with the Department of Health and Human Services, Office of Inspector General.

Amerigroup – A qui tam action regarding this Medicaid HMO Company resulted in a jury award of \$48 million Medicaid fraud verdict. The jury found the HMO to have discriminated against eligible Medicaid beneficiaries by failing to market its Medicaid managed care health plan to pregnant women and other people with extensive health conditions while receiving federal and state funds to do so. Amerigroup was paid \$243 million from 2000 through 2004. The jury award amount would be tripled under the False Claims Act for a total damage award of \$144 million. When settled the whistleblower will be entitled to receive between 15 – 25 percent of the damages involved in the case. This case is currently under appeal.

Schering-Plough - It is alleged that, in 1998 through 2003, Schering-Plough misreported best price information to HHS CMS for its drug Claritin, K-Dur 20, PEG-Inron, Rebetrone, and Inron A. During that time, Schering Plough had agreements with HMO, Kaiser Permanente, to sell Claritin and I-Dur products at lower prices. Additionally, Schering marketed Temodar for unapproved uses and provided kickbacks/considerations to physicians to prescribe Inron A, Rebetrone, and PEG-Inron.

To satisfy Medicaid claims, Schering-Plough agreed to pay the United States and participating states \$203,560,000.00 plus 4.92% per annum from July 27, 2005 until the Settlement Amount is paid. The Federal Medicaid Settlement Amount is \$111,958,000.00, plus the aforementioned interest. The combined participating States share is \$91,602,000, plus the aforementioned interest. The total settlement amount for the State of Illinois is \$8,212,329.54, which includes the State and Federal portions. The State of Illinois will receive the sum of \$4,570,300.95, plus applicable interest.

#### Other Prosecutions

Levon Coleman -In January 2006, Levon Coleman accepted a plea to one count of Vendor Fraud based on submitted claims for services not provided. Coleman owned and managed Lees Transportation Inc., a non-emergency transportation provider in Cook County. Coleman was sentenced to two years incarceration. The MFCU unit of the Illinois Office of the Attorney General prosecuted the case.

D & G Health Center Inc.- D & G Health Center accepted a plea to one count of Health Care Fraud in June 2006. D&G was the alternate payee for physician Jacquelyn Hall-Davis and billed for services not provide using the provider's billing information. The corporation was given five years probation and ordered to pay restitution to Medicaid in the amount of \$64,641.58. The USAO for the Southern District prosecuted the case.

Dr. Babubhai Patel – Dr. Patel pled guilty to one count of fraud and one count of theft in March 2006 based on billing for services not provided. Patel was sentenced in the Circuit Court of Cook County to 52 months incarceration. The Court ordered restitution of \$30,000.00, paid to HFS. The MFCU unit of the Illinois Attorney General prosecuted the case.

Michelle Anderson and Solutions II, Inc. - In August, 2006, Michelle Anderson and Solutions II, Inc. entered pleas of guilty to the offense of Vendor Fraud. Ms/ Anderson falsified prior approval

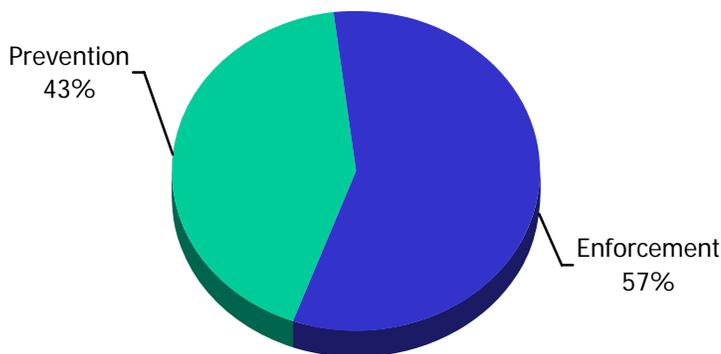
documents in order to support bills for services not provided. The Circuit Court of Cook County sentenced Anderson to 42 months probation and ordered her to perform 300 hours of community service. A civil judgment was also entered against Anderson for \$128,394.27 payable to HFS. Both defendants agreed to permanent termination from the Program. The MFCU unit of the Illinois Attorney General prosecuted the case.

