



Office of Inspector General

Illinois Department of
Healthcare and
Family Services

2009 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

March 16, 2010

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 2009. The achievements described within this report are the results of the hard work and dedication of OIG 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 provides data on over-payment recoupments, fraud prevention savings, sanctions against providers, and investigation results. It is my hope that the 2009 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
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Annual Report
Calendar Year 2009**

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 2009, the OIG had an authorized staffing of 179 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 2009, 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.

ENFORCEMENT ACTIVITIES

Provider Audits

Recoupment of Overpayments

During 2009, the OIG established \$19,456,333 in provider overpayments, which were identified through post-payment compliance 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 2009, the OIG completed 156 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 visited the providers' facilities.

DRG Inpatient Audits

The Inpatient Hospital Audit Program (IHAP) was implemented to identify and recoup erroneous inpatient billings and to help hospitals understand proper billing practices. Previous OIG hospital audits were limited to reviewing outpatient services. IHAP helps ensure the consistent review of inpatient hospital claims for added compliance.

During 2009, the OIG expended considerable effort to ensure IHAP's implementation. Early in the year, a Request for Proposal was issued and proposals from interested vendors were scored. Once the successful bidders were identified, the Department entered into contract negotiations in an attempt to obtain their services. In the fourth quarter of 2009, the contracts were finalized with two vendors to perform the IHAP reviews. OIG also trained the vendors regarding IHAP processing requirements.

The first IHAP reviews will be initiated during the first quarter of 2010. It is anticipated that these full-scale reviews of hospital Medicaid billings will result in significantly increased collections of overpayments. Budgetary constraints have limited the number of reviews that are to be conducted by the vendors during fiscal year 2010. However, the OIG anticipates these audits will result in a collections ratio of over \$4 for every \$1 spent, which for 2010 is expected to be \$1.3 million in additional collections.

Non-Emergency Transportation Pre-Pay Reviews

Pre-pay reviews of non-emergency transportation (NET) providers were instituted during 2009 to enable the OIG to review billings by providers prior to the execution of payment. These reviews are conducted on NET providers as a result of an analysis or referral that indicates the provider's billings may be erroneous. This type of review might also be done to ensure that a new NET provider, during its 180 day probationary enrollment, is accurately billing the Department and completing and retaining the minimum required documentation. The BMI audit staff conducted several pre-payment audits during 2009 and uncovered substantial findings where providers were not in compliance with Department policies and procedures. As a result of these findings, claims of over \$175K that were being held by the Department due to the audits were subsequently rejected. If problems were found that did not warrant removal from the Medical Assistance Program, the provider was required to enter into a corporate integrity agreement which would conditionally allow them to remain enrolled.

Abortion Study

In April 2008, HFS was contacted by the Medicaid Financial Management Branch of the federal Centers for Medicare & Medicaid Services regarding the high number of abortion services billed to the Illinois Medicaid program, as compared to previous years. In response to this inquiry, the OIG launched a comprehensive study to investigate the increase in abortion procedures and to determine whether the abortion procedure billings were appropriate within the law and policy of the Illinois Medicaid program. OIG's study included examining pertinent laws, policies and provider informational material, contacting other states to ascertain how they fund abortions, performing data analyses to determine billing patterns and conducting onsite quality of care and post payment compliance reviews of selected providers.

OIG could not find any clear factors to explain the increase in abortion claims. Data analysis did not reveal any non-provider related causes nor were any program coverage or rate changes noted during the timeframe. Results of the study established that in nearly every case reviewed, providers had the requisite documentation to support the billed abortion procedures and that the documentation reviewed verified compliance with the billing policies for the procedures.

Results of the survey of other states' Medicaid program coverage for abortion procedures showed that several states with large Medicaid populations do not use federal matching funds to pay for abortions at all, and Illinois is one of the few states that uses federal Medicaid dollars to pay for abortions in cases of rape, incest, and the physical health or life endangerment of the mother. These factors may have accounted for Illinois' claims being disproportionately high in comparison to the abortion claims of other states across the nation.

This study did not reveal any systemic problems with abortion procedures paid through the Illinois Medicaid Program; however, as a part of the reviews, some documentation, billing and quality of care issues were noted and addressed through subsequent action by the OIG.

Client Prosecution Cases

During 2009, the Bureau of Investigations (BOI) referred 257 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.

- Prosecution Investigation – Joint Investigation with US Treasury IG
Unreported Income from Spouse and Other Income / Child Care Fraud

BOI received a referral from the DHS Bureau of Child Care and Development alleging a client had unreported income. The US Treasury Inspector General for Tax Administration jointly investigated this case with BOI. The subject, an employee of the Internal Revenue Service (IRS), allegedly resided with her spouse and an adult daughter. The subject failed to report their income to DHS while receiving grant, food stamps and child care assistance in St. Clair County, Illinois.

The investigation shows that the subject received a food stamp overpayment of \$17,304.00 from July 2003 through January 2008 and a grant overpayment of \$931.00 from October 2007 through January 2008. The child care investigation was completed on January 12, 2009 and the subject also received a child care overpayment of \$20,761.68 from November 2005 through January 2008. The criminal prosecution investigation

report has been provided to the US Attorney–Southern District of Illinois (SDI) and this case is currently under advisement.

- Prosecution Investigation
Unreported Income from Spouse / Other Income / Assets

A referral from an anonymous source alleged that the subject was residing with her husband while receiving food stamps in Jackson County. The spouse supposedly had income from employment with the Illinois Department of Corrections and workers' compensation benefits. The couple also allegedly maintained a joint bank account, and she had income from providing child care.

The investigation determined that the subject received a total food stamp overpayment of \$26,646.00 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 on January 5, 2009. The subject pled guilty to one count of State Benefits Fraud on July 17, 2009. The subject was sentenced to 24 months probation, 100 hours of public service, and was ordered to pay \$26,646.00 in restitution and \$1,110.00 in court costs and fees.

- Prosecution Investigation – Joint Investigation with Illinois State Police and HHS-OIG
Assets / Unreported Children Out of the Home

This case was referred to BOI by a DHS local office. The investigation was conducted jointly with the Illinois State Police – Medicaid Fraud Control Unit and the US Department of Health and Human Services OIG (HHS-OIG). The investigation revealed that the subject received food stamps and Medicaid in St. Clair County for herself and for children who did not live with her. She also owned property that was not reported to DHS. The case was founded and resulted in a food stamp overpayment of \$14,887.00 and a Medicaid overpayment of \$24,484.24 from August 2002 through May 2009. The completed report has been provided to the US Attorney – SDI for consideration of criminal prosecution.

- Prosecution Investigation
Impersonation / Multiple Assistance

An investigation found that a recipient failed to report his receipt of public assistance and Social Security benefits in his name and another alias name. The investigation determined that the recipient assumed the identity of his deceased brother to receive benefits in a second public assistance case. The case was worked with the Social Security Administration OIG and combined with their investigation for federal criminal prosecution. The case was referred to the US Attorney's Office – NDI on February 26, 2009. BOI's referral included a \$49,048.51 overpayment; \$10,553.18 in financial assistance, \$16,711.00 in food stamp benefits and \$21,784.33 in Medicaid benefits. On November 13, 2009, a plea agreement was reached including restitution.

- Prosecution Investigation – Joint Investigation with SSA
Unreported Employment / Use of False SSN

This case was referred to BOI from the Division of Child Support Enforcement and was investigated with the Social Security Administration OIG. The subject had allegedly been working under three different SSNs while receiving food stamp benefits and Supplemental Security Income (SSI) in St. Clair County, Illinois.

The client eligibility investigation report was completed on April 10, 2009. The subject received a food stamp overpayment of \$2,072.00 from May 2006 through April 2009 and an SSI overpayment of \$18,785.65 from January 2006 through April 2009. The criminal prosecution investigation report was completed and presented to the US Attorney's Office – SDI.

The subject was indicted on five counts by the US District Court – SDI in East St. Louis on June 17, 2009. Arraignment was held on July 7, 2009, and the subject pled guilty on September 21, 2009.

- Prosecution Investigation – Joint Investigation with HHS-OIG and IRS
Food Stamp Fraud / Unreported Income / Child Care Provider Fraud

The DHS Bureau of Child Care and Development referred an allegation of fraud to BOI regarding a childcare provider in St. Clair County. The director and owner of the childcare facility was also a food stamp and Medicaid recipient in St. Clair County and allegedly did not report any income from her business to DHS.

Additional agencies who investigated this case with BOI were the US Department of Health and Human Services OIG and the Internal Revenue Service – Criminal Investigations. The Illinois Department of Children and Family Services OIG, the US Department of Agriculture OIG, the US Postal Inspector and the FBI also assisted in the investigation.

This investigation identified \$26,427.00 in food stamp overpayments and \$150,653.00 in child care overpayments. Additional losses to the government allegedly occurred in bankruptcy fraud and tax losses.

The subject pled guilty to a three count Indictment on September 18, 2009 in the US District Court – SDI in East St. Louis. The corporation that owns and operates the day care center also pled guilty on September 18, 2009 to a one count Information by falsely billing for \$150,652.84 in child care funds.

- Prosecution Investigation – Joint Investigation with SSA
Unreported Children Out of the Home

This case was referred to BOI for joint investigation by the Social Security Administration OIG. The subject allegedly received food stamps, Medicaid and SSI in St. Clair County for herself and for children who did not live with her. The case resulted in a food stamp overpayment of \$11,712.00 from September 2004 through April 2008 and a

Medicaid overpayment of \$21,414.52 from September 2004 through June 2009. The subject also received an SSI overpayment of \$26,909.18.

This case was presented to the grand jury at the US District Court – SDI in East St. Louis on July 21, 2009 and the subject was indicted on four counts of making false statements. Arraignment was held on August 6, 2009 at the US District Court – SDI.

- Prosecution Investigation – Joint Investigation with SSA and Veteran’s Affairs
Unreported Income from Spouse / Child Care Fraud

This case was referred to BOI from the Social Security Administration OIG and the Department of Veteran’s Affairs (VA) OIG. The subject allegedly resided with her spouse in Madison and St. Clair Counties, Illinois and he had income from VA and SSA disability benefits. The BOI investigation identified a food stamp overpayment of \$1,803.00 in St. Clair County, Illinois from April 2007 through March 2008 and a child care overpayment of \$2,890.00 in Madison County, Illinois from November 2007 through March 2008.

The criminal prosecution investigation report was completed and presented to the US Attorney’s Office – SDI. The subject was indicted, along with her husband, on six counts by the US District Court – SDI on June 17, 2009. According to the indictment, the husband was a member of the US Army who was about to be deployed when he had a one car vehicle accident. He allegedly faked his paralysis and defrauded the VA and the SSA, and filed a bogus personal injury lawsuit. The subjects received overpayments of \$107,857.00 from the VA and \$28,730.00 from SSA.

