



Office of Inspector General

Illinois Department of  
Healthcare and  
Family Services

2008 Annual Report

Pat Quinn  
Governor

John C. Allen, IV  
Inspector General



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

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Pat Quinn  
*Governor*

John C. Allen IV  
*Inspector General*

May 6, 2009

**To: The Honorable Pat Quinn, 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 2008. The achievements described within this report are the results of the hard work and dedication of almost 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 2008 Annual Report provides you with valuable information.

Sincerely,

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 2008**

***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 was split into two agencies on July 1, 1998, as much of the department's field operations were consolidated into the newly created Department of Human Services. DPA became the Department of Healthcare and Family Services (HFS) on July 1, 2005.

The position of Inspector General is appointed by the Governor, requires confirmation by the Illinois State Senate, and reports to the Office of the Governor through the Executive Inspector General. While the OIG operates within HFS, it 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 as an independent watchdog has enabled the program integrity component to greatly increase its impact on HFS'

programs. The OIG investigates possible fraud and abuse in all of the programs administered by HFS and some DPA legacy programs currently administered by 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, All Kids, food stamps, cash assistance and child care. The OIG also enforces the policies of agencies within the State of Illinois affecting clients, health care providers, vendors and employees.

The professionals that make up the OIG staff include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information technology specialists. During 2008, the OIG had an authorized staffing of 193 employees. Staff is primarily based in either Springfield or Chicago, and the remainder work out of field offices located throughout the state.

The OIG continued fulfilling its mission during 2008, with John C. Allen IV serving as Inspector General. The OIG continues its current fraud fighting efforts while working to expand its integrity activities by researching and developing new programs and tools.

## ***ENFORCEMENT ACTIVITIES***

### **Provider Audits**

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

During 2008, the OIG established \$22,856,630.15 in provider overpayments, which were identified through post-payment audits conducted on providers enrolled in the Illinois Medical Assistance Program. These audits were conducted by the OIG Bureau of Medicaid Integrity (BMI) staff auditors and CPA firms who were contracted by the Department to conduct audits on its behalf. While BMI staff auditors performed audits on all types of providers, CPA firms were only utilized to conduct audits of Long Term Care facilities.

In 2008, the OIG completed 293 audits of various medical providers participating in the Medicaid program. This total number included self audits and desk audits, as well as traditional field audits where auditors physically visit the providers' facility.

In October 2008, BMI began a pilot to increase collections by instituting a requirement that payment plans could not exceed 6 months and monthly payment amounts must be at least \$2,000.00. Based upon the preliminary data, less than 15 percent of all providers who agreed that they have been overpaid requested payment plans that are greater than 6 months. Only thirty percent of those providers who requested an extended payment plan actually qualified for the extended plan under OIG guidelines.

#### ***Limited Number of Re-Audits***

During 2006, the BMI Audit Section implemented the "One Re-Audit" policy. Since then, the percentage of multiple re-audits has been reduced from 25 percent to 9.5 percent in 2008. Because of this, providers are now more inclined to make a decision to settle the audit or proceed to hearing more quickly. Under the new policy, it is made clear that to settle disputed findings, only one re-audit providing an opportunity for the provider to submit additional material will be allowed prior to initiating a hearing before an Administrative Law Judge.

#### ***DRG Inpatient Audits***

The goal of the Inpatient Hospital Audit Program (IHAP) is to identify and recoup erroneous billings and to educate hospitals in proper billing practices. Current OIG hospital reviews are limited to outpatient services and to targeted inpatient self-audits of particular areas of concern. IHAP will ensure the consistent review of hospital claims for added compliance.

During 2008, the OIG performed three reviews as part of the pilot phase of the IHAP implementation. The OIG is in the process of contracting with a vendor to perform up to fifty hospital reviews per year. It is anticipated that these full-scale reviews of hospital Medicaid billings will result in significantly increased collections of overpayments. The pilot phase of IHAP resulted in \$306,484.78 in overpayments being identified. The OIG estimates recoveries of at least \$5 million per year from this project.

#### ***Automation of Contractor Audits***

During the last several years significant OIG efforts have been devoted to consolidating case management functions for all investigative, audit and review initiatives. In 2008, the OIG continued its efforts to lessen its dependence on paper documents by automating the exchange of data for the audits performed by contractors on behalf of the OIG. The first process involved

CPA firms that perform audits of Long Term Care facilities. Starting in 2009, CPA firms will be provided an Access database for each LTC facility audit. The database will include claims data for each Medicaid recipient who resided in the facility during the audit period. The new automated process requires the CPA firms to record their audits findings, meetings with the facilities, as well as their final audit report in the database. The firms are also required to capture “suspect” facility records in an electronic format, through scanning, instead of submitting paper copies. This new approach will result in a decrease in the per audit cost that will be paid to the CPA firms.

This automation and electronic exchange of data between the OIG and its contractors was built into the DRG Inpatient Audit initiative discussed above. This new automation process will not only support cost containment, but will help ensure that vendors complete their work within the required timeframes.

#### ***Combined Efforts between Audits and Peer Review***

In September 2008, the OIG Audit and Peer Review Sections jointly implemented Peer Review to Audit and Audit to Peer Review processes. These new processes ensure that payment and quality of care reviews of providers with potential deficiencies that require further evaluation/investigation are not closed until both sections have included their review findings.

This combined effort of audit and peer review staff investigating these cases has improved the closure outcomes and strengthened cases that require hearing processes and/or termination. It also combines the findings of both aspects of the review into one concise document for distribution to the provider.

#### **Client Prosecution Cases**

During 2008, the Bureau of Investigations (BOI) referred 30 cases to various prosecutors around the state. Several investigations that have been referred during this year, were adjudicated this year, or have elements of particular interest are highlighted below.

- Client Eligibility Investigation  
Unreported Income

The OIG received a referral that a recipient had been receiving Social Security retirement income since 1990 and had never reported the income to the Department of Human Services (DHS). On February 28, 2008, BOI completed an investigation which confirmed that the recipient had two Social Security numbers and received Supplemental Security Income (SSI), Social Security Administration (SSA) benefits and public assistance at the same time. The recipient had two active cases; one case was active during the period October 1990 through June 1996; the other case was active for the period July 1996 through February 2008. The overpayment amount identified was \$42,594 in food stamps and \$26,107 in grant assistance. The total estimated overpayment identified was \$68,701. The case has been referred to the DHS, Bureau of Collections, for collection activity and may be considered for possible referral for criminal prosecution. The Social Security Administration is recouping an overpayment

of SSI benefits from the recipient's SSI monthly allotment, which they determined the recipient was ineligible to receive.

- Client Eligibility Investigation  
Household Composition / Unreported Income

The OIG received a referral that a recipient in Tazewell County was not reporting spousal income. On April 7, 2008, BOI completed an investigation of the allegation. The investigator found that from March 2003 through August 2007, the recipient had been living with their employed spouse, which the recipient failed to report to the Department of Human Services (DHS). The food stamp overpayment for this case totaled \$30,100. This case was turned over to the Tazewell County State's Attorney's Office on April 18, 2008. In lieu of prosecution, the State's Attorney's Office allowed this recipient to participate in their deferred prosecution program. As a component of this program, the client must pay restitution to DHS by June 20, 2010.

- Prosecution Investigation  
Unreported Income

BOI received a referral that alleged a recipient failed to report earned income from employment at a university and a grocery store. In the investigation completed on May 28, 2008, BOI learned that the recipient used her married name at the places of employment while using another name to receive public assistance benefits. This fraud resulted in an overpayment of food stamps of \$10,354 for the period from November 1, 2004, through November 30, 2008.

This investigation was presented to the Rock Island States Attorney on June 10, 2008. On July 31, 2008, the BOI investigator signed the complaint at the Rock Island Criminal Justice Center and the recipient was arrested on August 14, 2008.

On October 21, 2008, the recipient pled guilty to the charge of State Benefits Fraud, a Class 3 felony. The recipient received thirty months probation, ordered to pay various fees and fines that totaled \$350, and was ordered to pay restitution of \$10,354, which is to be paid within the first 24 months of the recipient's probation. The recipient also received 180 days in jail which would be waived pending compliance with the terms the probation.

- Prosecution Investigation  
Household Composition / Unreported Income

BOI received information that a recipient received food stamp benefits from September 2003 through March 2007, by deliberately failing to report that their spouse was in the recipient's household and employed. The spouse's employment information, income tax returns and information from the Secretary of State was used to verify that the spouse was in the household and the recipient was not eligible for the \$20,034 in food stamp assistance that was received. The completed case was submitted to the Macon County State's Attorney's office on February 27, 2008. In July 2008, the recipient pled guilty to

Public Assistance Fraud, and was ordered to 48-months probation and order to pay restitution in the amount of \$20,034.

- Prosecution Investigation  
Household Composition / Unreported Income

The OIG received a referral that a former resident of St. Clair County had been residing with her spouse and had unreported income. The investigation was jointly conducted by BOI, the Social Security Administration (SSA) Office of Inspector General, the U.S. Department of Veterans Affairs (VA) Office of Inspector General, and the U.S. Railroad Retirement Board (RRB) Office of Inspector General. The evidence proved that a recipient failed to notify DHS that she resided with her spouse who had employment income, VA benefits and RRB disability income. The recipient while failing to notify DHS of the income, continued to receive food stamp benefits in St. Clair County. BOI completed the investigation on January 10, 2007 and identified a food stamp overpayment of \$22,188 and an overpayment of \$33,252 in SSI benefits. The recipient was charged with seven felony counts by a federal grand jury in East St. Louis. The recipient pled guilty to the charges and was sentenced on July 2, 2008 to two year's incarceration; 36 months supervised release; and full restitution to all agencies.

- Prosecution Investigation  
Unreported Income

A referral that a recipient allegedly received their mother's Social Security benefits after the recipient's mother passed away was investigated jointly by BOI and the Social Security Administration Office of Inspector General. The investigation revealed that recipient also received food stamps in Madison County and did not report the receipt of income causing a total food stamp overpayment of \$5,154 and SSA overpayment of \$31,790. BOI completed its investigation on January 18, 2008 and referred the case to the U.S. Attorney, Southern District of Illinois. The recipient was indicted on three counts of making false statements and theft of government funds by the federal grand jury at the U.S. District Court in East St. Louis on January 25, 2008. The recipient pled guilty to all three counts on April 18, 2008 and was sentenced on July 25, 2008 to five years probation and ordered to pay full restitution.