**FISCAL IMPACT**

**Fiscal Year Savings**

During Fiscal Year 2006, the OIG realized a savings of approximately \$66.5 million through collections and cost avoidances. This savings was more than triple the OIG FY2006 budget of \$17.8 million. Please note that this is the first year that savings as a result of new provider verifications have been included in this chart.

**FY06 Savings**



**Total = \$66,466,053**



Prevention Activities:

- Food Stamp Cost Avoidance
- Fraud Prevention Investigations
- Long Term Care—Asset Discovery Investigations
- Recipient Restrictions
- New Provider Verification
- Provider Sanctions Cost Avoidance

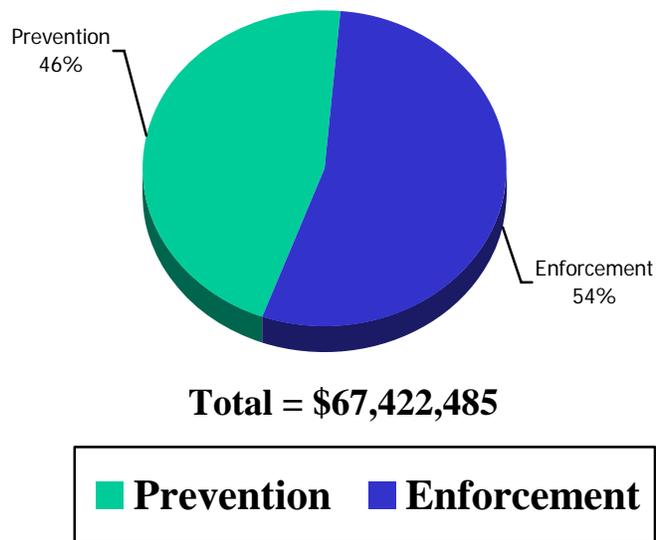
Enforcement Activities:

- Provider Audit Collections
- Fraud Science Team Overpayments
- Restitution
- Global Settlements
- Provider Sanctions Cost Savings
- Client Overpayments
- Food Stamp Overpayments
- Child Care Overpayments

### Calendar Year Savings

During Calendar Year 2006, the OIG realized a savings of over \$67 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings. The exact dollar amount associated with each prevention and enforcement activity can be found in the *2006 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 new provider verification to be included in this chart.

### CY06 Savings



#### Prevention Activities:

Provider Sanctions Cost Avoidance (*refer to page 26*)  
 Food Stamp Cost Avoidance (*refer to page 28*)  
 Fraud Prevention Investigations (*refer to pages 29-30*)  
 Long Term Care - Asset Discovery Investigations (*refer to page 30*)  
 Recipient Restrictions (*refer to page 31*)  
 New Provider Verification (*refer to pages 33-34*)

#### Enforcement Activities:

Provider Audit Collections (*refer to page 25*)  
 Fraud Science Team Overpayments (*refer to page 25*)  
 Restitution (*refer to page 25*)  
 Global Settlements (*refer to page 25*)  
 Provider Sanctions Cost Savings (*refer to page 26*)  
 Client Overpayments (*refer to pages 27-28*)  
 Food Stamp Overpayments (*refer to page 28*)  
 Child Care Overpayments (*refer to pages 28- 29*)

### CONCLUSION

During 2006, 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 tools and increased financial recoveries. Through these efforts, the OIG has succeeded in raising awareness of the importance of program integrity among clients, providers and the citizens of Illinois.