Arraignment in this case was held on July 7, 2009 and the subject pled guilty to all six counts on October 19, 2009. The husband pled guilty on November 6, 2009.

- Prosecution Investigation – Joint Investigation with SSA
Unreported Income

This case was referred to BOI for joint investigation by the Social Security Administration OIG. The subject allegedly received SSA benefits for her mother after her mother passed away. She also received food stamps in St. Clair County and did not report the receipt of that income to DHS. The BOI investigation determined that the subject received a food stamp overpayment of \$4,899.00 from August 2001 through December 2007. She also received an SSA overpayment of \$56,176.00.

The subject was indicted on four counts of making false statements and theft of government funds by the federal grand jury at the US District Court in East St. Louis on July 21, 2009. Arraignment was held on August 6, 2009 and the subject pled guilty on December 3, 2009.

- Prosecution Investigation – Joint Investigation with SSA
False Identity / Multiple Assistance

The Social Security Administration advised BOI that a client was receiving benefits for which they were not entitled. An investigation found that a recipient failed to report his receipt of public assistance and SSA benefits under his name and an alias name. The case was worked with the Social Security Administration OIG and combined with their investigation for federal criminal prosecution. The case was referred to the US Attorney's Office – NDI on August 27, 2009 and is pending indictment. BOI identified a food stamp overpayment of \$19,007.00.

- Prosecution Investigation – Joint Investigation with SSA
False Identity / Multiple Assistance

A Social Security Administration referral named a client who might be receiving benefits under an assumed name(s). A BOI investigation found that a recipient failed to report his receipt of public assistance and SSA benefits under his name and two alias names. The case was worked with the Social Security Administration OIG and combined with their investigation for federal criminal prosecution. The case was referred to the US Attorney's Office – NDI on September 2, 2009. BOI identified an overpayment of \$16,173.46; \$5,510.46 in financial assistance and \$10,663.00 in food stamp benefits. Discussions will be held with the Assistant US Attorney to review if medical benefits paid under the alias names should be included in the criminal prosecution case. The case is pending the Assistant US Attorney's action.

- Prosecution and Child Care Investigation
Household Composition / Responsible Relative in the Home

A referral received from the DHS Bureau of Collections alleged that a client failed to report the income of a spouse. An investigation found that a recipient failed to report her marriage or the earned income of her spouse. Additionally, the subject provided false income information for her employment and failed to report all of her employers. The prosecution investigation led to a child care investigation for the same reasons, and also found that she used her spouse as her childcare provider. The case was originally completed in February 2009 but due to administrative appeals, the case was not referred to the US Attorney's Office – NDI until September 30, 2009. BOI's referral included an \$117,793.11 overpayment; \$7,554.00 in financial assistance, \$17,358.00 in food stamp benefits and \$92,881.11 in child care benefits. On October 14, 2009, the assigned BOI investigator met with the Assistant US attorney to review the case. Subpoenas were being issued by the US Attorney's Office to obtain additional information.

- Prosecution Investigation --Update
Household Composition / Unreported Employment

A BOI investigation was combined with the Housing and Urban Development OIG and Social Security Administration OIG investigations for federal criminal prosecution. The BOI investigation found that the recipient failed to report her true marital status, household income and employment. The case was referred to the US Attorney's Office –

Northern District of Illinois (NDI) in February 2008. The referral included a \$76,021.00 overpayment; \$36,457.00 in financial assistance and \$39,564.00 food stamp benefits. In July 2008, the client was indicted on three (3) counts of Theft and eight (8) counts of Forgery. One count of Theft and two counts of Forgery were specifically related to BOI's investigation. The case had been delayed due to defense motions to suppress statements, the defendant's mental health issues and conflicting trial dates. In July 2009, the defendant was offered two years in the Department of Corrections if she pled guilty to a Class 3 felony. The judge stated probation would not be considered unless the defendant came up with \$50,000.00 in restitution.

- Prosecution Investigation--Update
Impersonation / False Identity

A BOI investigation found that a subject assumed the identity of an individual from the state of New York to receive public assistance in Illinois. Benefits were paid to or on behalf of the subject from July 2000 through May 2008, in three different assistance cases. BOI identified an overpayment of \$431,110.33; \$425,786.60 in medical benefits, \$619.68 in financial assistance and \$4,704.05 in food stamp benefits. The case was referred to the Cook County State's Attorney's Office in December 2008, for criminal prosecution. In January 2009, the grand jury returned a true bill of indictment against the subject and in February 2009, eight (8) felony criminal counts of theft were filed against the recipient. The theft counts stem from acts of "Unauthorized Control", "Deception", and "I.D. Theft". On February 20, 2009, the subject pled guilty to one count of Identity Theft and one count of Theft and was sentenced to 13 ½ years incarceration.

- Client Eligibility Investigation
Impersonation

The OIG received a referral from a medical center alleging that one of their patients was using someone else's name and SSN to receive medical assistance from the State of Illinois, but was really an illegal alien from Mexico. BOI completed its investigation into this allegation on March 10, 2009. The investigation confirmed that an illegal alien had fraudulently received medical assistance using someone else's name and SSN. The amount of the Medicaid overpayment was \$119,140.01 for the period of March 2007 through February 2009. No further action was taken because the client died shortly after returning to Mexico in March 2009.

- Client Eligibility Investigation
Assets / Employment / SSN Misuse – Discrepancy / Absent Child

A referral from the North Aurora Police Department resulted in a client eligibility investigation which found that the recipient falsely reported a UPS mailbox as his home address to the Department and other state and federal governmental agencies. The subject also used a number of alias names and failed to report his employment at, or ownership and operation of two restaurants, or his twenty-three bank accounts which were in his name or listed his name as a joint owner or business partner. Additionally, the investigation found that one of his daughters had been out of the household for 14 months in a facility where the agency paid for her care. The investigation, completed in February

2009, established a food stamp overpayment of \$45,675.00. The overpayment is currently under appeal and the recipient is represented by legal counsel. The recipient was also investigated by the Bolingbrook Police Department and criminally charged in Kane and Will Counties for other fraud charges.

- Client Eligibility Investigation – Joint Investigation with SSA
Alias Identity / Multiple Assistance

A referral from SSA resulted in a client eligibility investigation which found that a recipient had two Social Security Numbers and received public assistance in her married and maiden names. The case was worked with the Social Security Administration OIG. The BOI investigation, completed in March 2009, determined a \$25,597.00 overpayment total; \$4,768.00 in financial assistance and \$20,829.00 in food stamp benefits. The case was not referred for federal prosecution as SSA did not pursue federal charges against the recipient. Additionally, the Cook County State's Attorney's Office rejected the case for prosecution due to the recipient's advanced age and health condition. The overpayment was referred to the DHS Bureau of Collections for recovery/recoupment action.

- Client Eligibility
Residence Verification

BOI received a referral that a client received public assistance in Illinois while residing in Indiana. During the investigation the client admitted to receiving duplicate assistance and receiving food stamps in Illinois and Indiana. The client submitted an application for continued food stamp benefits in Illinois after she moved to Indiana. The investigation showed that due to Illinois residency requirements, the client did not qualify for food stamps, cash or medical assistance. The client inappropriately received food stamp and medical benefits in Illinois from October 2005 through February 2009, generating a food stamp overpayment of \$11,433.00 and a medical assistance overpayment of \$25,898.22. The overpayment was referred to the DHS Bureau of Collections for recovery/recoupment action. The medical assistance was canceled in March, 2009.

- Client Eligibility Investigation
Absent Children

A referral from the DHS Hotline resulted in a client eligibility investigation which found that a recipient failed to report the absence of two children included in her case; the children had lived with their father for two months and then resided with their mother. The investigation was completed in May 2009 and resulted in the local office calculating a \$6,759.00 food stamp overpayment. As a result, the DHS local office processed the overpayment and forwarded it to the DHS Bureau of Collections.

- Client Eligibility Investigation
False Identity / Multiple Assistance

An anonymous referral resulted in a client eligibility investigation which found that a recipient received public assistance in his name and an alias name. The investigation was completed in July 2009, and resulted in the local office calculating a \$13,106.00 food

stamp overpayment. The case was not referred for prosecution as case documentation was missing and the calculated overpayment did not include financial assistance received in the alias name. The overpayment was referred to the DHS Bureau of Collections for recovery/recoupment action.

- Client Eligibility and Child Care Investigation
Absent Child / Employment

A DHS Hotline referral resulted in a client eligibility investigation which found that a recipient failed to report the death of her child and all of her employment earnings with two employers. The investigation, completed in August 2009, estimated a total overpayment of \$32,443.00; \$11,619.00 in financial assistance and \$20,824.00 in food stamps. The client eligibility investigation led to a child care investigation as child care benefits were paid on behalf of the subject's deceased child. BOI's child care investigation estimated a \$4,455.16 child care overpayment. The food stamp and financial assistance cases were referred to the DHS local office for appropriate action. The child care case was referred to Child Care and Development for collection.

- Client Eligibility Investigation
Impersonation / False Identity

A referral from the Social Security Administration resulted in a client eligibility investigation which found that a subject impersonated a citizen of Arizona to receive public assistance in Illinois. The case was worked with the Social Security Administration OIG. The investigation was completed in September 2009, and referred to the local office for the calculation of an overpayment. BOI's investigation estimated a \$1,891.95 overpayment; \$1,253.00 in food stamps and \$638.95 in medical benefits. SSA terminated his benefits, but did not seek criminal prosecution due the subject's health condition. The case was referred to the DHS local office for overpayment calculation.

- Client Eligibility Investigation
Employment

The Social Security Administration made a referral to BOI which resulted in a client eligibility investigation that found a recipient failed to report her earnings from various employers and her self-employment. The recipient admitted in a SSA interview that she earned approximately \$6,500.00 a month in cash from babysitting and hair styling. The BOI investigation, completed in November 2009, identified a total overpayment of \$26,307.00; \$8,242.00 in financial assistance and \$18,065.00 in food stamps. The case was referred to the DHS local office for overpayment calculation.

- Client Eligibility Investigation
Family Composition/Responsible Relative

BOI received a referral that a client falsely reported to DHS that she was separated from and no longer living with her husband. The investigation revealed that the client failed to report her correct household composition and household income as the client's husband was employed and resided in the home. As a result, the client incurred a \$19,367.00 food

stamp overpayment from April 2005 to February 2008. The case was referred to the DHS local office for overpayment calculation.