- Prosecution Investigation  
Unreported Assets / Unreported Income

A resident of Jackson County was referred to BOI by the Social Security Administration, Office of Inspector General and the U.S. Attorney's Office, Southern District of Illinois. The recipient allegedly owned numerous rental properties and had income from those properties and other sources while receiving food stamps and SSI benefits. BOI completed its case on August 10, 2007, which identified a total overpayment of \$6,949 in food stamps. The case was referred for prosecution and the recipient was indicted by the federal grand jury in Benton, Illinois. The recipient pled guilty on September 29, 2008 and was sentenced on February 9, 2009. The recipient was sentenced to 92 months

incarceration and four years of supervised release. The recipient was also ordered to pay full restitution of \$41,802, including \$6,949 in food stamps and a special assessment of \$500.

- Prosecution Investigation  
Unreported Income

The OIG received a referral that a recipient was receiving food stamps in St. Clair County while allegedly residing with their spouse who had income from employment and unemployment insurance benefits. This case was investigated jointly by BOI and the Social Security Administration, Office of Inspector General. The investigation identified the recipient as receiving a total food stamp overpayment of \$7,006 and an overpayment of \$47,444 in SSI benefits. That information was presented to the U.S. Attorney Office, Southern District of Illinois. The recipient pled guilty at the U. S. District Court on September 4, 2008 and was sentenced on December 5, 2008 to six-month home confinement, five years probation and full restitution.

- Prosecution Investigation  
Duplicate Assistance

BOI received information that a recipient was receiving public assistance and Social Security Benefits in their factual name and two aliases. The investigation was completed on April 23, 2007 and it was proven the recipient failed to report their receipt of public assistance and Social Security benefits in their name and two alias names. The completed investigation was referred to the US Attorney's Office, and resulted in the guilty plea on October 7, 2008, to 1 count of Theft of Government Funds. The investigation was worked jointly with the Social Security Administration, Office of Inspector General and combined with their investigation for federal criminal prosecution. BOI identified overpayments of \$12,623 in cash assistance, \$28,632 in food stamp benefits and \$2,826 in medical assistance. The recipient was sentenced to 6 months incarceration, 2 years of supervised release and \$298,476 in restitution; \$44,081 to HFS and \$254,395 to Social Security.

- Prosecution Investigation  
Household Composition / Unreported Employment

BOI looked into a referral alleging a recipient failed to report their true marital status and household income from employment. The investigation was completed on February 11, 2008, and evidence showed a \$76,021 overpayment, with \$ 36,457 in cash assistance and \$39,564 in food stamp benefits. BOI worked the case jointly with Housing and Urban Development, Office of Inspector General and the Social Security Administration, Office of Inspector General. BOI's case was combined with their investigations for federal criminal prosecution. The case was referred to the US Attorney's Office and the recipient was indicted in July 2008, on 3 counts of Theft and 8 counts of Forgery; 1 count of theft and 2 counts of forgery are specifically related to BOI's investigation. The US Attorney's Office is in plea negotiations with the recipient.

- Prosecution Investigation  
Impersonation / False Identity

BOI received information that a recipient was allegedly using another person's identity to obtain public assistance benefits. BOI completed the investigation on November 17, 2008 and referred it to the Cook County State's Attorney's Office. In this case, a subject fraudulently assumed the identity of another person by using the other person's date of birth (DOB) and Social Security Number (SSN) to apply for and receive public assistance benefits in that other person's name. The recipient received assistance in the name of another person from December 2002 to November 2008. The overpayment totaled \$121,091 with \$39,120 in excess food stamps and \$81,970 in Medicaid assistance. The Cook County State's Attorney's Office is considering the case for criminal prosecution.

- Prosecution Investigation  
False Identity / Unreported Income

An investigation referred by BOI to the Cook County State's Attorney Office, resulted in a recipient's guilty plea on October 16, 2008 to one (1) count of Theft by Deception. The recipient created three false identities and fictitious family members to receive public assistance. The investigation also found that for a period, the recipient was employed with the Chicago Transit Authority and later, received disability retirement benefits. The recipient's actions also resulted in fraudulent Child Care payments being paid out by the Department of Human Services and the recipient received fraudulent Child Care payments as a Child Care provider. In addition, the recipient received fraudulent homemaker services payments from the Department of Rehabilitation Services (DRS) by using an alias name. BOI determined an overpayment of \$88,447 in financial assistance, \$87,522 in food stamp benefits, \$10,334 in medical benefits, \$21,021 in Child Care payments and \$4,557 in homemaker services payments. The case was referred for prosecution and the recipient was ordered to serve three (3) years probation and pay \$211,881 in restitution.

At the time of the referral a second prosecution case was included against the recipient's husband who received homemaker services payments from DRS for providing services to the recipient. The defendants falsified documents and failed to report their spousal relationship. An overpayment of \$33,937 was referred against the recipient's spouse. In June 2006, the husband pled guilty to Theft by Deception and was sentenced to two (2) years probation and six (6) months of home confinement.

- Prosecution Investigation  
False Identity / Multiple Assistance

The OIG received a referral that while a resident of Chicago, a recipient allegedly assumed the identity of an individual from the state of New York. BOI completed an investigation on December 30, 2008 and found that the recipient impersonated the

individual to receive public assistance in Illinois. Benefits were paid to or on behalf of the recipient from July 2000 through May 2008 in three (3) different assistance cases. BOI identified an overpayment of \$431,110; \$425,786 in medical benefits, \$620 in financial assistance and \$4,704 in food stamp benefits. The case was referred to the Cook County State's Attorney's Office for criminal prosecution.

In January 2009, the grand jury returned a true bill of indictment against the recipient. In February 2009, eight felony criminal counts of theft were filed against the recipient. The theft counts stem from acts of "Unauthorized Control", "Deception", and "I.D. Theft". The counts were also filed as two Class X Felonies, four Class 1 Felonies, one Class 3 Felony, and one Class 4 Felony.

- o Prosecution Investigation  
Unreported Income / Assets

BOI received an anonymous complaint alleging a recipient in Jackson County resided with their spouse, and that they had income from employment with the Department of Corrections and workers' compensation benefits while the recipient received food stamps. They also allegedly maintained a joint bank account and had income from providing child care. The case was initially referred to the Office of the Executive Inspector General (OEIG) because the spouse was a State employee. The OEIG returned the case to BOI for investigation.

The BOI investigation report was completed in September 2008. The recipient received a total food stamp overpayment of \$26,646 from July 2003 through August 2008. The criminal prosecution investigation was completed on December 12, 2008 and criminal charges were filed by the Jackson County State's Attorney's office on January 5, 2009. The case remains pending with the State's Attorney's office.

### **Food Stamp EBT Referrals and Disqualifications**

Federal Regulations mandate states to disqualify household members when a finding of Intentional Program Violation (IPV) is established. OIG's Food Stamp Fraud Unit (FSFU) reviews cases referred for suspected food stamp fraud. The cases are reviewed and evidence is compiled. If sufficient evidence is available to prove the suspected violation, 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. There are two types of cases referred:

***Suspected Intentional Program Violation (SIPV)*** – unreported earned income; unemployment; household composition; duplicate assistance; unreported assets.

***Electronic Benefits Transfer (EBT)/Link Card*** – clients selling their card benefits.

Since the inception of the Food Stamp EBT Program in 1999, FSFU has received 30,877 referrals from the USDA Food and Nutrition Services (FNS) and 390 referrals from field staff and hotline calls. The Chief of Program Operations Section for the USDA, FNS Midwest Region, has once again recognized the FSFU for their program integrity efforts in Illinois.

*“Illinois has the longest running and most successful EBT client integrity project in the Midwest Region. Although FNS made fewer referrals this year, Illinois’ activity in this area based on past referrals continues to lead the nation. To date, Illinois has successfully disqualified over 4,700 clients based on EBT trafficking. This level of success in Illinois could not have been achieved without a commitment to integrity and the dedication of resources to this important project.”*

*Tim English, Regional Director, Food Stamp Program  
Food & Nutrition Services, Midwest Regional Office  
December 15, 2008*

In 2008, FSFU received a total of 3,273 SIPV and EBT referrals, completed 2,133 reviews, participated in 590 ADHs and received 793 positive hearing decisions. In addition, FSFU processed 391 signed waivers and 17 prosecution cases. FSFU efforts resulted in the disqualification of 1,201 clients and a cost savings to the State of Illinois of \$2,299,216.

### **HFS Employee Investigations**

The OIG Bureau of Internal Affairs (BIA) completed 238 employee and vendor investigations during 2008. Several of these cases are described below:

- The Office of Executive Inspector General forwarded a complaint that alleged that an individual may be using HFS databases to develop confidential information on the complainant.

The investigation determined an HFS Office Coordinator used the HFS computer system for personal use in violation of policy. She admitted that the subject content of the personal activity was not appropriate for the workplace. She also acknowledged that she had looked at medical eligibility for her sister and her mother. The personal documents retrieved from her email contained 551 documents related to personal correspondence. The employee received a Written Reprimand for her misconduct.

- The Division of Personnel and Administrative Services staff received information from the Office of the Comptroller that indicated an Information Systems Analyst had income from HFS that appeared to overlap with contractual income from the Illinois Secretary of State (SOS).

The investigation determined that the HFS employee violated multiple policies when he used the computer system for personal use during regular work hours and used the Agency’s computer network and email to communicate with individuals outside the state of Illinois. The personal documents retrieved from his computer contained over 370 documents related his personal activities and private business. The employee admitted to and recovered evidence substantiated the content of the information was not work-related and was strictly personal.

The employee also abused his time and falsified official HFS documents when he signed an HFS Form 2053 for 1.5 hours of sick leave for a date in August and then went to work for the SOS on the same date during the same time period.