### *2006 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*

<b>Type of Audit</b>	<b># Recoupments Established</b>	<b>Total Dollars Established</b>
Field	259	<b>\$25,356,656</b>
Desk	269	
Self	65	

#### **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*

<b>Type of Collection</b>	<b># Cases</b>	<b>Total Dollars Collected</b>
Provider Audits (includes Fraud Science Team Overpayments)	797	<b>\$29,670,258</b>
Restitution	35	
Global Settlements	4	

### 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	25
Termination/Recoupment	9
Recoupment	18
Suspension	2
Denied Application	5
LTC/Hospital Assessment	0
Decertification	29
Child Support License Sanctions	69

Final Decision	# Cases	Total Medical Provider Sanction Dollars
Termination	16	<b>Cost Avoidance: \$406,044</b> <b>Cost Savings: \$2,958,444</b>
Termination/Recoupment	6	
Recoupment	6	
Suspension	3	
Voluntary Withdrawal	10	
Settlement	9	
Denied Application	3	
Reinstatement	1	
Barment	6	
Child Support License Sanctions	36	

### 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*

<b>Outcomes</b>	<b># Cases</b>
Cases Reviewed	<b>944</b>
Recommendations to Provider	18
Refer for Audit	116
Refer for Quality of Care Review	307
Refer for MFCU Investigation	1
No Further Action at This Time	502

**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*

<b>Enforcement Activities</b>	<b># Cases</b>
Referrals to Law Enforcement	87
Law Enforcement Data Requests	76

**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*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Overpayments Established</b>
Investigations Completed	<b>938</b>	<b>\$2,752,609</b>
Founded	539	
Unfounded	399	
Convictions	<b>28</b>	

Type of Investigations	Percent
Absent Children	12%
Absent Grantee	1%
Assets	6%
Duplicate Assistance	1%
Employment	19%
Family Comp/RR In Home	14%
Family Composition	15%
Food Stamp Trafficking	4%
Impersonation	1%
Interstate Duplicate Assistance	2%
Other Income	10%
Questionable Situation	1%
Questionable Residence	1%
Residence Verification	11%
Third Party Liability	2%

### 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	4,510	<b>Cost Avoidance: \$3,050,577</b> <b>Food Stamp Overpayments:</b> <b>\$1,045,011</b>
Pending Administrative Disqualification Hearing	7,150	
Disqualifications	1,149	
Unsubstantiated	63	

### 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*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Dollars Established</b>
Investigations Completed	<b>7</b>	<b>\$118,373</b>
Founded	7	
Unfounded	0	
Convictions	<b>0</b>	

**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*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Dollars Established</b>
Investigations Completed	<b>66</b>	<b>\$16,362</b>
Founded	43	
Founded In-Part	3	
Unfounded	20	

**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 eleven-year estimated average savings of \$12.12 for each \$1.00 spent by the state. FPI has averaged a 65% denial, reduction or cancellation rate of benefits for the 31,945 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings has reached over \$74.5 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 2006, the program generated 2,215 investigations, of which, 1,639 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated net savings for calendar year 2006 of more than \$9.6 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps.

*Fraud Prevention Investigations*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Cost Avoidance</b>
Investigations Completed	<b>2,215</b>	<b>\$9,685,212</b>
Denied Eligibility	409	
Reduced Benefits	1,148	
Cases Canceled	82	
Approved	576	

**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*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Cost Avoidance</b>
Investigations Completed	<b>526</b>	<b>\$13,823,847</b>
Approved		
Impose Sanction Period/Group Care Spenddown	62	
Impose Sanction Period/Regular Group Care Credit	31	
No Sanction Period/Group Care Spenddown	191	
No Sanction Period/Regular Group Care Credit	76	
Denied		
Client Requested Application be Withdrawn	48	
Client Refused to Cooperate/Failed to Provide Verifications	118	

**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*

<b>12 Month Restrictions</b>	<b># Clients</b>	<b>Total Cost Avoidance Client Medical Abuse</b>
Clients Restricted as of 12/31/2005	<b>534</b>	<b>\$1,620,072</b>
Client Reviews Completed	<b>535</b>	
New Restrictions	159	
Released or Canceled Restrictions	259	
Converted to 24 Month Restrictions	117	
No Restrictions	0	
Clients Restricted as of 12/31/2006	<b>317</b>	
<b>24 Month Restrictions</b>	<b># Clients</b>	
Clients Restricted as of 12/31/2005	<b>422</b>	
Client Reviews Completed	<b>295</b>	
New Restrictions	117	
Re-Restrictions	25	
Released or Canceled Restrictions	153	
Clients Restricted as of 12/31/2006	<b>411</b>	