- Client Eligibility Investigation
Assets/Employment

A referral to BOI reported that a client underreported her income and assets to DHS. The client failed to report that she had been receiving child support payments from her husband, had income from rental property and had income from self-employment. The undisclosed assets and underreported income resulted in the client being ineligible for food stamps and medical benefits. The food stamp overpayment was \$5,209.00 and the medical overpayment was \$10,403.77. The case was referred to the DHS local office for overpayment calculation.

- Prosecution Investigation--Joint Investigation with SSA
Unreported Earned Income

BOI received a referral from the Social Security Administration OIG that a recipient was using a second identity and social security number for employment purposes while receiving social security benefits and food stamps under the first identity. This case was investigated jointly by BOI and the SSA-OIG. The investigation identified the recipient as receiving a total food stamp overpayment of \$4,171.00, a medical overpayment of \$780.39, and an estimated SSA overpayment of \$50,000.00. BOI was notified on November 6, 2009 by SSA- OIG that their case was accepted by the US Attorney's Office. On November 10, 2009, BOI's investigation report regarding the welfare fraud part of the case was presented to the US Attorney's Office for appropriate action.

Supplemental Nutrition Assistance Program Referrals and Disqualifications

Federal Regulations mandate the Department to disqualify household members when a finding of Intentional Program Violation (IPV) is established within the Supplemental Nutrition Assistance Program (SNAP). SNAP was formerly known as the Food Stamp program. OIG's SNAP Fraud Unit (SFU) is responsible for evaluating all cases referred for suspected SNAP fraud. The cases are reviewed, evidence is compiled and a determination is made whether sufficient evidence is available to prove the suspected violation. If so, the client is notified of the charges and is provided the opportunity to return a signed waiver admitting to the charge. If the client does not return the signed waiver, an Administrative Disqualification Hearing (ADH) is scheduled. There are two types of cases referred:

Suspected Intentional Program Violation (SIPV) – unreported earned income; unemployment; household composition; duplicate assistance and unreported assets. These cases are referred to SFU by the DHS Local Offices, OIG staff, and the general public through hot line calls.

Electronic Benefits Transfer (EBT)/Link Card – client selling their card benefits. These cases are referred by the general public through a variety methods such as hot line calls, OIG staff or USDA Food and Nutrition Services (FNS).

Since the inception of the EBT Program in 1999, SFU has received 34,092 referrals from FNS and 490 referrals from field staff and hotline calls. According to the Acting Deputy Regional Administrator, FNS Midwest Region, Illinois is the most active state in the Midwest Region in pursuing clients suspected of EBT fraud.

“Illinois has the longest running and most successful EBT client integrity project in the Midwest Region. Illinois’ activity in this area based on past referrals continues to lead the nation. To date, Illinois has successfully disqualified over 5,300 clients based on EBT trafficking. The next closest state in the region has completed 1,300 disqualifications. The remainder of Midwest Region states are in the hundreds of disqualifications. This level of success in Illinois could not have been achieved without a commitment to integrity and the dedication of these staff and resources to this important project. Illinois staff continues to be a pleasure to work with on these activities.

Illinois is held up nationally by FNS as a model of a successful EBT client integrity project. We know that in this environment of limited resources tough decisions have to be made on where to expend our efforts, so we commend you and your staff for your commitment and ongoing efforts to improve the integrity of the Supplemental Nutrition Assistance Program by ensuring that clients are held accountable for the proper use of program benefits.”

Tim English, Acting Deputy Regional Administrator, Food & Nutrition Services, Midwest Regional Office

In 2009, SFU received a total of 4,037 SIPV and EBT referrals, completed 2,598 reviews, participated in 558 ADHs and received 568 positive hearing decisions. The number of positive hearing decisions includes decisions from hearings initiated during 2008. In addition, SFU processed 371 signed waivers and 19 prosecution cases. SFU efforts resulted in the disqualification of 958 clients and a cost savings to the State of Illinois of \$2,042,384.00 during 2009.

HFS Employee Investigations

The OIG Bureau of Internal Affairs (BIA) completed 185 employee and vendor investigations during 2009. Several of these cases are described below:

- The contractor that services the DCSE State Disbursement Unit (SDU), fielded a call regarding theft from the account of a DCSE custodial parent (CP) using an EPPICard. The card was requested by phone and the caller apparently met all of the criteria to authorize changing the address for the CP and getting a new card issued. A card was issued and as of the date of the complaint about \$10,000 had been withdrawn from the child support account.

The CP made a report to her local police department. The police obtained video images of the person making the card transactions and provided them to the contractor. The contractor determined that the photo was their employee.

The BIA investigation confirmed the contractor's employee used an EPPICard to access a CP's account to steal funds. In oral and written statements to local police officers and an Internal Affairs investigator, the employee admitted removing the funds.

The investigation also confirmed that other EPPICard clients were victims of the same type of theft as the complainant CP, in that their identifying information was compromised, an EPPICard was mailed to a fraudulent address, and funds were withdrawn from their EPPICard accounts. The victims were reimbursed by the contractor for their losses.

The contractor's employee was convicted and was sentenced to 24 months probation, 14 days (time served) in jail and ordered to make restitution in the amount of \$10, 873.75. The employee was terminated by the contractor.

- Division personnel staff reported that an Office Clerk made a complaint of sexual harassment against her Executive 2 supervisor. The Office Clerk indicated that when she was working overtime, her supervisor asked her some questions, reached over as if there was something on her shirt over her right breast, and removed whatever was there, while stating, "That's been bugging me." The supervisor allegedly made other inappropriate remarks. Two days after the initial incident, the supervisor again engaged in inappropriate behavior when he placed his hand on the back of the hip of the victim while assisting her with an issue at her work station.

The BIA investigation substantiated the allegations. The Executive 2 was issued a five-day suspension.

- A DCSE custodial parent alleged she received an unsigned letter containing personal information including both her and her daughter's Social Security Numbers and a listing of her last five employers. She suspected the letter originated from an Office Coordinator who is the wife of the alleged father on the CP's child support case. This alleged complaint could not be substantiated.

The investigation established, however, that the Office Coordinator improperly accessed the CP's child support case. An electronic monitoring on the case in question established that the Office Coordinator accessed the Key Information Delivery System (KIDS) and spent 23 minutes reviewing various screens associated with the complainant's child support case; thus, violating HFS policy.

The Office Coordinator was issued a 5-day suspension.

- A Division bureau chief reported that a Manpower Temporary Services employee alleged that her agency supervisor, an Executive 2, engaged in inappropriate behavior during two separate smoke breaks on September 19, 2008. In the first incident, the supervisor allegedly made a remark to the temporary employee that she interpreted as being a sexual advance. Approximately one hour later, the supervisor allegedly wrapped his feet around the temporary employee's ankles and calves and rubbed his feet up and down her legs. The investigation determined that Manpower Temporary Services employee complaint against the Executive 2 was credible, based on the strength of her statement, witnesses'

statements and limited admissions made by the Executive 2.

During the investigation, additional allegations came to light involving inappropriate comments and unwanted touching by the Executive 2 involving a female subordinate and other female staff. The Executive 2 acknowledged that, in retrospect, his behavior was inappropriate.

The employee's lack of complete cooperation with investigators and his selective recall of the events involving the Manpower Temporary Services employee appeared to be intentional and misleading. Approximately one week after the incident with the temporary employee, the Executive 2 remarked to another employee that if he had to go to Internal Affairs, he would deny everything and that he could not be held accountable for his actions because of his mental illness and his use of prescription medications.

The Executive 2 was issued a 5-day suspension.

- A female Family Support Specialist (FSS) alleged that on two separate occasions, another FSS made unwelcome physical contact with her in the presence of a female Office Coordinator.

The investigation determined that HFS policies were violated when the male FSS made unwelcome physical contact with the female FSS on two separate occasions. An Office Coordinator heard the complainant object to the behavior with a stern rebuke each time. The female FSS had previously warned the offender that his behavior was inappropriate and unwelcome.

The male FSS was issued a 3-day suspension.

- A Division Office Specialist was suspected of failing to accurately record her absences due to late arrivals and early departures from her work location in Chicago. The employee's duties included serving as the timekeeper for the office.

The BIA investigation established that the employee violated multiple HFS policies. The employee admitted and surveillance records established that on multiple occasions in 2008, she arrived late for work. On multiple occasions the employee failed to use ABT to account for late arrivals and early departures. It was also established that the employee falsified official payroll records by reflecting herself present when she was not. The Office Specialist failed to use ABT and failed to accurately record her absences on Agency payroll records.

As a result of the investigation and the pre-disciplinary hearing, the employee received a 30-day suspension. In addition, the Union, the employee and the agencies all signed a "Last Chance Agreement," wherein the employee agreed to the 30-day suspension and upon her return from suspension any further incidences relative to the charges for discipline will result in discharge.

- It was reported to the Office of Inspector General that 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 other's bid. A Public Service Administrator (PSA) was identified as the leader of the RFP review team.

Based upon interviews with staff members from the various entities associated with the RFP process in question, there was 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 the SPSA had been recused. In addition, he allowed another SPSA, an employee not assigned to the RFP review team, to complete a portion of a review team member's score sheet.

The investigation further determined that the team leader PSA intended to deceive the Department by repackaging the contents of the pricing proposals that had been opened prior to the official bid opening date. The PSA's efforts to deceive the Department included ensuring the envelopes used and the cover sheets therein, were exact matches to those submitted by the bidders.

The investigation also determined that the SPSA engaged in conversations with the team leader PSA regarding the RFP from which she had been recused. Her recusal was based upon a personal relationship with one of the bidders. This same SPSA opened the price proposals for the RFP and had a subsequent conversation with the team leader PSA telling him that the prices were close and the RFP should be cancelled.

The investigation determined that the non-team member SPSA provided false and misleading information to investigators when she denied speaking with the team leader PSA on the date of the issue with the price proposals.

The non-team member SPSA was issued a 14-day suspension. The team member SPSA, through negotiations with the Office of Labor Relations, was allowed to resign her position with HFS. Based on the team leader PSA's culpability in this matter, he received a 60-day suspension.

- A Division administrator provided BIA a typed timeline that indicated a Family Support Specialist (FSS) and a supervisor from another team worked on the FSS's daughter's child support case.

The investigation substantiated that the FSS violated multiple HFS policies. The employee created a conflict of interest when she allowed her private and personal interest to conflict with her work related duties and responsibilities. Accessing her daughter's child support case through the KIDS database in order to obtain confidential child support information created a prohibited conflict of interest.

The FSS, while on medical leave, resigned her position with the department. She elected to retire in lieu of returning to work to receive disciplinary action.

- The mother of an NCP reported to DCSE staff that an Office Coordinator looked up her son's child support cases in the DCSE computer system and told him, his friends, and his co-workers the details about his child support cases.