The employee provided false and misleading information to Internal Affairs investigators during his initial interview. He did not divulge his current employment relationship with the SOS, having signed a fiscal year 2008 contract with them in June 2007. Further, in both his oral and written statements he led investigators to believe he ceased all his outside employment prior to accepting his position with HFS. The employee was issued a 7-day suspension.

- It was reported to BIA that an Office Coordinator (OC) allegedly serviced a custodial parent's child support case as a walk-in even though the OC was assigned to another region. Policy requires employees to refer clients to their appropriate region.

Further reports indicated the client returned to the office and was observed talking with the employee in what appeared to be a tense or hostile verbal exchange. Afterwards, the client asked if she could speak with a supervisor about how her case was handled by the employee. When the client spoke with the supervisor, she stated that the affidavit of direct pay she signed in March 2006 had the wrong amount on it. Furthermore, the child in the case allegedly told the client that his father (the non-custodial parent) had paid the employee \$300 to "fix" the case.

Because the complaint contained an allegation of bribery, BIA referred the matter to the Illinois State Police, Division of Internal Investigation (DII). DII investigated this matter and concluded that insufficient evidence was available to pursue criminal charges. Internal Affairs subpoenaed DII's investigative report and launched an administrative investigation.

The Internal Affairs investigation established that without appropriate authorization, the employee affected case action on a client's case that was assigned to another region. The action taken was in favor of the non-custodial parent (NCP) resulting in the zero-out balancing of his arrearage.

Although the investigation could not establish the full and complete extent of the relationship between the employee, the NCP and the client, sufficient evidence existed that some type of an arrangement existed between the three parties. Evidence established that the client was specifically seeking out an employee with a specific first name that the NCP had prearranged for her to meet. The evidence also established that two telephone calls were made from the employee's desk to the NCP on a specific date in March 2007, one day before the client and the employee met to sign the Affidavit of Direct Child Support Payments.

Insufficient evidence existed to substantiate the bribery allegation; however, BIA determined that the OC violated multiple HFS policies. The employee was issued a seven-day suspension.

- It was reported to Internal Affairs that a NCP claimed that his ex-mother-in-law, who is an HFS Public Service Administrator was looking at his child support case and telling his ex-wife when his child support payments had or had not posted. The NCP said that the employee had a telephone conversation with his former mother-in-law in which she told him that he needed to make a child support payment because she was sitting at her desk

and was looking at his case.

The investigation determined that the employee violated HFS policy when she used the HFS Key Information Delivery System (KIDS) for personal use. She admitted viewing her daughter's case and computer monitoring evidence confirmed that she accessed KIDS for purely personal use not associated with her duties.

She allowed her private and personal interest to conflict with her work related duties and responsibilities. She misrepresented to Internal Affairs investigators facts surrounding contact with department officials, when she said that the CP was present on 3-party calls.

The investigation also established that another employee in the office violated HFS policy when she knowingly and willingly provided information regarding the employee's daughter's child support case without proper authorization on file. This employee also blind copied an email to the CP's mother containing the NCP's confidential case information and work-related communications between staff.

The second employee knowingly misrepresented an email as an official intra-agency inquiry when she knew this inquiry was from an employee who is the mother of a participant in the case. In addition, the second employee made several entries into the KIDS case notes suggesting official involvement with another agency bureau knowing that the inquiries were of a personal nature.

The employee who intervened in her daughter's child support case was issued a 14-day suspension. The second employee was issued a seven-day suspension.

- Routine Internet monitoring revealed that a PA Family Support Specialist 1 may have visited websites that are inappropriate for the workplace, non-work related and have a pornographic overtone.

The subsequent investigation determined that the employee used the HFS computer system for personal use in violation of several HFS policies. He admitted to and recovered evidence substantiated, that the subject content of the personal activity was not appropriate for the workplace. He was issued a one-day suspension.

- A complaint was reported by a custodial parent that her caseworker changed the non-custodial parent's employer from the VFW to the Crowne Plaza. The change was allegedly made to assist the non-custodial parent in lowering his child support payments as the VFW was the higher paying of the two employers. The CP alleged that our employee frequents the VFW and might have had a conflict of interest.

BIA determined the employee violated multiple HFS policies when he engaged in conduct that would lead a reasonable person, knowing all the circumstances, to a conclusion that he might be biased. Being deceitful with the custodial parent in telling her he did not know there was a VFW in Springfield when in fact he was a regular customer shows a pattern of deception. The preponderance of evidence collected also shows that the employee caused a withholding order to be terminated, knowing and

admitting to the past and accepted practice at the office that higher paying employers should be served.

The investigation also substantiated that the employee violated HFS policy when his systemic treatment of clients at the office resulted in complaints by clients and observations of co-workers that his behavior was discourteous and at times inappropriate. Two other CPs described his behavior as inappropriate or rude. Three out of four of the employee's subordinates provided information which also demonstrated a pattern of discourteous treatment, inappropriate conduct, or rudeness toward both custodial and non-custodial parents. The employee was discharged for cause.

- HFS staff became aware of information that raised ethical issues in the handling of a client's estate case by an Executive 1. The case involved a lien settlement and funeral and burial pre-pay irrevocable contracts on cases. In the case in question, the pre-pay was done in 2004 by a family member; the family was just now settling the lien on a house that sat for three years. An attorney was seeking a settlement for funeral and burial reimbursement as well as other house maintenance expenses.

Supervisory review of documents and other information in the case file discovered what appeared to be altered documents and documents that contained questionable data.

The investigation determined from documents obtained by subpoena that the Executive 1 had entered false and altered documents into the official case file for the settlement of a lien. In June 2008, investigators interviewed the employee and when confronted with the evidence, she admitted to creating a forged receipt for the monument, altering and submitting a receipt for cemetery plots and other improper handling of the case. During the interview, the employee voluntarily resigned her position with HFS.

- Division management reported that an employee of one of the state's attorneys may be viewing her personal child support cases through the Key Information Delivery System (KIDS). The investigation determined that the employee accessed and viewed her own personal child support information through KIDS on fourteen occasions during the period Internal Affairs monitored her KIDS usage. In addition, she kept an ongoing dialogue with an HFS employee via email regarding her child support cases.

The results of the investigation were passed on to the state's attorney and on July 27, 2008, BIA was notified that action was taken "commensurate with the alleged violation."

- Routine Internet monitoring revealed that an Office Coordinator may be visiting websites that were inappropriate for the workplace, non-work related and had pornographic overtones. The investigation determined that the employee used the HFS computer system for personal use in violation of HFS policy. She admitted that the subject content of the personal activity was not appropriate for the workplace. Forensics evidence also substantiated that she accessed her MySpace page while being compensated for 18.43 hours of overtime pay.

The employee was issued a 10-day suspension. She signed a voluntary repayment agreement with the Department for reimbursement of the overtime pay of \$513.12 she

was paid but was not entitled to receive due to her time abuse.

- A Family Support Specialist (FSS) alleged that a few months after a co-worker became her supervisor, the supervisor told the FSS three times that she needed \$300. The FSS alleged that since this incident the supervisor's attitude towards her changed and that "her life has been an endless nightmare." The FSS claimed that her supervisor's action constitutes retaliation because she did not acknowledge the supervisor's request for the \$300.

The investigation determined that the supervisor violated HFS policy when she reprimanded the FSS in front of clients and threatened to write her up. This occurred in a public arena that allowed for clients and other employees to overhear her comments.

The investigation also uncovered sufficient evidence to substantiate that this supervisor created a conflict of interest violating HFS policy, when she solicited a \$2,000 personal loan from another FSS. The loan was subsequently consummated on state property during work hours.

The supervisor violated HFS policy by creating a hostile work environment. The fear of discipline intertwined with an "over-the-shoulder" monitoring of daily work activities created undue stress upon a majority of the employees. She also was discourteous to several employees and did not hesitate to openly display disrespect to them face-to-face or in front of clients. There was not 100% agreement among all those interviewed; however, the majority had trepidation about working for this supervisor because of the offensive, intimidating, or oppressive atmosphere she generated. In this setting and under these conditions, the supervisor's behavior was pervasive enough to foster and create a hostile work environment.

The supervisor tendered her resignation and retired from state government.

- In June 2008, during routine monitoring of HFS email traffic sent outside the Agency, BIA identified an Office Associate (OA) as one of the more frequent users (676 outgoing emails) of the Department's email system. The personal email indicated the OA was corresponding with a female acquaintance.

A preliminary review of the employee's live GroupWise activity revealed that he responded to, created and sent non-employee, personal email. The employee habitually and immediately deleted the email, placed the email in the GroupWise trash and then immediately emptied the trash in an effort to hide his inappropriate behavior. His email exchanges were monitored from July 1 through July 16, 2008. During that monitoring period there were 1,232 personal email exchanges; all which were personal and sexually graphic. The employee also had a limited amount of email exchanges with his wife centering on dinner plans, after work activities, their children and their financial situation.

During his Internal Affairs interview, the employee was presented with the allegations, evidence, and the Agency's stance on sexually graphic email content. After investigators explained his options, he elected to resign from HFS immediately with no reinstatement rights to the Agency.

- The HFS Office of Labor Relations forwarded a complaint that alleged a Health Facilities Surveillance Nurse (HFSN) told a registered nurse at a Supportive Living Facility (SLF) to correct a medication error that was discovered during the annual survey and she would not note it in her report. A second SLF registered nurse was present when the alleged remark was made.

The investigation determined that the HFSN violated HFS policy when she instructed SLF nurses to change a resident's medical chart in order to cover up a documentation error. The employee admitted that she told them to change the resident's medical dosage from 15 milligrams (mg) to 75 mg to reflect the actual dosage prescribed on the prescription.

The employee admitted that she exercised bad judgment when she failed to document the error in her write-up and when she failed to inform the lead surveyor of her omission. The HFSN claimed she had no specific policy to follow in this situation and she used her own judgment. She elected to resign her position with the Agency.

- A custodial parent alleged in her complaint that the non-custodial parent's ex-girlfriend accessed her child support case and shared the information with him. BIA established a 30-day monitoring of the child support case in question. The monitoring disclosed that a DHS Human Services Caseworker used the KIDS to access the complainant's child support information on three separate occasions.