### 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*

<b>Enforcement Activities</b>	<b># Cases</b>
Investigations Completed	<b>140</b>
Substantiated	86
Unsubstantiated	48
Administratively Closed	6

<b>Types of Allegations Investigated</b>	<b>Percent</b>
Non-Criminal (Work Rules)	<b>71.5%</b>
Discourteous Treatment of Others	17.3%
Failing to Follow Instructions	5.7%
Negligence in Performing Duties	8.8%
Conflict of Interest	5.7%
Falsification of Records	3.6%
Sexual Harassment	2.6%
Release of Confidential Agency Records	3.1%
Misuse of Computer	9.7%
Work Place Violence	11.0%
Time Abuse and Excessive Tardiness	3.1%
Other Work Rule Violations	0.9%
Criminal (Work Rules)	<b>15.6%</b>
Theft or Misuse of State Property	4.1%
Misappropriation of State Funds	1.5%
Commission of or Conviction of a Crime	2.8%
Public Assistance Fraud ILCS 305	0.6%
Criminal Code ILCS 720	6.6%
Security Issue, Contract Violation	<b>12.6%</b>
Special Project, Background Check, Assist other Agencies	<b>0.3%</b>

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 2006 are listed below.

<b>Misconduct Outcomes</b>	<b># Actions</b>
Misconduct Identified	<b>54</b>
Employee	43
Vendor	6
Other	5
Misconduct Resolutions	<b>54</b>
Discharge	7
Resignation	7
Suspension	14
Other, such as reprimands	16
Referred to Other Sources for Resolution	5
Administrative Action Pending at Year End	5
No Action Taken by Agency	0

### **New Provider Verification**

Since June 2001, the OIG has processed approximately 1069 non-emergency transportation (NET) and Durable Medical Equipment (DME) provider applications. Part of the application process for these providers includes an on-site visit to the business address listed on the provider application. The visits are designed to verify the legitimacy of the businesses prior to enrollment into the Medicaid program. During the visits, the business' location and existence are confirmed, information provided on the enrollment application including ownership information is verified and the business' ability to service Medicaid clients is assessed.

Of the 1069 (577 – NET and 492 –DME) applications reviewed, 109 (10%) have been returned (enrollment into the Medicaid program not authorized) due to one or more of the following reasons: incomplete enrollment package, non-operational business, inability to contact applicant, requested withdrawal by the applicant, the applicant applied for the wrong type of services and applicant did not comply with fingerprinting requirements. Approximately 13 (1%) applications have been denied enrollment into the program for reasons such as the applicant did not establish ownership of vehicles, fraud was detected from another site affiliated with the applicant, the applicant was participating in the Medicaid program using another provider's number and the applicant provided false information to the department. During 2006, the OIG processed 188 (90-NET and 98 DME) applications.

*New Provider Verification*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Cost Avoidance</b>
Reviews Completed	<b>188</b>	
Enrolled	172	
Not Enrolled		<b>\$2,292,038</b>
Applications Returned	15	
Applications Denied	1	

**APPENDIX A - OIG PUBLISHED REPORTS**

<b>Title</b>	<b>Date</b>	<b>Description</b>
<i>New Provider Verification Report April 2001 to September 2003</i>	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.
<i>Medicaid Eligibility Quality Control Report FFY02</i>	April 2005	Cited a case error rate of 14.62% and a payment error rate of 3.06% for the Medicaid (Title XIX) population.
<i>Illinois Healthy Women Survey Report 1<sup>st</sup> Quarter 2005</i>	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 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.

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

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<b>Title</b>	<b>Date</b>	<b>Description</b>
<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 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  
CY2006*

Total Number of Scripts	24,153,250	
Amount Payable		\$1,272,346,424
Scripts Not Subject to RTS	58,498	
Amount Payable		\$5,407,022
Scripts Subject to RTS	24,094,752	
Amount Payable		\$1,266,939,402
Rejected Number of Scripts		1,150,126
Estimated Savings		\$74,146,332

***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 [www.state.il.us/agency/oig](http://www.state.il.us/agency/oig) under the heading of Calendar Year 2006 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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Welfare/Medical Fraud Hotline  
1-800-252-8903