Based on the evidence obtained via the monitoring of the son's two cases, and by the Office Coordinator's own admission, the allegation was substantiated. The employee violated multiple HFS policies and further admitted to viewing her own child support case.

The Office Coordinator was issued a 20-day suspension.

- A Division Bureau Chief alleged that an Office Associate had left several troubling voicemail messages on two co-workers cellular telephones. The messages were not only disturbing, but one contained a message of a physical threat towards her supervisor.

The investigation determined the employee violated multiple HFS policies in relation to and associated with her actions with her co-workers during five separate incidences. During the investigation an additional allegation came to light and was substantiated involving the employee's utilization of the HFS computer system and printer for personal use.

The Office Associate was issued a 3-day suspension.

- The Director's Office received an anonymous typed letter alleging that a Human Services Caseworker (HSC) misused the state telephone and computer systems and abused time while engaging in personal communications with the anonymous author's unidentified boyfriend.

Personal cellular telephone numbers for the HSC and state telephone numbers found on the boyfriend's personal cellular telephone were provided in the complaint.

The investigation determined the HSC violated multiple HFS policies when she used the agency telephone system to place 214 personal calls to 15 different telephone numbers. The 214 calls totaled nine hours and six minutes. These calls were not made in accordance with Agency policy.

The HSC was issued an Oral Reprimand.

- Staff from the HFS Labor Relations Unit received a complaint from Division staff that an Office Administrator 3 (OA3) was stumbling and had a strong odor of alcohol. Investigators were requested to go to the work site and talk to the employee to make a fitness for duty assessment and report their observations to Labor Relations.

Investigators met with staff who reported that the OA3 was observed stumbling in the work area and one employee smelled alcohol when she entered the employee's cubicle. When investigators arrived at the employee's cubicle entrance, they noticed a distinct alcohol smell. She was slow getting out of her chair and noticeably unsteady on her feet while walking from her office to another area. Her eyes were bloodshot and glassy and when she spoke she was hesitant and did not speak in complete sentences.

The employee admitted to consuming alcohol late in the evening the night before and had gone to bed thereafter. She said she and her husband had stopped at a local bar after work, and had three beers each before going home. Later, she admitted to one of the investigators that she had awoken between 1 a.m. and 2 a.m. and drank two more beers.

Based on background information from staff plus the observations of our two investigators, the conclusion was that the OA3 was alcohol impaired. The employee, who had a last chance agreement for an earlier incident, was discharged for cause.

- A Department employee reported she received a telephone call from a Medicaid client in which the client alleged that an HFS Office Assistant had obtained access to her records or used her computer access to obtain confidential information regarding her grandchild.

The investigation determined that the Office Assistant violated multiple HFS policies, when she admitted that she used the HFS KIDS database and the DHS PACIS database for personal use. The employee admitted accessing the KIDS database to view her own child support information. This was supported by evidence obtained during a forensic examination of the employee's Agency assigned computer. Also, the employee admitted she accessed the DHS PACIS database to view personal information associated with five of her relatives. The employee acknowledged it was against agency policy to use the Agency computer system for reasons not associated with her official duties.

The Office Assistant was issued a 30-day suspension. Upon receipt of her notification of suspension, the employee elected to resign.

- A Division Bureau Chief forwarded a complaint received from an Illinois Medicaid provider against an HFS employee. The author of the document complained about the conduct and work performed by a Program Integrity Auditor 2 that occurred while the employee conducted an audit at a facility in southern Illinois. The complainant took issue with the auditor's findings and planned to challenge those findings. The letter also described alleged inappropriate behavior by the employee.

The investigation determined the Program Integrity Auditor 2 violated HFS policy when he allowed his private, personal, spiritual and religious interest to conflict with his work-related duties and responsibilities as an auditor. The employee distributed non-work related literature to the provider. The literature contained religious quotes and was clearly not related to his job duties as an auditor.

There were no third party witnesses to independently support or refute that the employee made the remarks attributed to him.

The employee was issued a Written Reprimand.

Computer Tampering

Computers in the workplace have brought a new age of ease and efficiency for staff. Communication between employees now often occurs via email rather than by telephone. With computers playing such an integral role in the workplace, it becomes inevitable that computer

related crimes will evolve as well. An employee's misuse of workplace technology recently crossed the ethical line and became a computer crime.

The most well known form of computer crime is called "hacking" and those engaging in the act are known as "hackers." In common usage, a hacker is a person who accesses a computer system by circumventing its security system. This act can be considered computer tampering and is illegal under Illinois law. Computer tampering happens when a person knowingly and without authorization accesses a computer, program, or data, whether or not the person acquires data or services.

- A Senior Public Service Administrator (SPSA) filed a complaint with the Internal Affairs Computer Forensics Manager alleging that someone was opening her work email without her permission. The SPSA had been communicating back and forth with another SPSA on several management/labor issues when she noticed an email in her account open and then marked "read later." The complainant suspected someone was tampering with her work email.

The Computer Forensics Manager immediately began examining and auditing various information systems reports available to her and was able to successfully narrow down the suspected tampering to an HFS Information Service Specialist 2 (ISS 2). Although the initial complaint involved a single incident, the Computer Forensics Manager concluded that the hacker's activities were more widespread than initially report.

The Illinois State Police, Division of Internal Investigation (DII) launched a criminal investigation of the incident. The employee's work computer was examined and it was determined to contain evidence of multiple unauthorized accesses to HFS employees' email accounts. The computer examination also produced multiple email and draft documents created by many of the users whose accounts had been breached by the ISS 2.

Based upon the evidence collected by the BIA Computer Forensics Manager, DII's computer examination and the employee's admissions to investigators, charges were filed against the ISS 2 on July 28, 2009, in Sangamon County for Computer Tampering, a Class B misdemeanor. The Department removed the employee from the workplace and placed him on a suspension pending judicial verdict. On September 9, 2009, the employee pled guilty to Computer Tampering, received a \$200 fine plus court costs and was ordered to serve six months court supervision.

Following the guilty plea, the employee resigned from the Department.

Time Abuse Investigations

This year has shown an increase in cases in which there is a time abuse component. There is a generally held notion that these cases are simplistic in nature. However, the opposite is actually true. Many times, other areas of misconduct are discovered during one of these investigations. These cases can demand an immense amount of time and allocation of resources for the investigator assigned the case. Some require surveillance, others not. There is a multiplicity of investigative tools and techniques that are employed besides surveillance. If the employee travels in the course of their job duties, travel vouchers have to be analyzed. If the case involves a secondary employment interface, then the secondary employer's payroll records may have to

be obtained and examined. On limited access work sites, the BIA investigator can obtain information on arrival times as well as determine when an employee accesses his or her computer. Computer forensics may also be performed on an employee's hard drive, email reviewed and other storage medium examined. There is a vast amount of data that has to be scrutinized before anyone is ever interviewed.

- In one case, BIA received an anonymous complaint that alleged a Senior Public Service Administrator within a division was habitually late in reporting for work. The investigation determined that the employee had falsified their Healthcare and Family Services Ethics Time Sheets, and failed to turn in Healthcare and Family Services' Employee Absence Request/Report forms (HFS 2053) for time off from work, submitted falsified HFS 2053's for time off of work, and falsified a State of Illinois, Form C-10, Travel Voucher.

The analysis determined that the employee submitted eleven Healthcare and Family Services' Ethics Time Sheets which contained false and altered data. The 11 fraudulent time sheets contained 111 fraudulent entries that were false and misleading. This conduct allowed the employee to receive wages to which she was in fact not entitled.

The employee admitted her behavior to investigators, resigned her position and agreed to reimburse the Department the amount of \$2,593.84 for unearned wages.

- In another case, an anonymous complainant reported that a Public Service Administrator (PSA) employee was habitually late in reporting for work. The source further alleged that the employee falsified their Healthcare and Family Services Ethics Time Sheets, failed to turn in Healthcare and Family Services' Employee Absence Request/Report forms (HFS 2053) for time off from work or submitted falsified HFS 2053's for time off from work.

It was determined that the employee submitted twelve (12), Healthcare and Family Services' Ethics Time Sheets which contained false and altered data. The 12 fraudulent time sheets submitted contained 206 fraudulent entries that were false and misleading. These acts allowed the individual to receive wages to which they were not entitled.

The employee submitted eight HFS 2053s, which contained false data. Surveillance confirmed that a HFS 2053 submitted for the date the investigators tracked the PSA contained information that was false and misleading regarding her time spent on official state business. On that date in January 2009, the employee reported for work at 10:28 a.m., not the fraudulent entry of 9:30 a.m. as reported on the HFS 2053.

When investigators interviewed the PSA, she admitted that she frequently arrived to work late, failed to submit absence request forms and failed to accurately record her arrival times on her ethics timesheets. Shortly following the interview, the employee went on a non-service connected disability leave and retired shortly thereafter. The Department recovered \$3,172.64 in unearned income from the employee's accumulated vacation and sick time.

- In a case which was opened in 2008 and completed during 2009, it was reported that an HFS employee was allegedly conducting real estate business during assigned work hours.

BIA conducted a forensic examination of the employee's Agency issued PC, reviewed a six month period of local and long distance telephone calls generated from the desk telephone and examined the incoming and outgoing calls from their personal cellular telephone during their scheduled work hours. BIA also interviewed co-workers and the employee's supervisor who may have had knowledge of secondary employment activities.

BIA determined that the employee was accepting and making personal and secondary employment related telephone calls from the desk telephone and personal cellular telephone during the work day. The individual was also creating secondary employment related documents and accessing personal and secondary employment related email, by way of his agency issued PC. On the day the employee's Agency PC was seized, investigators discovered numerous real estate related documents in view within the immediate work area.

The employee received a 20-day suspension. In addition, this employee compensated HFS in the amount of \$827.68 for lost hourly wages as well as costs related to the use of the telephone.

- In a case which was initiated in July 2008 and completed in 2009, an HFS employee was suspected of leaving work early without taking available benefit time (ABT). BIA investigators conducted surveillance between the period of August 8, 2008 and September 19, 2008. The investigation was not concluded until 2009 because the employee was on leave from October 15, 2008 through June 5, 2009. BIA examined numerous records and computer audit reports that captured computer log-in/log-out times during this period. The investigation established a pattern of time abuse and falsification of time keeping records. A total of 39 hours and 21 minutes of tardiness and unauthorized absences was established, which equated to \$976.44 in unearned income.

After returning from an extended medical leave, the employee was discharged for cause.

During this investigation additional misconduct came to light involving the employee's supervisor. The supervisor failed to properly follow established department policy and procedures when aware of the employee's habitual misconduct and failed to take appropriate action in the performance of the duties of a supervisor.