The caseworker is suspected of violating DHS policy that governs the access and release of confidential Department information. Since the individual is not a HFS employee, BIA forwarded the completed investigation report to the Office of Executive Inspector General.

- An Office Coordinator (OC) alleged that an Office Administrator 4 (OA4) was discourteous to her by using profanity and loud language that threatened violence. The OC alleged that the OA4's behavior was inappropriate and unbecoming a state employee.

A total of seven employees, including the OA and OA4 were interviewed to determine the veracity of OA's complaint against the OA4 for allegedly threatening her with bodily harm. The OA4 denied threatening the OA, as well as, using any profane language during their verbal discourse. None of the witnesses heard any threatening remarks or profanity.

It appeared to be common knowledge in the office that both employees had a history of problems working together. The OA4 admitted that she should have handled this situation differently and in retrospect she regrets the language she used. The investigation revealed that there were multiple violations of HFS policy by both employees during a verbal discourse that led to the complaint. Discipline was administered to both employees in the form of Written Reprimands.

- During the price proposal opening of an RFP, it was discovered that price proposal envelopes from the two bidders each contained a copy of the others' bid. The

complainant notified the Acting State Purchasing Officer and the Deputy Inspector General of the incident. A Public Service Administrator (PSA) was identified as the leader of the RFP review team.

Interviews were conducted with staff from several HFS offices. These interviews provided evidence of misconduct by multiple employees.

The investigation determined that the PSA team leader violated HFS policies when he engaged in conversations with a Senior Public Service Administrator (SPSA) regarding the RFP from which she had been recused. The PSA also failed to promptly report the SPSA's involvement and that the pricing envelopes had been opened by the SPSA prior to the "official" opening date. The investigation further determined that the PSA violated HFS policy when, with intent to deceive, he repackaged the contents of the pricing proposals. He aggravated the circumstances by ensuring the envelopes used and the cover sheets therein, were exact matches to those submitted by the bidders. In addition, the PSA allowed another SPSA, an employee not assigned to the RFP review team, to complete a portion of another team member's score sheet.

The investigation also determined that the SPSA violated HFS policies when she engaged in conversations with the PSA regarding the RFP from which she had been recused. Her recusal was based upon a personal relationship with one of the bidders.

The investigation determined the SPSA who completed the score sheet violated HFS policies when, with intent to deceive, she completed a portion of an RFP team member's score sheet. This employee was issued a 14-day suspension. The other SPSA who opened the bid envelopes was allowed to resign. Disciplinary action is still pending against the PSA team leader.

The Office of Executive Inspector General was informed of the investigation and pursuant to Article 50, Procurement and Disclosure, 30 ILCS 500/50-40 Reporting Anticompetitive Practices, a notice of the relevant facts was transmitted to the Office of the Attorney General and the State of Illinois Chief Procurement Officer.

### **Threat Assessments**

In addition to conducting employee and contractor investigations, the OIG's Bureau of Internal Affairs (BIA) is also involved in the physical security of HFS offices. Along with the usual security functions of overseeing the building guards, alarms and access control, BIA also conducts "threat assessments" related to individuals whose behavior has created a safety concern. HFS does not tolerate words or actions that are considered threatening and makes every effort to maintain a safe working environment.

When an employee's, contractor's, client's or visitor's words or actions create an environment that places others potentially at risk, a threat assessment is completed. The threat assessment involves collecting information that allows BIA to evaluate the subject's past history to determine if they are capable of carrying out a threat or if the subject has a history of making threats. Department historical notes, public record histories and contact with local law

enforcement agencies are some of the tools used to assist BIA in determining whether the subject is a viable threat.

During the past year threat assessments have been conducted on non-custodial parents who have threatened to harm HFS staff, the custodial parent and in some instances their own children. Threats of this type are generally reported to local law enforcement in the communities where each party resides. In some cases a determination is made that the person making the threat should be limited in their ability to access HFS offices. When that determination is made, the OIG notifies the subject of the threat assessment that he or she is required to conduct any future business with HFS via telephone or mail.

In several instances, non-custodial parents have indicated to child support staff, usually by telephone, that they are unable to cope with the issues related to their case and are contemplating harming themselves. In these instances, BIA does a threat assessment that includes contacting local law enforcement and requesting that a welfare check be made on the individual.

The vast majority of threats received by HFS are related to child-support issues. To a lesser extent, BIA has fielded threats from medical providers and Medical Program clients related to payment and coverage issues. These threats are handled in the same manner as those related to child-support. Threats to HFS property also occur and are generally reported to local law enforcement once it is determined that a true threat exists.

HFS staff have been provided information and training on the types of threats that may be made and the process to be used to prevent an occurrence of violence. The HFS Bureau of Training offers a ½ day program entitled *Workplace Safety* that is available to all HFS employees. Also, the HFS Security Coordinator maintains a relationship with the Facility Safety Coordinators at HFS facilities and provides educational material for the coordinators to use in their roles.

During calendar year 2008, BIA conducted a total of eighty (80) threat assessments. This is an increase of 170% over the threat assessments conducted in the previous year. The increase reflects both the increased level of Child Support enforcement and the current downward trend in the economy.

### **Electronic Monitoring of Computer Activity**

Internal Affairs has a significant role in investigating, monitoring and examining staff's activities of HFS resources to insure compliance with the Department's Computer Security and Internet Policy. During 2008, BIA reviewed 26 allegations of Misuse of the Computer System. Of the 26 allegations, 16 were substantiated.

In addition to investigating the aforementioned allegations, the bureau also performs monthly monitoring of HFS staff's Internet and email activities. This is accomplished by the following methods:

Computer Forensic Examinations - BIA examined 17 Agency computers in the course of conducting internal affairs investigations regarding violations of the Department's Computer Security and Internet Policy. This was accomplished by using the industry standard in computer forensic investigation technology.

Internet Monitoring – Specialized Internet monitoring software allows BIA to continuously monitor employees’ and contractors’ usage of the Internet on a monthly basis. The software determines, but is not limited to, the total length of time spent accessing the Internet, addresses of sites visited, general categories of sites accessed, and demographic patterns of usage. HFS is one of the few state agencies that monitor employee Internet utilization to this level. As the result of such monitoring, 41 employees and contractors were identified as participating in questionable Internet activity. Several of the more egregious users were referred for investigation while less severe infractions were referred to the employee’s division for administrative handling.

Email Monitoring – BIA monitors email sent to, and received from, sources outside of the Department. Specialized Email monitoring software allows BIA to monitor the number of incoming messages, the number of outgoing messages, and the size of the email. As a result of this monitoring, BIA discovered several employees sending and receiving inappropriate information. BIA examined the internal email of 65 employees suspected of misusing the Department’s email system. This review resulted in seven internal investigations being initiated.

### **Hiring Practice Investigations**

During the course of 2008, BIA conducted five investigations dealing with issues surrounding hiring and promotional processes and specifically issues involving violations of Rutan mandates. These investigations proved to be unique and complex, requiring a large amount of preparation and research before the investigators were able to conduct any interviews.

- An Information Systems Analyst 1 reported issues he was having within his work unit in Springfield; however, the issue that seemed to be the most significant to this employee was not being interviewed or hired into a position in his unit that would have been a promotion. He said that there was a posting issued for an Information Systems Analyst 2 for which he applied, but had not been interviewed. He claimed that the person who ultimately received the position had been a contractor, and he felt that he should have been interviewed.

The employee advised that when he inquired about the reason he was not interviewed, he was told something about having a break in service and not qualifying.

BIA obtained information from the Division of Personnel and Administrative Services regarding the filling of the job posting for the ISA 2 position. Investigators learned that this position was filled under terms of the AFSCME Agreement, which requires that this job be filled by seniority. Interviews are not conducted. The only contact between the management of the area where the job is located and the candidates is to let them know they are the senior candidates to see if they are interested in the position.

If no one who qualifies under the specific terms of the AFSME Agreement takes the position, it would then go to “other means” which would then allow others to be interviewed. Since this would have been a promotion for the complainant, he was not considered for the position under “other means.”

BIA's review of the records for this ISA 2 position disclosed that the process was proper and the person who was given the position was the person who qualified under the terms of the AFSME contract.

- After the personnel office fielded a complaint from AFSCME wherein it was alleged that a manager went out of her way to discourage a union member from accepting a position because the manager had another employee in mind for the job, HFS Personnel Administrator and HFS Labor Relations Chief requested that BIA initiate an investigation. BIA was also requested to investigate the handling of waivers for an Executive 1 position that was posted for that manager's area. The investigation disclosed the manager provided false and misleading information to many of the candidates, which directly influenced them to submit waivers for the promotion. Six of the eleven applicants waived the promotion based on the false and misleading information provided by the manager.

The manager also violated the provisions of a Separation Agreement in which she had agreed not to seek or accept employment at the Illinois Department of Public Aid (HFS' predecessor). Between 1983 and 2006, the employee submitted six employment applications and two employment related forms containing false and misleading information regarding her criminal felony convictions or the fact she was fired from her position at Public Aid in 1982, based upon those felony criminal acts.

BIA substantiated the above allegations and the manager was discharged for cause.

- An employee working for the Bureau of Selection and Recruitment conducted an interview for a Rutan Administrative Assistant (AA) 2 vacancy. During the interview with an AA 1, the interviewer became suspicious of several of the candidate's responses to the questions. Based upon the interviewee's responses, she suspected the candidate possibly had prior knowledge of the interview questions and their corresponding ideal responses.

BIA established that the candidate obtained the questions and the ideal responses for the AA 2 position. During her investigatory interview, the candidate admitted to investigators that she obtained the interview questions and ideal responses for the AA 2 position from a Public Service Administrator (PSA) within the bureau to which she was applying. Both employees acknowledged having a personal friendship with the other.

While both employees gave conflicting accounts of how the questions and ideal responses ended up in the candidate's possession, the evidence established that the two essentially agreed that the candidate had an interest in the PSA's former position of AA 2 and that the PSA desired that her friend do well in the interview. Both individuals agreed that a meeting took place in the PSA's office, the position duties were discussed at that meeting, the PSA was instrumental in arranging an introduction between the candidate and the bureau chief and that following the candidate's Selection and Recruitment interview the two met and discussed the candidate's performance. Both employees' descriptions of the compromised document that contained the AA 2 questions and ideal responses were nearly identical. The candidate took a polygraph examination which in the opinion of the examiner noted no deception regarding the candidate receiving the questions and ideal responses from the PSA.

Both employees were cited for violations of policy, State of Illinois Personnel Code, and the Illinois Administrative Code, with the results forwarded to the divisions. Disciplinary action is pending for both employees.

- Upon receipt of the allegation, the Office of Labor Relations reported to BIA that a HFS manager allegedly provided Rutan interview questions to a Family Support Specialist (FSS) subordinate employee. Material provided included an email thread between the manager and the FSS from October 23, 2000, where the FSS advised that she was going to be interviewed for a vacant position. The manager asked if she would like the interview questions. There were handwritten notes on the documents that appeared to be information used to provide answers to the questions.

The investigation established that the manager violated policy and the State of Illinois Personnel Code by providing the interview questions for the FSS position to a subordinate employee prior to her interview with Selection and Recruitment. The manager's denial of this fact is countered by the subordinate's statement as well as the fact that he offered the questions and was then present in her work location the morning of her telephonic interview.

The manager was issued a 29-day suspension; however, the subordinate claimed a subsequent injury and went on a workers compensation leave. The Agency is holding her discipline in abeyance until she returns to work from her leave.

- The agencies' Equal Employment Opportunity Officer (EEO) office reported that an Executive 2 (E2) alleged during an EEO complaint that questionable practices may have taken place during the filling of a Public Service Administrator (PSA) position. The E2 alleged that she was passed over for a PSA promotion because management wanted another employee in the position. During her Internal Affairs interview, the complainant claimed that two Senior Public Service Administrators (SPSA) notified another employee regarding the PSA posting and prepared him for the interview.

There was no evidence to support the allegations against either SPSA that they conducted themselves in an unbecoming manner or released confidential records. Furthermore, the investigation did not find a conflict of interest when one of the SPSAs informed subordinate staff of upcoming positions or postings. The Bureau Chief of the Bureau of Selection and Recruitment clarified that the Rutan process is not compromised when a supervisor informs a subordinate of an upcoming position or posting.

Selection and Recruitment indicated that the SPSA did not try to promote the selected candidate as her preferred candidate, nor did she have any input in the final selection of the recommended candidate. The interviewer did not believe the selected candidate was coached for the interview, nor did he have access to the interview questions and/or answers. In addition, the selected candidate denied being informed individually of the promotional posting and of meeting privately with either SPSA to help him prepare for the interview.

### **Administrative Litigation Initiatives**

Attorneys from OIG's Bureau of Administrative Litigation (BAL) represent the Department in administrative hearings. In 2008, BAL implemented several new initiatives aimed at improving the efficiency and overall management of cases within the Department, expediting resolution of BAL cases and increasing monies recouped by the State.

Phase I implemented the Preliminary Call process, wherein nearly one half of the BAL cases were reassigned to a single extended call in an effort to streamline the prosecution of cases that involve limited legal issues and facts. Cases heard on the Preliminary Call include termination, conviction, HHS decertification and child support cases. Phase II created the Expedited Recoupment Initiative, which improved the evaluation process of BAL audit recoupment cases, established parameters for settlement, and expedited hearings. Phase III revised the BAL Peer Termination Case process, with a focus towards improving the evaluation and prosecution of provider cases involving the quality of care rendered to Medicaid recipients.

As a result of these initiatives, BAL's case management process has become significantly more efficient. BAL initiated 324 hearings in 2008. The number of resolved child support license cases increased from 46 in 2007 to 115 in 2008. Notably, the number of resolved cases increased from 101 in 2007 to 288 in 2008. Also significant are the increased year-to-year dollar recoupments received as a result of BAL administrative actions. In 2008, BAL resolved cases totaling over \$4.7 million dollars; an increase of over \$2.2 million dollars from 2007.

#### ***Preliminary Call Initiative***

In April 2008, the Preliminary Call was established to streamline and expedite the evaluation and hearing process of cases within the Department. To achieve this goal, cases transferred to the Preliminary Call are evaluated and set for hearing within 30 days of assignment to the call. A Preliminary Call is scheduled once a month at a minimum. In most instances, cases assigned to the call are resolved in one hearing. Cases heard on the Preliminary Call include: child support delinquency cases, default recoupment cases in which the provider was served with the Department's notice of right to a hearing yet failed to respond and provider denial, suspension and termination cases related to (1) decertification by the US Department of Health and Human Services, Center for Medicare and Medicaid Services, (2) revocation or suspension of a provider license, (3) improper provider licensure, (4) a provider's conviction of Medical Assistance Program fraud, murder, or a Class X felony or (5) an individual's improper and/or prohibited conduct if, at the time of such conduct, the individual had management responsibility for a provider, owned either directly or indirectly 5% or more shares of stock in the provider, was previously terminated from participation in the Illinois Medical Assistance Program or has been convicted of a prohibited offense.

#### **Child Support Delinquency Cases**

The Child Support matters included on the Preliminary Call involve cases wherein the non-custodial parent, who holds a state-issued license, is more than 30 days delinquent in complying with a child support order. After providing an opportunity for a hearing, the Department may certify to the licensing agency that the non-custodial parent is delinquent in child support payments, thereby allowing the licensing agency to suspend the individual's license pursuant to 305 ILCS 5/10-17.6 and 89 Ill Code Section 160.77. The Department may also suspend a provider's eligibility to participate in the Medical

Assistance Program if the provider is not in compliance with child support payments pursuant to 305 ILCS 5/5-16.6 and 89 Ill Code Section 140.16(c).

As a result of the transfer of child support cases to the Preliminary Call, BAL achieved resolution of 115 cases in 2008 as compared to 46 cases in 2007. In 2008, BAL brought actions certifying \$3,328,631 millions dollars in past-due child support payments compared to the \$1,298,391 identified in 2007. Notably, the transfer of child support cases to the Preliminary Call has resulted in \$1,163,211 million dollars in acceptable payment arrangements with DCSE and new support orders. This represents a nearly one million dollar increase from the \$206,852 attained in 2007.

#### Default Recoupment Cases

Preliminary Call actions include seeking recovery of money improperly or erroneously paid pursuant to 305 ILCS 5/12-4.25 (E) and 89 Ill. Adm. Code Section 140.15. The provider is first given an opportunity to present information at a formal conference pursuant to Department notice of a right to hearing. For those providers who, despite receiving notice via certified mail or personal service, fail to appear at a formal conference scheduled by the Department and fail to request a hearing, a motion for default is filed, pursuant to 89 Ill. Adm. Code Section 104.210(d) and 104.285. The motion for default includes a request that the Department's decision, and the grounds asserted in the Department's notice setting forth the basis for that decision shall be a final and binding administrative determination. This motion is brought on the Preliminary Call to expedite resolution of the matter.

#### Provider Denial, Suspension and Termination Cases

One of the OIG's key concerns is ensuring that the physicians providing care to recipients in the Medical Assistance Program are providing quality care. It is paramount that individual healthcare professionals who fail to meet the licensing standards are expeditiously brought to hearing and suspended or terminated from the Medical Assistance Program. The Preliminary Call, therefore, also includes HFS cases wherein BAL moves to effectuate the immediate denial, suspension or termination of a provider from the Medical Assistance Program when such vendor is not properly licensed or when such vendor's professional license or certification has been revoked, suspended, not renewed or otherwise terminated by the appropriate licensing agency. (See 305 ILCS 5/12-4.25 (B) and in accordance with 89 Ill. Adm. Code Section 140.16(a)(2)).

Equally important to the program integrity of the Medical Assistance Program is the denial, suspension or termination of any person, firm or corporation convicted of a felony offense involving: (1) fraud or willful misrepresentation related to the program, (2) a conviction of application of federal or state laws or regulations relating to the Medical Assistance Program, (3) a conviction of Murder or a Class X felony and/or (4) the previous termination from the Medical Assistance Program or conviction of a prohibited offense by the vendor, a person with management responsibility for a vendor, or an officer or person owning either directly or indirectly 5% or more shares of stock in the vendor. (See 305 ILCS 5/12-4.25 (A)f)(g)(A-5)(A-10) and (C), and in accordance with 89 Ill. Adm. Code Section 140.16(a)(8)(9) and (10)). Therefore, it is anticipated that assigning this class of cases to the Preliminary Call will expedite the reduction of potential provider fraud and/or abuse of the Medical Assistance Program.

***Expedited Recoupment Initiative***

One of the program integrity functions of the OIG is to conduct audits of Medicaid providers to ensure that payments made for services rendered are appropriate, and that identified overpayments made to providers are recovered. BAL attorneys represent the Department in actions wherein the Department is seeking recovery of money improperly or erroneously paid. In 2008, BAL implemented the Expedited Recoupment Initiative to improve the efficiency of case evaluations, establish parameters and guidelines for settlement of cases, streamline the process whereby cases are brought to hearing and case resolution. Recoupment cases generally involve complex medical and statistical issues. The evidence and expert testimony that must be established at administrative hearings is substantial and often results in lengthy hearings. In some instances hearings can take years to complete, delaying recoupment and case resolution.

To implement the Expedited Recoupment Initiative, a team of BAL attorneys and staff was established to manage and prosecute all audit recoupment cases. The team meets weekly to evaluate case-specific issues, establish team assignments and report on the progress of cases. Evaluation of cases includes a review of all relevant medical and statistical data. The team selects cases appropriate for settlement and sets the parameters for settlement. Members of the team contact providers in an effort to amicably and appropriately resolve the case prior to hearing. On a weekly basis, the team determines the progress of ongoing settlement negotiations and the likelihood of settlement. In cases wherein resolution cannot be reached through settlement, BAL expeditiously moves to hearing.

Through the Expedited Recoupment Initiative, BAL has achieved a marked increase in settlements and expedited recoupments to the Department. In 2008, BAL resolved 69 audit recoupment cases, a notable increase from the 5 cases brought to resolution in 2007. At the close of 2008, there were approximately 150 cases assigned to the Expedited Recoupment team. Since the April 2008 commencement of the initiative, BAL achieved an additional \$1,069,000 in recoupment of overpayments through settlement alone. This significantly contributed to BAL's termination / recoupment recovery total of \$3,450,484.78 dollars for 2008. As a result of the initiative, Recoupment cases typically resolve within 3 months of assignment. This is a vast improvement from the 12 - 36 months previously required through the administrative hearing process. These improvements are attributed to substantial efforts to resolve cases through settlement.