Furthermore, the supervisor had been submitting Healthcare and Family Services Employee Daily Time Logs which contained false and misleading information. The supervisor failed to certify that the employee work hours were accurate and true when she certified the document at the beginning of the workday prior to employees actually signing in.

Disciplinary action is pending against the supervisor.

- In April 2008, Internal Affairs launched an investigation on an HFS executive staff member for alleged misconduct. From reports received, it appeared that HFS policy was violated by the employee acting in an unprofessional and inappropriate manner in a public setting. Although the behavior occurred off-duty, the actions reflected poorly upon the Department and were related to that employee's tardiness on repeated occasions.

The employee violated HFS policy by acting in an inappropriate manner on multiple occasions at an HFS facility during the early morning hours. This individual appeared at the state facility inappropriately dressed or in an intoxicated state on several dates. During one of the incidents, the employee reportedly arrived at an HFS building in the early morning hours wearing only nightclothing and accompanied by a non-staff member. Both people stayed in the building for several hours and left before the workday began.

A forensic examination of this individual's computers substantiated that HFS policy had been violated by utilizing state-issued computers for personal reasons. There were a large number of images retrieved that did not have any correlation to HFS or the employee's role at HFS. Many of the images were graphic and displayed nudity and alcohol consumption.

An internet usage report identified numerous non-work related sites that were regularly visited by this individual. In addition, there were numerous emails of a personal nature sent and received through the Department's email system. There were also emails from various personal business sources the employee had signed up for and requested that correspondence be sent to her work email address.

The employee also provided false and misleading entries on travel vouchers. The employee violated HFS policy by misrepresenting her departure and arrival times. While under surveillance by investigators, the employee was witnessed arriving late to work on several different occasions. On one occasion, surveillance placed the individual shopping at Dick's Sporting Goods and TJ Maxx while the times appearing on the travel voucher placed her in travel status. During the time of the shopping, the employee sent an email to a subordinate employee indicating she was "on the road."

The investigation also determined the employee failed to contact the Office of Communications before releasing information to the media that appeared on an Internet site. This action violated HFS policy.

Information was also developed that a municipal police department launched a criminal investigation of the HFS executive after it was determined that she called a female civilian a minimum of 20 times and sent a minimum of 18 text messages in August 2009. The employee and the victim were dating the same person. The employee continued to attempt to contact the victim even after being advised by a police officer that these contacts should cease. The victim reported that the employee called her a vulgar name and told the victim that if she saw the boyfriend again, something bad was going to happen to her. Criminal charges were subsequently served on the HFS employee in November 2009. The employee further violated HFS policy when she allowed private and personal interest to conflict with work-related duties and responsibilities, first by

promising to get the boyfriend a state job and then by making a threat to prevent him from ever obtaining employment with the state government in Illinois.

Based upon the findings from a joint investigation this office conducted with the Office of Executive Inspector General, the employee was discharged for cause.

- BIA opened a case on a senior managerial staff member based on an allegation that the employee had been engaging in time abuse and defrauding the state of Illinois. The complaint also alleged that in addition to time abuse, the employee traveled to Chicago for pleasure and bills the state for hotel and travel expenses.

A preliminary examination of the complaint indicated the allegations may be factual and also indicated that the employee may be violating the Department's computer security and Internet policies by sending and receiving a large volume of personal email.

BIA examined numerous documents related to this investigation covering the time period of January 1, 2008 through June 15, 2009. The investigation determined that multiple HFS policies were violated, many of which revolved around time abuse issues. BIA was able to validate that this employee failed to report absences, arrival and departure times and lunches in over 40 separate occasions which totaled 129 hours of time abuse. Often these abuses involved the falsification of official Agency attendance and payroll records. The calculation of funds to recover is \$5,024.80.

Investigators examined thirty-seven travel vouchers the employee submitted. These vouchers were cross-checked against other records. The employee was provided the dates and times in question and was afforded time, at the employee's request, to research the issues and formulate a response; yet, the employee failed to provide convincing records or responses to dispute the investigators' assertions. There was little evidence to support the necessity for the trips. In fact, several of the travel vouchers for trips were determined to be strictly for personal reasons. The total amount of funds calculated eligible for recovery was \$6,042.18 in wages and \$9,198.98 in travel expenses.

The investigation determined that the individual used the HFS GroupWise and Outlook email systems for personal use both during and after work hours. The content of some of this email was obscene and contained sexually graphic language. There were over 175 non-work related photos found on the employee's work computer. In addition, this employee misused the Agency telephone and state-issued Blackberry for 2963 minutes of personal use and 413 minutes of desktop office telephone misuse. Based upon policy, the funds eligible for recovery totaled \$4,376.00.

The employee also violated several Department policies governing the use of time when she allowed MC staff within her bureau to claim travel time as compensatory time. The Department's Equivalent Earned Time (EET) policy prohibits MC staff from claiming travel time. The employee told investigators that she circumvented the EET policy because she did not believe it to be fair.

A decision on disciplinary action is pending.

Misrepresentation of Employment Information

Individuals who apply for and receive employment or promotions within HFS are required to provide honest information on their applications and trustworthy responses during their interviews. Three recent Internal Affairs investigations have shown the hiring and promotional processes can be undermined by those who choose to misrepresent their work experience, education and military history in exchange for personal gain.

Applicants are required to complete the Examining/Employment Application (CMS100) or the Promotional Employment Application (CMS100B) in detail with comprehensive descriptions of their work experience duties, a complete and accurate list of their education, and identification of their military experience, if applicable. Additionally, by affixing their signatures to the applications, the applicants certify that the information contained within is true and accurate. The application states that misrepresentation of any material fact may be grounds for ineligibility or termination of employment.

- An administrator brought to the Department's attention information within an employee's deposition that appears to conflict with information the employee reported on her CMS applications. The employee's deposition on April 18, 2007, regarded a civil action the employee was taking against several supervisors within her division, recently became available to the Department. The employee was already awaiting disciplinary action for her participation in an earlier act that undermined the Department's selection and recruitment process, through her inappropriate access to Rutan interview questions in advance of her interview with the Bureau of Selection and Recruitment.

An investigation by Internal Affairs determined that the employee falsified nine separate CMS employment applications. The employee provided false and misleading work history information on her various applications that included fabricating her salary, length of employment, job classification and job duties for several businesses within the private sector. In one instance, the employee claimed she was a salaried paralegal of a law firm but was in fact working as an unpaid college intern. The employee also claimed she left her employment with the law office when the firm decided to move to another state. This claim was also rebuked by the purported employer.

The investigation also uncovered evidence that the employee provided false and exaggerated information regarding her semester and quarter credit hours from two community colleges and two state universities. In one instance, the employee claimed she earned an Associates of Applied Science Degree; however, when the records were secured from the college it revealed the employee was 28 quarter hours short of the requirement for securing an associates degree.

The investigation further determined the employee submitted to the Department of Central Management Services an altered Certificate of Release or Discharge from Active Duty form (DD Form 214) with the intent to knowingly defraud the State of Illinois by augmenting or fabricating her job duties, length of military service, rank, and conditions under which she was discharged while serving active duty in the US Air Force.

Lastly, the investigation determined the employee provided false and misleading information pertaining to employment, education and military experience to Department staff with whom she interviewed for various positions within the Department. Had the employee accurately presented her work, education and military history, she would not have been entitled to an "A" grade for the Family Support Specialist 1 position and would not have been eligible for the promotion she received on November 1, 2000.

The employee was discharged for cause on December 8, 2009.

- An anonymous complaint received by Internal Affairs alleged that an HFS Public Service Administrator (PSA) was soon to be awarded a Senior Public Service Administrator (SPSA) Rutan position and that the employee neither had the program knowledge nor the experience required for the position. The complainant questioned why the Department would conduct Rutan interviews and then award the job to a candidate who was less qualified than other candidates who applied for the same position. BIA determined that the employee was awarded the position and had begun working as an SPSA by the time the complaint was received and assigned.

The scope of the investigation included reviewing and analyzing numerous CMS employment applications and the interview questions and responses that were on file with the Bureau of Selection and Recruitment. Investigators also examined the employee's merit compensation evaluations and conducted interviews with HFS and CMS staff.

The investigation determined that during his recent Rutan interview and on his CMS employment applications, the PSA provided false and misleading information pertaining to previous job duties, scope of authority and educational background. The employee had previously interviewed for the same position several years earlier and after being selected as the top candidate, declined the position. BIA determined that during this earlier interview he also provided false and misleading information to the Bureau of Selection and Recruitment. In both instances, the employee claimed that while working in a previous position at another agency, he had acquired management experience, drafted policy and procedure and developed a database that emulated the requirements set forth in the HFS SPSA Rutan position.

As a result of the employee's false and misleading statements during both interviews, the employee was ranked as the top candidate for the position. In fact, based upon the criteria established by the hiring division, had the employee provided true and accurate information, he would not have been eligible nor offered an interview for the SPSA position. The investigation determined that the employee provided false and misleading information on his employment applications and during his interviews that inflated his educational background.

The employee also failed to maintain the confidentiality of the Internal Affairs investigation by making contact with one of the witnesses and discussing aspects of the investigation with the witness. Lastly, the employee failed to cooperate with Internal Affairs during his investigatory interview by providing false and misleading responses.

Disciplinary action is pending for the employee.

- The Office of Labor Relations advised Internal Affairs that during a grievance review for a non-certification issue, the office discovered a discrepancy in the application of an Information Systems Analyst 2 regarding the employee's college information. The dates regarding educational information on the employee's application for a Public Service Administrator promotion did not coincide with dates in an attachment to the application listing his educational background and classes he attended.

The investigation determined that on two separate occasions, the employee submitted CMS employment applications for a Program Analyst 2 and a Public Service Administrator, respectively that contained educational information that was false and misleading. The employee listed on the applications that he attended the University of California at Berkley, when in fact he had not. On the more recent application, the employee also falsely claimed to have earned a Bachelor of Science degree. When confronted with the falsifications, the employee acknowledged his actions and admitted that he had neither attended the university nor earned a Bachelor of Science degree as he claimed on his employment applications.

The employee was issued a 30-day suspension.

Administrative Litigation Initiatives

Attorneys from the Bureau of Administrative Litigation (BAL) represent the Department in recovery actions, actions seeking the termination, suspension or denial of a provider's Program eligibility, child support actions, and state income tax delinquency cases. BAL also handles joint hearings with the Department of Public Health (DPH) when DPH is seeking to decertify a long-term care facility.