***Peer Review Initiative***

Another OIG key function is to ensure that the medical providers rendering care to recipients in the Medical Assistance Program are providing quality care. Therefore, it is paramount that individual healthcare professionals providing care to Medicaid recipients meet certain professional standards. BAL brings peer termination actions against providers who furnished goods or services to a recipient which, when based upon competent medical judgment and evaluation, are determined to be (1) in excess of the recipient's needs, (2) harmful to a recipient or (3) of grossly inferior quality. Peer termination cases, which are brought for the sole purpose of denying, suspending, or terminating a provider's participation in the Medical Assistance Program, involve complex medical and legal issues, which require evaluation by both staff attorneys and consultant health care professionals. Additionally, prosecution of peer termination cases includes presentation of extensive medical evidence and medical expert testimony. Due to the complexity of these cases, administrative hearings can take up to several years to complete.

In an attempt to expedite the resolution of these cases, BAL has launched the Peer Review Initiative.

In 2008 the BAL launched the Peer Review Initiative to expedite the overall resolution of Peer Review cases within the Department. The initiative sought to more expeditiously evaluate Peer Review cases prior to hearing, and to streamline the presentation of complex evidence at hearing. As part of the initiative, Attorneys from the BAL meet with nurses from the OIG Peer Review Section immediately following a decision by Peer Review Section to terminate or to suspend a Provider due to Quality Care concerns. This collaborative effort allows for a greater, more efficient understanding of the medical and legal issues involved in each case. As a result, the time needed by the BAL attorney to draft Notices and prepare cases for hearing has been substantially reduced. Additionally, such collaborative efforts have resulted in a more clear, concise presentation of the evidence at hearing. While Peer Termination cases will continue to require presentation of complex medical and other evidence at hearing, the collaborative efforts of the BAL attorneys and BMI staff have substantially improved the timely evaluation of Peer Review cases, reduced the time required to bring cases to hearing, and have expedited the overall resolution of Peer Review cases.

### ***PREVENTION ACTIVITIES***

#### **Fraud Prevention Investigations**

OIG's Fraud Prevention Investigation (FPI) program was started in six Cook County Department of Human Services (DHS) local offices during 1996 to verify applicant information prior to initiating recipient benefits. The OIG rightfully believed that these pre-approval investigations would detect and prevent incorrect issuances of financial, medical or food stamp benefits. The FPI program has provided a thirteen-year estimated average savings of \$13.61 for each \$1.00 spent by the state. FPI has averaged a 66% denial, reduction or cancellation rate of benefits for the 40,333 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over \$106.9 million.

If a DHS intake caseworker has reasonable grounds to question any statements, documents or other representations at the time of application, the caseworker can refer the case to FPI. 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 July 2006, the FPI program expanded to include the four DHS local offices in the Metro East counties of Madison and St. Clair. The OIG and their DHS partners in those counties had a goal of five referrals from each of the four local offices. For the next two fiscal years the Metro East local offices struggled to provide the requisite number of quality referrals to make their

inclusion cost effective. Through mutual agreement, the OIG and DHS ended the FPI program in the Metro East area effective July 1, 2008.

In 2008, a Request for Proposal (RFP) was posted and the contract was awarded to a new vendor. That vendor began taking referrals in September 2008, in Cook County only.

During calendar year 2008, the program generated 3,227 total investigations, of which, 2,102 cases led to reduced benefits, denials or cancellation of public assistance. The overall denial rate for this period was 65%. BOI calculated an estimated gross savings for calendar year 2008 of approximately \$10.7 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps. The program estimated cost savings for calendar year 2008, was \$12.19 for each \$1.00 spent on the program.

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

In a partnership with the Department of Human Services (DHS), the OIG's Long Term Care-Asset Discovery Investigations (LTC-ADI) unit targets error-prone long term care Medicaid applications. DHS local office staff throughout the state refer applications to LTC-ADI that meet error prone criteria. LTC-ADI evaluates the Medicaid applications to identify undisclosed or improperly diverted assets in an effort to prevent ineligible persons from receiving long term care benefits.

OIG's LTC-ADI unit identified a gross savings of \$21,955,960 for not providing long term care benefits to ineligible persons based on 753 referrals during 2008. The efforts of LTC-ADI realized a return of \$14.53 of savings for each dollar spent in conjunction with the program.

#### **Notable Cases:**

- The DHS local office in Macon County made a referral to the LTC-ADI unit due to the applicant's failure to answer the questions on the application. The application offered minimal information, specifically listed no reportable assets. As a result of the LTC-ADI, assets totaling \$39,968 were revealed. The assets consisted of a checking account and two life insurance policies. A significant portion of the total asset balance came from one life insurance policy with a cash value of \$37,654. The life insurance policy was discovered by verifying recurring disbursements reported on the checking account statements. The recurring disbursements turned out to be life insurance premium payments to a specific life insurance company. The LTC-ADI analyst sent an inquiry to the life insurance company and the response revealed the policy's owner and cash value.

The applicant was able to use his excess assets to pay for the cost of care at the nursing facility where he resided. The savings to the Department was 13 months totaling \$35,388.

- While an over the road truck driver from California was passing through Morgan County in Illinois in early summer 2008, he suffered a debilitating stroke. The stroke rendered the truck driver unable to communicate. He was admitted to a nursing home upon discharge from the hospital. Due to the truck driver's inability to communicate, a temporary guardian was appointed for him by an Illinois court. The DHS local office referred the application to LTC-ADI because of the truck driver's unknown financial status. The only known asset was provided from the Social Security clearance that was

generated through the DHS intake system (AIS). The clearance revealed that the truck driver was receiving SSA benefits and that those benefits were directly deposited to a bank account. Research was completed and verification was provided. The LTC-ADI recommendation to the DHS local office included two bank accounts owned by the truck driver in Northridge, California. The total value of the discovered assets was \$58,202.

The applicant's available assets were paid towards 14 months of the cost of his care at the nursing facility where they resided, saving the Department \$51,832.

- While some referrals are made because of the lack of information provided on the application, other referrals are made because of the content of the information reported on the application. An application referred to the OIG from Cook County Medical Field Operations in 2008 reported numerous assets of significant value including non-homestead property in Florida, certificates of deposits and an inheritance. The final asset tally at the conclusion of the OIG investigation revealed eight certificates of deposit, three checking accounts, one savings account, one life insurance policy, one money market account, one parcel of real property and an inheritance.

In addition to identifying assets owned by the applicant during the look back period, the OIG uncovered numerous asset transfers made for less than fair market value. The deed for real property located in Florida was changed to include the applicant's two children as owners, leaving the applicant one third ownership.

The property transfers for which the applicant did not receive fair market value resulted in a 40 month penalty period and a \$148,092 savings for the Department.

- Bank accounts are a common asset reported on applications, and checking accounts are the predominant source of information that leads to the discovery of unreported assets. Undisclosed assets are not the only possible source of funds for the Department reported on bank statements. In 2008, LTC-ADI identified ten applicants who had Long Term Care (LTC) insurance as a result of reviewing transactions reported on their bank statements. The LTC-ADI staff forwarded information regarding the LTC insurance to the Bureau of Collections and Technical Recovery. The subsequent reimbursements from the Long Term Care facilities were another source of savings to the Department.

### **Predictive Modeling Medicaid Transformation Grant**

During 2008, the OIG continued its efforts to design and develop the various components of the Predictive Modeling System which resulted from a federal Medicaid Transformation Grant awarded in February 2007. The primary goal of this grant is to establish a Predictive Modeling System that will provide a significant and ongoing capacity to detect and address inappropriate treatment and payment errors. The initial focus of the Predictive Modeling System is to identify collusion between psychotherapy and non-emergency transportation providers and improve care for asthmatic patients by identifying providers rendering substandard care to the asthmatic recipient population.

To accomplish the creation of the Predictive Modeling System, the OIG has formed relationships with two State universities to manage, administer and implement portions of the predictive modeling project. The OIG has partnered with the National Center for Rural Health

Professionals (NCRHP) of the University of Illinois to develop and implement the asthma predictive modeling component of this Medicaid Transformation Grant. With input and guidance from an expert panel, the NCRHP has developed an analytical plan to identify providers who fail to deliver the proper standard of care to asthma patients and identify providers that demonstrate poor outcomes of care. Information from these predictive modeling components will be utilized for quality of care reviews and will aid in the on-going mission to improve the care provided to Medicaid recipients.

The OIG also partnered with Northern Illinois University (NIU) to assist with project administration and management, data mining and a wide variety of systems development and integration tasks. NIU is charged with development of the various analysis, datasets and routines to perform the predictive modeling, which will lead to the detection of collusion between psychotherapy and non-emergency transportation providers. In addition, various infrastructure components such as analytical dataset construction, routine development and distribution, and system integration platforms are being achieved through this contractual agreement with NIU.

During 2008, NIU performed initial exploratory analyses of transportation and individual practitioners, which has shown great potential in identifying aberrant behaviors. These analyses were performed to hone in on predictors gleaned from analysis and review of completed OIG cases. These analyses focused on frequency and distribution of services and various prescribing and diagnosis patterns. Even though these analyses have not yet been fully developed into fraud detection routines or fully integrated into the Predictive Modeling System, they are useful in analyzing providers on a case by case basis and have been incorporated into monitoring of new providers and have been used to strengthen law enforcement cases. However preliminary the results may be, they are promising and have already changed the way OIG analyzes providers. Full implementation of the Predictive Modeling System in March 2010 is expected to revolutionize and transform the OIG fraud detection efforts.

### **Federally Mandated Medicaid Eligibility Quality Control (MEQC) Program**

The Medicaid Eligibility Quality Control (MEQC) program was initiated by the U.S. Department of Health and Human Services (HHS), Centers for Medicaid and Medicare Services (CMS) as a self-management tool to help states identify and correct problems in issuing benefits to clients and to reduce erroneous expenditures by monitoring eligibility determinations. Measurement of the accuracy of eligibility determinations were based on certain non-financial and financial factors including things as residency, age or disability. Financial factors included such things as income and assets. Error rates (case and payment) were computed based on a random sample of Medicaid eligibles in the universe and reported to CMS on an annual basis.

In the late 1970s, CMS became concerned that the state error rates were too high. As a result, the requirements for the MEQC were formalized by CMS. After several changes to the tolerance level for error rates, in 1994 CMS decided to allow states to operate pilots instead of the random samples. A pilot is any other type of sample or study that addresses error reduction in the Medicaid program. CMS approves the pilots as long as the state proves a workload equivalency to the prior MEQC random sample.

Each federal fiscal year (FFY), the OIG operates the MEQC program according to 42 CFR 431.800 and completes approximately 13,650 (6825 each six months) hours of Medicaid (Title XIX) eligibility reviews. The OIG has been conducting pilot (targeted) reviews of Medicaid

eligibility since it was offered by CMS in 1994. During 2008, the OIG operated the FFY07 and FFY08 pilots and designed the review protocol for the FFY09 pilot. The following is a description of those reviews for each FFY.

### ***Redetermination Accuracy Reviews***

The OIG reviewed approximately 1092 Medicaid cases throughout 2008 to satisfy the MEQC federal requirements for Federal Fiscal Year 2007. This project was implemented in October 2006 and was designed to verify the accuracy of redeterminations. The review used the same review techniques required of caseworkers when completing a Medicaid redetermination. As in prior pilots, ongoing monitoring and analysis was used throughout the reviews to feed immediate corrective action. The completion of the required summary of findings is pending.

### ***Health Benefits for Workers with Disabilities (HBWD)***

The OIG reviewed approximately 153 HBWD cases during 2008. The OIG targeted the HBWD program, which was implemented in January 2002 and designed to help people with disabilities return to work with full Medicaid (Title XIX) health care benefits. The MEQC project is designed to determine the correctness of the eligibility determinations to ensure the appropriateness of Medicaid (Title XIX) payments for the HBWD program. A summary of findings will be completed in 2009.

### ***Negative Corrective Action Reviews***

In January 2008 the OIG completed the federally mandated FY07 Negative Corrective Action Review (NCAR) analysis. A total of 264 negative case actions (i.e., denials of assistance and terminations of assistance) were sampled for the October 2006 through September 2007 review period. Eight cases (3%) were not reviewed either because the negative action could not be verified or the client had Medicaid coverage for the period under review. This is a 77% reduction from last year's drop rate of 13%.

The remaining 256 were reviewed to determine the accuracy of the negative action and to ensure that timely advance notice was sent. Of these, two errors were identified, resulting in an accuracy rate of 98.93%. The OIG monitored the two error cases to ensure the completion of corrective action by the DHS local office.

### ***Illinois Healthy Women (IHW) Surveys***

In June 2003, the Department's Bureau of Contract Management (BCM) was awarded approval by the Centers for Medicare and Medicaid Services to implement the Family Planning Expansion Initiative. This initiative was implemented on April 1, 2004 as the Illinois Healthy Women program and provides family planning/birth control and related reproductive health care for women between the ages of 19 and 44 when they lose their Medicaid benefits.

Approval of the initiative was contingent upon compliance with Special Terms and Conditions (STCs). Included in the STC was a requirement to conduct customer satisfaction surveys to assist in assessing whether Family Planning Expansion Initiative participants were:

- Able to access family planning services,
- Satisfied with the services provided,
- Referred for primary services and able to access those services, as needed.

The survey was also designed to provide feedback regarding resource/referral assistance provided to waiver participants.

In April 2008, the OIG finalized the Illinois Healthy Women Survey Report for Waiver Year 3.<sup>1</sup> A total of 256 surveys for those receiving services were completed, and 50 surveys on those not receiving services were completed. Results of the surveys for those receiving services revealed a 90% satisfaction with quality, a 57% satisfaction with access and a 53% satisfaction with referrals to services. Results of the 50 surveys with no IHW services utilized revealed the majority of clients have not used services under IHW because they decided they did not want family planning services at this time and/or they wanted to keep the card.

### **Legislative Audit Commission Request**

Due to a legislative inquiry regarding the All Kids/Family Care program, the OIG agreed to conduct a special study of income and prior insurance coverage (third party liability or TPL) for participants in the All Kids/Family Care program.<sup>2</sup> The OIG collected income information from electronic resources and TPL information from employers and families. For purposes of this study, the OIG annualized income identified from electronic sources to determine a household total.

The purpose of this special study was to determine if the annualized incomes of All Kids/Family Care families was in excess of their current program eligibility standards and to identify prior TPL coverage for 229 families randomly selected for review.

In accordance with current policy, program eligibility for the cases in this study was determined by calculating monthly income as represented by one pay stub. For purposes of this study, the OIG predicted eligibility utilizing annualized income. The OIG finalized their results in December 2008 and reported 1% of the families reviewed were no longer eligible for the All Kids/Family Care program and 1.6% of the families had TPL coverage prior to their eligibility determination for the All Kids/Family Care program.

### **Office of Energy Assistance Quality Control Initiative**

During 2008, the OIG conducted approximately 231 case reviews of the Office of Energy Assistance (OEA), Low Income Heating Energy Assistance Program (LIHEAP). These cases were reviewed according to a quality control (QC) program designed by the OIG to verify the eligibility requirements (income, household size, fuel type and geographic location) of the one-time annual benefit portion of LIHEAP. Results of the 300 sampled reviews will be provided to the OEA along with recommendations for program improvement.

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<sup>1</sup> The OIG committed to conducting these surveys for year one (2002), year three (2005) and year five (2007) of the waiver.

<sup>2</sup> All Kids is medical coverage for children only and Family Care is medical coverage for adults and children.

## *COOPERATIVE EFFORTS*

### **Joint Terrorism Task Force**

In 2008, the OIG's Bureau of Investigations (BOI) continued to work with the Joint Terrorism Task Force (JTTF). Cooperation with the JTTF began in 2006 when the Joint Terrorism Task Force, 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 had under reported, their assets and/or income to the Department of Human Services (DHS) in order to fraudulently receive public assistance benefits. Since October of 2006, BOI has had an investigator assigned to the task force. At the end of 2008, the BOI had six pending joint investigations with the JTTF. It is expected that in 2009, the federal grand jury will begin issuing indictments on these cases.

### **Restitution**

OIG procedures were instituted during December of 2008 to notify and assist courts in the enforcement of their orders relating to State of Illinois restitution payments. This is as a direct result of OIG's Fraud and Abuse Executive (FAE) discovering several instances where individuals were not meeting their restitution obligations established by the courts. One case that brought this issue to the forefront was a medical provider, who in 2004 was ordered in Cook County Circuit Court to pay the State of Illinois \$107,000 in yearly installments of \$26,750, based on the Healthcare Fraud conviction. In another instance, a medical provider was ordered in 2008 by Cook County Circuit Court to pay the State of Illinois \$146,000 in restitution, by monthly payments of \$4000. As of December of 2008, neither provider has paid any of the court ordered restitution. In both cases, the FAE worked with the proper authorities to address these delinquencies.

Documents show that individuals have been ordered by local courts, both in Illinois and surrounding states, to pay restitution to the State of Illinois. The restitutions are all determined on the courts' findings that an individual or company had either abused or committed fraud within Illinois' Medicaid Program. The restitution determined by the local courts is based on information from the OIG through the Illinois Attorney General and United States Attorney's Office.

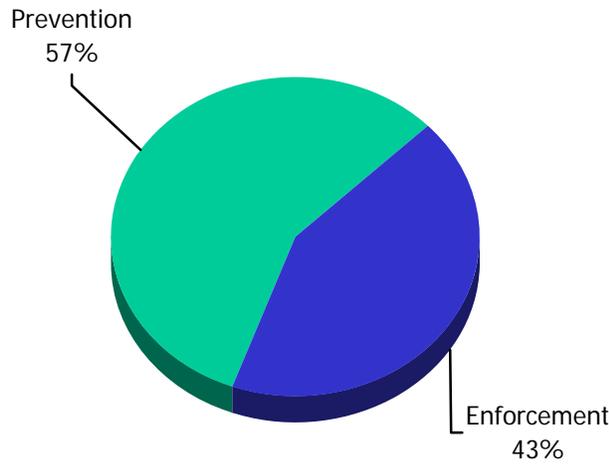
Through its case management system, the OIG now closely monitors all the varying parameters in the court orders, including total amount, payment amounts and frequency terms as well as length of probation or incarceration. In the event any of these parameters are not met, the OIG in turn notifies the responsible courts requesting remedy.

**FISCAL IMPACT**

**Fiscal Year Savings**

During Fiscal Year 2008, the OIG realized a savings of approximately \$80.5 million through collections and cost avoidances. This savings was more than four times the OIG FY2008 budget of \$20.1 million.

**FY08 Savings**



**Total = \$80,476,033**



Prevention Activities:

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

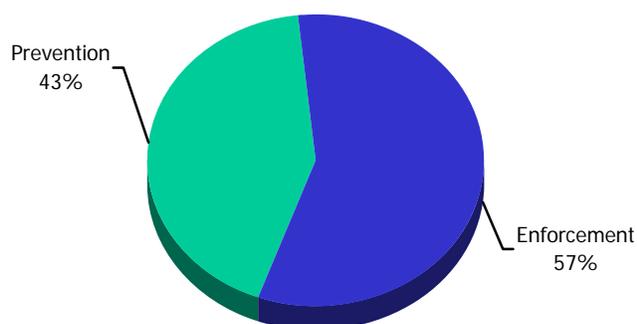
Enforcement Activities:

- 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 2008, the OIG realized a savings of over \$91.6 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 *2008 OIG Savings and Cost Avoidance Tables* portion of this report on the page numbers indicated in parentheses next to the activities listed below.