In 2009, BAL expanded previously established initiatives to further streamline the resolution of cases, increase recoupment of dollars to the State, and improve the efficiency and overall management of cases within BAL. As a result, year-to-year total monetary recoveries achieved through BAL administrative actions increased to over \$12 million. This represents a substantial increase from BAL's total termination / recoupment recovery of \$4.7 million in calendar year 2008.

In 2009, BAL expanded the Expedited Recoupment Initiative and achieved notable success in case resolutions. Specifically, BAL focused its efforts on resolving cases and recouping dollars prior to the commencement of an administrative hearing. Additionally, BAL implemented a "Closed Door" Initiative wherein the Department aggressively pursued non-responsive providers who received Department notification of overpayment liabilities as established by BMI audits and subsequently closed their businesses instead of reimbursing the Department. Finally, BAL expanded its Preliminary Call Initiative that had been implemented to increase recoupments resulting from successful management of payment plans in child support delinquency cases. The following provides a summary of these initiatives.

Expedited Recoupment Initiative

A key program integrity function of the OIG is to conduct post-payment audits of Medicaid providers. These audits ensure that payments made to providers for services rendered were

appropriate. If overpayments are identified at audit, the Department takes action to recover the overpayment from the provider. Recoupment cases generally involve complex medical and statistical issues. The evidence and expert testimony presented at administrative hearings is substantial, often resulting in lengthy hearings. In some instances, hearings can take years to complete, resulting in delayed case resolution and delayed recoupment of funds. By expeditiously resolving complex cases prior to hearing, BAL is able to avoid incurring both the tangible costs associated with administrative hearings, including retention of statistical and other expert witnesses and the intangible costs, such as attorney time.

The Expedited Recoupment Initiative was established with the goals of (1) improving the efficiency of case evaluation and management, (2) establishing parameters and guidelines for case settlement, (3) streamlining the process by which cases are brought to hearing and (4) reducing the time required to reach resolution. To achieve these goals, a team of BAL attorneys manages and prosecutes recoupment and termination/recoupment cases. The team meets weekly to establish assignments, report on the progress of ongoing cases, evaluate medical and statistical case issues, select cases appropriate for settlement and set resolution parameters. The team also discusses the progress of ongoing negotiations and analyzes the likelihood of reaching resolution prior to hearing. BAL expeditiously moves to hearing in cases that cannot be resolved through negotiation.

Calendar year 2009 saw a marked increase in the number of recovery actions initiated by the Expedited Recoupment team; 121 cases, up from 29 in 2008, as well as a significant increase in resolutions realized. Specifically, the team resolved 118 cases, an increase from 69 cases resolved in 2008 and 5 cases in 2007. Dollars attributed to the Expedited Initiative in 2009 amount to a total recovery of over \$8.9 million.

The team responsible for carrying out the Expedited Recoupment Initiative has proven extremely adept at reaching resolution in recovery cases. Following the successes of the first half of 2009, BAL expanded the Initiative to include termination and recovery cases. In these cases, the Department seeks recoupment of funds as well as termination of a provider's Program eligibility. The first termination/recovery case transferred to the team resulted in a Final Administrative Decision of \$6,597,845.58 rendered in the Department's favor. The success of the Expedited Recoupment Initiative is due, in part, to a modification of the Notices sent to providers. To manage cases more efficiently and expeditiously, the Notices, which previously included only a formal conference date, now include hearing dates and discovery requests. This addition has reduced the average time of Expedited Recoupment case resolution to four months. More importantly, these results show that, through diligent case management and relationship building with providers, the Department can realize significant success. For that reason, BAL will apply the lessons learned through this Initiative to all cases in 2010.

Closed Door Initiative

In 2009, BMI referred 89 cases to BAL in which the providers, having received notification of overpayment liabilities established by audits, had gone out of business without responding to BMI's notification of audit findings. Subsequent attempts by BMI staff to contact the providers by phone proved unsuccessful. Prior to 2009, Department practice was to place this type of provider on "inactive" status and categorize the loss as bad debt.

In 2009 BAL implemented a “Closed Door” Initiative in a final attempt to recover overpayments from providers no longer in business prior to writing off the loss as bad debt. Pursuant to this initiative, BMI referred these non-responsive providers to BAL, which then aggressively pursued recovery actions against the providers. BAL conducted extensive research to obtain contact information for all providers involved and, as part of the “Closed Door Initiative,” filed administrative actions against all of the referred providers. The Expedited Recoupment team took responsibility for pursuing these actions to resolution. Of the 89 cases referred as part of the “Closed Door Initiative,” only 19 resulted in a categorization as bad debt. Of the remaining 71 cases, 15 were resolved pursuant to settlement agreements, 49 were resolved through a Final Administrative Decision, and six remain active with scheduled hearing dates. Such cases are of paramount importance to the OIG. Through the efforts of the Closed Door Initiative, the Department established liabilities against those providers who would have otherwise avoided responsibility for their debts by closing their doors. More importantly, the State has been adjudicated entitled to recovery.

Preliminary Call Initiative

The Preliminary Call, established in 2008 to streamline and expedite case management, has proven essential to the efficient resolution of cases as BAL is now able to set cases for hearing within 30 days of assignment to the Call. Cases regularly managed on the Call included provider denial, suspension and termination cases related to (1) decertification by the U.S. 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. In 2009, the Preliminary Call was expanded and over 150 cases were handled through the Preliminary Call.

Default Recoupment Cases - In 2009, Preliminary Call actions included 52 cases seeking, pursuant to 305 ILCS 5/12-4.25 (E) and 89 Ill. Adm. Code, Ch. I, Section 140.15, recovery of money improperly or erroneously paid to a Program provider. Following receipt of the Department’s Notice to recover and right to hearing, the provider is first given an opportunity to present information at a formal conference. For those providers who fail to appear at a formal conference scheduled by the Department and further fail to request a hearing, a motion for default is filed pursuant to 89 Ill. Adm. Code, Ch. I, Sections 104.210(d) and 104.285. The motion for default includes a request that the Department’s decision, and the grounds asserted in the Notice setting forth the basis for that decision, shall be a final and binding administrative determination. To expedite resolution of these matters in concert with the Expedited Recoupment Initiative, the Preliminary Call handles these motions.

Child Support Delinquency Cases - The Child Support matters included on the Preliminary Call involve cases wherein a non-custodial parent (NCP) who holds a state-issued license or permit 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 NCP is delinquent in child support payments. Once the Department makes this certification, the licensing agency is entitled to suspend the individual’s license pursuant to 305 ILCS 5/10-17.6 and 89 Ill. Adm. Code, Ch. I, Section 160.77. If the licensing agency is IDHFS, 305 ILCS 5/5-16.6 and 89 Ill. Adm. Code, Ch. I, Section 140.16(c) allow the Department to suspend the delinquent NCP’s eligibility to participate in the Medical Assistance Program.

In 2009, BAL received 70 child support referrals from DCSE and issued 77 notices seeking certification of in past-due child support payments. By focusing on the efficient use of the Preliminary Call, BAL effectuated an increase in both the number of payment plans executed and the average amount of recovery in each resolved case. Ninety-three cases, including some initiated in 2008, were resolved in 2009. The combined dollars established as a result of BAL's child support delinquency actions totaled over \$1.5 million.

BAL's success is due to the focused efforts to obtain service on non-custodial parents, to expedite cases to hearing and to secure settlements involving support payment plans. Often, the joint efforts of BAL, BOI and the Division of Child Support Enforcement (DCSE) are required to obtain service on an NCP. In instances where the NCP has refused service, BOI assists with effecting personal service on the NCP. Once service is complete and the action initiated, BAL engages in settlement discussions aimed at educating the NCP as to the impact of the sanction sought, including revocation of license or permit.

Child support delinquency actions result in successful resolution by several methods. In some instances, DCSE and the NCP work together to create payment plans; in other cases, DCSE begins income withholding or the NCP returns to the Circuit Court to enter into new support orders. Importantly, after an NCP enters into a payment plan, the case remains on the Preliminary Call for compliance monitoring. If an NCP complies with the terms of the plan, BAL withdraws the case. If the NCP is not compliant, the case proceeds to hearing.

Provider Denial, Suspension and Termination Cases - One of the OIG's key concerns is ensuring that the physicians enrolled in the Medical Assistance Program are providing quality care to Program recipients. It is paramount that BAL seeks to suspend, terminate or deny Program eligibility to healthcare professionals who fail to meet licensing requirements. The Preliminary Call, therefore, also includes 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.

Equally important to the 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.

Final Administrative Actions

In the Calendar year 2009, over 125 Final Administrative Decisions were rendered on BAL cases. Notable decisions are described below.

- Pharmaceutical Provider – Final Administrative Decision in the amount \$1,014,377.14

BAL filed a Notice to recover against a pharmaceutical company alleging numerous instances in which the company billed for unauthorized prescriptions and prescription refills. The matter proceeded to hearing on the merits. Statistical experts testified at hearing regarding of the Department's extrapolation. The Administrative Law Judge (ALJ) found the testimony of the Department statistician credible and compelling. The ALJ determined that in certain instances the pharmacy had exceeded its authority to issue prescriptions, and, in other instances, had failed to demonstrate any authority to fill prescriptions. As a result, the ALJ awarded HFS \$1,014,377.14. The final administrative decision affirmed the award as reflected in the recommended decision.

- Non Emergency Transportation Provider - Final Administrative Decision in the amount of \$6,597,845.58

BAL brought a termination/recovery action against a non-emergency transportation provider who BMI had determined, after a compliance audit, owed the Department \$6,597,845.58 in extrapolated overpayments. Specifically, audit found 387 instances of overpayment for regular transportation services due to improper duplicate billing, 248 instances of overpayment for regular transportation services due to billing for non-covered services, 168 instances of overpayment for duplicate transportation services due to missing records of specific services, and 24 instances of overpayment for duplicate transportation services due to billing for non-covered services. In addition to seeking recovery of funds, OIG felt it appropriate to seek the provider's termination from the Medical Assistance Program. Pursuant to statutes and administrative rules regarding a provider's termination, the Department also sought to bar the provider's owner from continued Program participation. The ALJ issued a recommended decision noting, "[t]he Department's decision and the grounds asserted for the basis of that decision ... to recover \$6,597,845.58 should be upheld." The Judge further recommended termination of the provider and barring of the owner. In October 2009, the Department Director issued a final administrative decision adopting the ALJ's decision in full.

- Non Emergency Transportation Provider - Final Administrative Decision in the amount of \$104,528.49

Based upon allegations that a non-emergency transportation provider had received \$104,528.49 in overpayments due to 4,889 instances of duplicate billing, BAL brought action to recover the overpayment. In June 2009, the Administrative Law Judge conducted a hearing with both counsel participating and issued a recommended decision noting "the Department's decision and the grounds asserted for the basis of that decision ... to recover \$104,528.49 should be upheld." In August 2009, the Department Director issued a final administrative decision adopting the ALJ's decision and allowing the Department to recover 100% of the amount sought.

- Physician – Peer Termination

BAL filed a six-count termination complaint against a physician alleging that the care rendered to Program recipients was of grossly inferior quality, placed the recipients at an unacceptable risk of harm and was in excess of the patient's needs. In particular, OIG alleged that the physician failed to adequately evaluate and manage a patient with signs

and symptoms of congestive heart failure; failed to adequately manage a patient with diabetes mellitus; prescribed antibiotics without clinical indication; failed to properly evaluate a patient with a urethral discharge; prescribed improper medications; and failed to address abnormal lab results. At hearing, BAL presented extensive medical expert testimony relating to the physician's care of Program recipients. At the conclusion of the hearing, the ALJ recommended the physician's termination from the Program. The Department Director adopted the ALJ's recommendation and terminated the physician from the Program. As a result of the Director's final decision and the physician's resultant termination, the Department was able to ensure that the provider would no longer be able to render inadequate care to Program recipients. Moreover, pursuant to 89 Ill. Adm. Code, Ch. I, Section 104.272, the Department is entitled to withhold payments to the provider after initiation of the peer termination proceedings. When the Department prevails at hearing, any amounts billed during the pendency of a case are disallowed. In this case, the provider had billed \$345,000 during the pendency of his hearing. Because the Department prevailed in its termination action, the entire \$345,000 was disallowed, thereby creating a substantial cost savings for the State.

- **Physician – Peer Termination**

BAL filed a termination action against a medical provider who subjected recipients to risk of harm through inappropriate and excessive prescription of narcotic medications. After a review and intense investigation of the physician, OIG determined that the physician, through his personally owned clinic, inappropriately prescribed medication with no evidence of medical necessity. Research also revealed that the physician was prescribing an excessive amount of narcotics, including benzodiazepines and other drugs that, in combination, could result in depression of the respiratory system and possibly death. After initiation of BAL's termination action, the physician, in Federal Court, pled guilty to knowingly or intentionally dispensing a controlled substance outside the scope of professional practice and not for a legitimate medical purpose.

- **Barred Individual – Reinstatement Denial**

Pursuant to 89 Ill. Adm. Code, Ch. I, Section 140.14, the Department may deny a provider's application for reinstatement to the Medical Assistance Program when an applicant, who was previously terminated, has engaged in activities which constitute grounds for termination or suspension of participation in the Program under 89 Ill. Adm. Code, Ch. I, Section 140.16. When the Department receives a reinstatement application from a previously terminated provider or barred individual, the Department may deny said application if the provider/individual fails to present information sufficient to establish that he could reasonably be expected to meet the Department's written requirements for participation. The Department may also deny reinstatement if it determines that the activities leading to the earlier termination and/or barring were of such a nature that it would be inappropriate to reinstate the provider/individual.

BAL filed an action seeking to deny a barred individual's application for reinstatement in the Program. The applicant, when first barred from participation, was the treasurer and partial owner of a pharmacy. The co-owner of the pharmacy was found guilty of mail fraud and filing of false claims. As a result, the Department terminated the pharmacy's

Program eligibility and barred both owners from continued participation. At hearing, the Department prevailed on the merits and the Department's denial of the applicant stood.

- Real Estate Broker - \$58,063.80 in delinquent child support payments

BAL brought action against a licensed Real Estate Broker seeking to collect \$58,063.80 in delinquent child support payments. After commencement of the administrative action, income withholding payments were initiated. The case was monitored on the Preliminary Call to confirm compliance with the payments. Once the NCP established compliance, the BAL action was withdrawn. DCSE began income withholding within weeks of the Department's filing of its Notice.

- Licensed Security Guard - \$27,944.42 in delinquent child support payments

Administrative action seeking \$27,944.42 in delinquent child support payments for two children was initiated against a licensed security guard. Within 30 days of initiation of the hearing, the NCP entered into a payment plan in which he agreed to repay the entire delinquent amount as well as the court-ordered current and ongoing support payments. The case remained on the Preliminary Call for over four months to confirm compliance. Once compliance was satisfactorily established, BAL withdrew the action.

- Boat Owner - \$102,604.13 in delinquent child support payments certified

BAL brought an action against an individual with a boat registration license seeking \$102,604.13 in delinquent child support payments. After providing an opportunity for a hearing, the Department certified to the licensing agency that the NCP was delinquent in child support payments. Once the Department made this certification, the licensing agency is entitled to suspend the individual's license pursuant to 305 ILCS 5/10-17.6 and 89 Ill. Adm. Code, Ch. I, Section 160.77.

- Licensed Security Guard - \$102,604.13 in delinquent child support payments certified

As a result of a licensed security guard's delinquency in making child support payments, BAL brought administrative seeking \$132,851.49 against the individual. This case involved four children and four separate support payments. BAL's action resulted in certification of the delinquency to the licensing agency.

- Licensed physician - \$191,559.15 in delinquent payments certified and suspension from the Medicaid Program effected

BAL brought an action against a licensed physician seeking both \$191,559.15 in delinquent payments and his suspension from the Medicaid Program based on delinquent child support payments. BAL was successful both in certifying the delinquency and in effecting the doctor's suspension from Program participation.

PREVENTION ACTIVITIES

Fraud Prevention Investigations

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

The 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 business days for all Food Stamp / Supplemental Nutrition Assistance Program (SNAP) only cases and eight 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.

The FPI program has provided a fourteen-year estimated average savings of \$13.23 for each \$1.00 spent by the state. FPI has averaged a 66% denial, reduction or cancellation rate of benefits for the 43,805 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over \$118.9 million.

During Calendar Year 2009, the program generated 3260 total investigations, of which, 1822 cases led to reduced benefits, denials or cancellation of public assistance. The denial rate for this period was 56%. The denial rate has fluctuated annually, with a fourteen year average denial rate of approximately 66% since the program's inception. BOI will closely monitor the denial rate and conduct outreach to our DHS partners to improve referrals if the annual denial rate continues to decline.

BOI calculated an estimated gross savings for Calendar Year 2009 of approximately \$10.3 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps / SNAP. The program's estimated cost savings for Calendar Year 2009 was \$8.63 for each \$1.00 spent on the program.

Long Term Care - Asset Discovery Investigations

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program looks at error-prone long term care Medicaid applications. In partnership with OIG, the Department of Human Services (DHS) local offices throughout the state participate in this effort. LTC-ADI evaluates Medicaid applications meeting special criteria for pre-eligibility investigations. The program's goal is to prevent ineligible persons from receiving long term care benefits, thereby saving tax dollars and making funds available to qualified applicants who meet the eligibility requirement

based on Medicaid standards. The investigations uncover undisclosed assets and unallowable asset transfers.

The OIG made recommendations on 607 referrals for investigation for the 2009 calendar year. The gross savings realized in 2009, for not providing public assistance to ineligible persons due to LTC-ADI, was \$12,895,665.00. For every \$1 spent on administration costs relevant to the LTC-ADI program, \$8.26 of savings was realized. Since 2006, LTC-ADI has completed 2634 cases, with a gross savings to taxpayers of \$64,940,028.00.

The LTC-ADI Unit completed 607 cases during the year. Several of these cases are described below:

- The LTC-ADI unit received a referral from DuPage County in June of 2009. The applicant was represented by an attorney for the purpose of assisting with the application process. The applicant had transferred homestead real property located in Hancock, Wisconsin to her son in March of 2009. The Medicaid policy which allows for transfers of homestead property to a person's child requires that either the child be disabled or for the child to have lived with and cared for the parent for a period of two years immediately prior to the parent entering a nursing home or applying for Medicaid.

Typically the applicant's attorney will note the criteria for the homestead property transfer in the application packet and include supporting verification. Examples of acceptable verification would include proof of a disability determination or documentation to confirm residence for the applicable time parameters. The application packet in this case did not include information identifying the reason for or documentation of the transfer.

Using resources available to the LTC-ADI analyst, a search of the Medical Assistance Eligibility database was made in an effort to determine if the applicant's son was a recipient of Medicaid benefits as a result of a disability, which was not the case. Additionally, the data base revealed that the son had not lived in Wisconsin for a period of two years immediately prior to the applicant applying for Medicaid or entering a nursing home, so he did not meet the Medicaid requirements which allow a parent to transfer homestead property to an adult child. Instead the applicant's child had applied for assistance in the State of Illinois on three separate occasions during the applicable two year period. The OIG investigative report to the DuPage County DHS office included information on the transfer of homestead real property to the son. OIG's recommendation concluded that the transfer did not meet criteria for exemption and therefore should be considered a transfer for less than fair market value considering the applicant received no monetary compensation for change in ownership of the real property. The unallowable transfer resulted in a 35 month penalty period. The savings to Illinois taxpayers was \$82,278.00.

- The OIG received a referral from Tazewell County in the fall of 2009. The application had been filed online via the DHS Website. The application reported saving and checking accounts held at a credit union, a life insurance policy, money market account, IRA and an annuity. During a review of withdrawal transactions from the investment and IRA accounts, the discovery was made that the applicant did not receive the withdrawn

funds. The funds were withdrawn from the applicant's accounts and deposited to an account solely owned by the applicant's daughter. The sum of the transfers resulted in a 20 month penalty period for which the State will not pay the long term care costs of the applicant, resulting in a savings to the State of \$75,984.00 in Medicaid expenditures.

- In addition to investigating assets at the point of application, LTC-ADI personnel represented the OIG findings during an appeal hearing in November 2009 at the Madison County DHS Office. The reason for the appeal was based on a decision rendered by DHS on an application that had been referred to LTC-ADI. The investigation findings included reporting the transfer of homestead property to the applicant's daughter. An attorney representing the applicant in the Medicaid application process requested exemption for the transfer based on the premise that the child had reportedly lived with and cared for the parent for a period of two years immediately prior to the parent entering a nursing home or applying for Medicaid.

During the course of the investigation LTC-ADI discovered that the applicant had not lived in the homestead property during the applicable two year period prior to the transfer and application for Medicaid or entry into a nursing home. In fact, the applicant had relocated to North Carolina to be close to other family members for six months during the two year period, while the daughter remained in the homestead property.