## CY08 Savings



**Total = \$91,617,042**

**■ Prevention ■ Enforcement**

#### Prevention Activities:

Provider Sanctions Cost Avoidance (*refer to page 34*)  
 Food Stamp Cost Avoidance (*refer to page 36*)  
 Fraud Prevention Investigations (*refer to page 37*)  
 Long Term Care - Asset Discovery Investigations (*refer to page 38*)  
 Recipient Restrictions (*refer to page 38*)  
 New Provider Verification (*refer to page 40*)

#### Enforcement Activities:

Provider Audit Collections (*refer to page 32*)  
 Fraud Science Team Overpayments (*refer to page 32*)  
 Restitution (*refer to page 32*)  
 Global Settlements (*refer to page 32*)  
 Provider Sanctions Cost Savings (*refer to page 34*)  
 Client Overpayments (*refer to page 35*)  
 Food Stamp Overpayments (*refer to page 36*)  
 Child Care Overpayments (*refer to page 36*)

### CONCLUSION

During 2008, the OIG has moved forward on numerous fronts to expand the depth and breadth 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. While not predictive of future results, the dividends have been better prevention methods, faster and broader detection tools and increased financial recoveries. The savings realized not only benefit Healthcare and Family Services, but several other state agencies as well. Through these efforts, the OIG has succeeded in raising awareness of the importance of program integrity among clients, providers and the citizens of Illinois. All OIG activity figures have already been assumed in HFS budget presentations.

### *2008 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 generally cover a 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	174	<b>\$22,856,630.15</b>
Desk	309	
Self	18	

#### **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)	601	<b>\$45,081,282.65</b>
Restitution	31	
Global Settlements	9	

### Medical Provider Peer Reviews

OIG's Peer Review Section monitors the quality of care and the utilization of services rendered by practitioners to Medicaid recipients. Treatment patterns of selected practitioners are reviewed to determine if medical care provided is grossly inferior, potentially harmful or in excess of need. Provider types selected for Peer Reviews include physicians, dentists, audiologists, podiatrists, optometrists, and chiropractors.

OIG staff nurses schedule onsite reviews with providers to review original medical records. A written report documenting findings and recommendations is then completed. Possible recommendations may include case closure with no concerns, case closure with minor deficiencies identified, or referral to a department physician consultant of like specialty for further review of potentially serious deficiencies. Based upon the seriousness of the concerns, the physician consultant's recommendations may include: case closure with no concerns identified, case closure with minor concerns addressed in a letter to the provider, Continuing Medical Education, Intra-agency or inter-agency referrals, onsite review by the consultant, or appearance before the Medical Quality Review Committee (MQRC). In addition to the above recommendations, the provider may be referred for suspension or termination from the Medical Assistance Program based on recommendations from the MQRC.

#### *Medical Provider Peer Reviews*

<b>Peer Review Outcomes</b>	<b># Cases</b>
Letter to Provider with Concerns	147
Letter to Provider without Concerns	52
Referral for Sanction	2

### 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*

<b>Hearings Initiated</b>	<b># Cases</b>
Termination	38
Termination/Recoupment	8
Recoupment	29
Suspension	4
Denied Application	6
Decertification	17
Child Support License Sanctions	222

Final Actions	# Cases	Total Medical Provider Sanction Dollars
Termination	32	<b>Cost Avoidance: \$213,880</b> <b>Cost Savings: \$1,724,675</b>
Termination/Recoupment	6	
Suspension	2	
Voluntary Withdrawal	2	
Recoupment	69	
Decertification Resolution	27	
* Barment	12	

\*Represents number of individuals barred in relation to a terminated provider

Reinstatement Actions on Sanctioned Providers	# Cases
Denied Application	6
Reinstated	7

Administrative Actions for Other State Programs	# Cases	Total Payment Plan Dollars Established
Child Support Delinquencies	115	<b>\$1,312,103</b>
Certified Arrearages	66	
Payment Compliance	49	
State Income Tax Delinquencies	10	
Payment Compliance	10	

### 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 or excluded from further scrutiny at that time. *It should be noted that the numbers in the chart below reflect activity from January 2008 through July 2008. The NRC was placed in hiatus due to the restructuring of the exception processing routines.*

#### Medical Provider Analysis: Narrative Review Committee

Outcomes	# Cases
Referrals	<b>367</b>
Refer for Audit	91
Refer for Quality of Care Review	159
Refer for MFCU Investigation	5
No Further Action	112

### 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	108
Law Enforcement Data Requests	146

### 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>789</b>	<b>\$3,962,050</b>
Founded	542	
Unfounded	247	
Convictions	<b>19</b>	
<b>Type of Investigations</b>		<b>Percent</b>
Absent Children		12%
Absent Grantee		1%
Assets		6%
Duplicate Assistance		2%
Employment		13%
Expenses Exceed Income		1%
Family Comp/RR In Home		19%
Family Composition		13%
Food Stamp Trafficking		5%
Impersonation		1%
Interstate Duplicate Assistance		2%
Other Income		9%
Questionable Situation		1%
Questionable Residence		1%
Residence Verification		10%
SSN Misuse/Discrepancy		1%
Third Party Liability		3%

### 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*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Dollars Established</b>
Reviews Completed	1,918	<b>Cost Avoidance: \$2,299,216</b> <b>Food Stamp Overpayments:</b> <b>\$1,582,373</b>
Pending Administrative Disqualification Hearing	7,368	
Disqualifications	1,201	
Unsubstantiated	25	

### 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>8</b>	<b>\$39,954</b>
Founded	7	
Unfounded	1	
Convictions	<b>1</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>43</b>	<b>\$29,087</b>
Founded	12	
Founded In-Part	24	
Unfounded	7	

**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 thirteen-year estimated average savings of \$13.61 for each \$1.00 spent by the state. FPI has averaged a 66% denial, reduction or cancellation rate of benefits for the 40,333 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings has reached over \$106.9 million.

The FPI program continues to prove its value to help ensure the integrity of public assistance programs in Illinois and to increase savings for the taxpayers. During calendar year 2008, the program generated 3,227 investigations, of which, 2,102 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated net savings for calendar year 2008 of approximately \$10.7 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>3,227</b>	<b>\$10,688,496</b>
Denied Eligibility	154	
Reduced Benefits	1,798	
Cases Canceled	150	
Approved	1,125	

**Long Term Care-Asset Discovery Investigations**

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

*Long Term Care Asset-Discovery Investigations*

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	<b>753</b>	<b>\$21,955,960</b>
Approved		
Impose Sanction Period/Group Care Spenddown	65	
Impose Sanction Period/Regular Group Care Credit	65	
No Sanction Period/Group Care Spenddown	312	
No Sanction Period/Regular Group Care Credit	158	
Denied		
Client Requested Application be Withdrawn	61	
Client Refused to Cooperate/Failed to Provide Verifications	91	
Other		
Returned to Local Office without Recommendation	1	

**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*

Client Restrictions	# Clients	Total Cost Avoidance Client Medical Abuse
<b>Client Reviews completed</b>	<b>973</b>	<b>\$1,133,157</b>
12 Month Restrictions		
New Restrictions	317	
Released or Canceled Restrictions	128	
Converted to 24 Month Restrictions	71	
24 Month Restrictions		
New Restrictions and Re-restrictions	109	
Released or Canceled Restrictions	99	
<b>Total Clients Restricted as of 12/31/2008</b>	<b>782</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>238</b>
Substantiated	108
Unsubstantiated	122
Administratively Closed	8

<b>Types of Allegations Investigated</b>	<b>Percent</b>
Non-Criminal (Work Rules)	<b>71.0%</b>
Discourteous and Inappropriate Behavior	7.3%
Failing to Follow Instructions	3.6%
Negligence in Performing Duties	11.1%
Conflict of Interest	6.2%
Falsification of Records	3.6%
Sexual Harassment	0.1%
Release of Confidential Agency Records	0.1%
Misuse of Computer	4.8%
Work Place Violence	2.9%
Time Abuse and Excessive Tardiness	5.3%
Conduct Unbecoming State Employee	26%
Criminal (Work Rules)	<b>4.8%</b>
Theft or Misuse of State Property	1.1%
Misappropriation of State Funds	0.1%
Commission of or Conviction of a Crime	0.1%
Public Assistance Fraud ILCS 305	>.1%
Criminal Code ILCS 720	3.5%
Security Issue, Contract Violation	<b>23.1%</b>
Special Project, Background Check, Assist other Agencies	<b>1.1%</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 2008 are listed below.

<b>Misconduct Outcomes</b>	<b># Actions</b>
Misconduct Identified	<b>54</b>
Employee	52
Vendor	2
Misconduct Resolutions	<b>33</b>
Discharge	2
Resignation	5
Suspension	10
Other, such as reprimands	16
Referred to Other Sources for Resolution	2
Administrative Action Pending at Year End	6
No Action Taken by Agency	4

### **New Provider Verification**

Since June 2001, the OIG has processed approximately 1,529 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 1,529 (831–NET and 698–DME) applications reviewed, 189 (12%) 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 12 (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 2008, the OIG processed 253 applications (131 NET and 122 DME).

#### *New Provider Verification*

<b>Enforcement Activities</b>	<b># Cases</b>	<b>Total Cost Avoidance</b>
Reviews Completed	<b>253</b>	
Enrolled	208	
Not Enrolled		<b>\$2,935,997.67</b>
Applications Returned	45	
Applications Denied	0	

**APPENDIX A - OIG PUBLISHED REPORTS**

<b>Title</b>	<b>Date</b>	<b>Description</b>
<i>All Kids Family Care Special Study Report</i>	December 2008	Determined 1% of the families reviewed were no longer eligible for the All Kids/Family Care program and 1.6% of the families had TPL coverage prior to their eligibility determination for the All Kids/Family Care program.
<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>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.
<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.

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

<b>Title</b>	<b>Date</b>	<b>Description</b>
<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.
<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  
CY2008*

Total Number of Scripts	25,617,160	
Amount Payable		\$1,437,916,998
Scripts Not Subject to RTS	54,434	
Amount Payable		\$5,774,789
Scripts Subject to RTS	25,562,726	
Amount Payable		\$1,432,142,209
Rejected Number of Scripts		1,240,533
Estimated Savings		\$85,753,767

***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 under the heading of Calendar Year 2008 Annual Report/Data on the OIG website identified on the back cover of this report. 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