LTC-ADI learned that upon return to Illinois, the applicant moved back to her homestead where she received services from the Visiting Nurses Association through the Department on Aging (DOA). The applicant remained at home for seven months before moving to a nursing home and applying for Medicaid. Information received by LTC-ADI revealed an elder abuse claim filed by a visiting nurse against the daughter who lived with and cared for the applicant. In preparation for the appeal, the DOA was contacted by the OIG regarding the claim. The DOA provided a statement of their findings which substantiated the claim of physical and mental abuse toward the applicant by her daughter. The findings of the DOA report were provided as part of the OIG testimony as evidence during the appeal hearing. The information further substantiated the LTC-ADI recommendation findings that the transfer of homestead property to the daughter was unallowable.

The DHS final administrative decision has yet to be rendered, but if the originally assessed 15 month penalty period is upheld; the saving for the taxpayers will be \$44,883.00.

New Provider Verification

The OIG continues to dedicate itself to combating fraud and abuse among the community of highly suspect non-emergency transportation (NET) providers by reengineering the New Provider Verification (NPV) program that was launched in 2001. Monitoring of NET and durable medical equipment providers (DME) providers began in June 2001 by OIG performing pre-enrollment on-site visits to verify their business legitimacy and by performing analysis of their billing patterns to detect aberrant behaviors. The NPV program was modified in 2004 to accommodate implementation of administrative rules that were amended requiring NET providers to undergo pre-enrollment criminal background checks and mandatory fingerprinting; and authorizing a 180 day probationary enrollment period.

During 2009, the NPV program was overhauled to take advantage of the vast investigative and analytical expertise and experience within the OIG. Investigators within the OIG Bureau of Investigations took over the responsibility for conducting the on-site visits and have restructured the interview process by honing in on items pertinent to enrollment which include collecting and verifying information on owners, officers and other individuals responsible for the day-to-day operations of the NET and DME providers. The investigators also perform follow-up investigations as suspect behavior is discovered during the NET providers 180 day probationary period. This may entail a one-time drive-by to determine if the provider is still in business or, in rare circumstances, full blown surveillance activities.

The analysis phase encompassing the 180 day probationary period was strengthened in 2009 by adoption of early detection methodologies that include review of trips through prior approvals for providers that have not yet submitted claims and inclusion of fraud detection routines created by the OIG predictive modeling project. Assessment of the providers billing patterns and prior approvals was also modified to begin shortly after the 180 day probationary enrollment period begins. Fraud routines developed by the OIG Fraud Science Team to support the predictive modeling system have been incorporated into the analysis and include evaluation of the NET provider's duplicate services, rejected services, recipient characteristics, interrelationships with other providers and dates of service patterns. The outcomes from NPV may lead to probe audits and subsequent corporate integrity agreements, termination from the Medicaid program, and/or referrals to the Illinois State Police Medicaid Fraud Control Unit.

Information Technology Initiatives

Predictive Modeling System

The OIG is in the final stages of implementing the Predictive Modeling System which was federally funded by a Medicaid Transformation Grant awarded in February 2007. This new system assures the OIG movement into the next generation of fraud detection. The system uses cutting edge predictive modeling techniques to detect aberrant behaviors at the earliest possible time. Various analytical phases were completed during 2009 that included exploratory and network analysis. Focus has now been shifted to finalize construction of fraud detection routines, continued development of the data distribution component and integration with the operational data systems. Full system implementation is expected early Calendar Year 2011.

Great strides were taken during 2009 to set the stage for implementation of the Predictive Modeling System. Integration of the predictive modeling routines within the day to day operations of the OIG is underway with utilization of several routines that were developed as part of the Structured Case Review component. These routines included reviews of existing cases to glean billing problems which could then be analyzed to uncover patterns of abuse among other providers. These various routines are now being utilized to monitor and evaluate non-emergency transportation providers as part of their 180 day probationary period and individual practitioners on a case by case basis.

Integration

One of the key components of the predictive modeling system is to put in place the infrastructure that will integrate the analytics with the operational systems and promote future growth by setting the stage for the next round of routines to be incorporated into the system. Up until now, linkages and integration between the various routines and data systems has been labor-intensive

and required manual coordination and intervention to synchronize the disparate data systems. Work has begun to bridge the gap between the predictive modeling analytics and the operational data systems.

Provider Claim Detail

The Provider Claim Detail (PCD) system is used to draw samples and produce detailed claim information for use in provider compliance/financial audits and quality of care reviews. It was modified during 2009 to accommodate the claims universe and sample datasets created by the predictive modeling environment thereby allowing audit staff to continue to use the same reports and processes to conduct audits. The PCD was also enhanced to allow for dynamic sample stratification for all audit types. These upgrades provide enormous flexibility in defining audits and streamline the audit and quality of care process by providing a transparent exchange of data between these systems.

Surveillance Utilization and Review System

Java-Surveillance Utilization and Review System (J-SURS) is the exception processing system utilized in Illinois. Results of the exception processing routines will be incorporated into the predictive modeling risk score calculations. Integrating the predictive modeling and exception processing predictors will allow for a cohesive risk score to be developed that encompasses all OIG routines. Business processes are also changing as implementation of the Predictive Modeling System draws near. Historically, OIG's Narrative Review Committee (NRC) assessed providers identified by exception processing routines and determined which should be selected for an audit or a quality of care review. These routines and subsequent analysis have been revamped to reflect a more precise view of the providers' behaviors. The provider selection process is being reengineered to accommodate distribution, evaluation, and selection of the combined exception processing and predictive modeling results. The new process will revolutionize the selection efforts and allow for a more streamlined review of potential audit or peer review candidates.

Participation in Agency Initiatives

MMIS Upgrade

Illinois began the upgrade of its Medicaid Management Information System (MMIS) in earnest during 2009. A contract was awarded to Fox Systems for the Planning and Independent Verification & Validation/Quality Assurance components. The Planning phase is currently underway with the end product being an RFP for the Design, Development and Implementation of a replacement MMIS. The design of the new MMIS will be completed using the federal CMS Medicaid Information Technology Architecture (MITA) principals that include documenting each business process, its current functionality (As-Is), and its desired functionality (To-Be). There were approximately 78 business processes reviewed and documented using the MITA standards from April 2009 through July 2009. OIG, as a primary stakeholder, continues to participate in all aspects of this major project that during 2009 included participation in all MITA sessions and To-Be prioritization sessions, review of all project deliverables, and provide program integrity oversight at all levels of this mission critical project.

HIPAA 5010 and ICD-10

Federal CMS has mandated full conversion to the new Health Insurance Portability and Accountability Act (HIPAA) 5010 electronic transaction file formats by January 2012 and to the new International Classification of Diseases, 10th Revision (ICD-10) codes by October 2013. In

2009, Illinois developed workgroups, of which OIG is a participating member, dedicated to these conversion efforts. Migration to these new HIPAA layouts and ICD-10 code sets is a daunting task. Each HIPAA transaction must be walked through to determine what has changed and the impact of the change. The new ICD-10 standard creates many new codes and changes the size of the code. Migration to the new ICD-10 diagnosis and institutional procedure codes will require massive changes throughout MMIS which includes all OIG data systems, queries and reports. These workgroups are time consuming and require ongoing dedication and commitment from staff to ensure a successful conversion effort and to implement changes that will further enhance ongoing program integrity efforts.

Federally Mandated Medicaid Eligibility Quality Control Program

Health Benefits for Workers with Disabilities

The Health Benefits for Workers with Disabilities (HBWD) program was implemented in 2002 by the Department and was designed to help people with disabilities return to work with full Medicaid (Title XIX) health care benefits. The OIG targeted this program to ensure eligibility requirements for the program were being applied properly, to correct any deficiencies found and to provide feedback to the Department for program improvement.

A total of 1440 (689 active and 751 negative) HBWD cases were reviewed by the OIG for the FFY08 sample period. The OIG reviewed 153 cases in CY 2008 and completed the remaining 1287 cases in CY 2009. Results of the reviews were submitted to CMS in July 2009.

A payment error rate of 4.87% was reported for the HBWD active reviews. Of this error rate, 44% was a result of the client not being employed (employment is one of the basic non-financial program eligibility requirements for the HBWD program). Assets, mostly bank accounts/cash on hand, were responsible for 38% of the payment error rate, followed by 18% for income, both earned and unearned. The majority of the payment errors resulted from information not being reported by the client.

A case error rate of 1.60% was reported for the HBWD negative reviews. Five of the errors were due to the denial of eligibility for individuals not covered under Social Security's Section 1619 for the severely disabled. (Individuals determined severely disabled by Social Security under Section 1619 are provided medical coverage under the Medicaid program and therefore are not eligible for HBWD). Five of the error cases were negative actions due to income, one was due to the denial of a disabled individual and one was due to the incorrect application of policy/procedures.

Passive Redeterminations

The passive renewal process was implemented by the Department in February 2006 and was designed to simplify the renewal process for families enrolled in family health plans. A renewal form is sent to families and if there are no changes affecting the children's Medicaid eligibility, the family does not have to return the renewal form to the Department. The renewal is automatically completed and eligibility is updated for another year using the information previously coded on the system. The adults within the case receiving medical benefits are required to return the renewal form if they wish to continue receiving medical benefits. The OIG selected passive redeterminations as the targeted review for the FFY09 MEQC pilot due to the FFY07 redetermination pilot revealing that the passive renewal process contained the majority of

the identified errors. A total of 884 cases were reviewed during 2009 and a summary of findings will be completed in 2010.

Negative Corrective Action Reviews

The State is federally mandated to complete reviews of negative actions to ensure clients are not being denied or terminated from the Medicaid program in error. The OIG submitted the FFY08 Negative Corrective Action Review analysis to the federal CMS in January 2009. The OIG sampled 256 negative case actions and completed reviews on 249 cases. Two error cases were discovered resulting in a 0.55% case error rate. Individual case corrective actions were completed on all error and drop cases, where appropriate.

Illinois Healthy Women

The OIG received approval in October 2009 to target the Illinois Healthy Women (IHW) program for the FFY10 MEQC pilot. Reviews will be conducted of the initial eligibility determinations and re-enrollments of women covered under the IHW program. The IHW program provides family planning services to women between the ages of 19 and 44. The program began in April 2004 with automatic enrollments for women who lost medical benefits due to program specific criteria and women were given the opportunity to apply for the IHW program beginning May 2007. The review will identify eligibility errors and overall program discrepancies that could impact Medicaid (Title XIX) funds. Reviews will begin in 2010 and will conclude in 2011.

New Administrative Rules

The Office of Inspector General each year performs activities, including fraud prevention research, financial audits, quality of care reviews and other projects aimed at identifying and resolving specific vulnerabilities within the Medical Assistance Program. In some instances, new rules and statutes must be implemented in order to address potential and identified vulnerabilities within the Program. The following administrative rules were enacted in 2009 to strengthen the OIG's prevention efforts.

Rule 89 Ill. Adm. Code, Ch. I, Section 140.44 - Withholding of Payments upon Evidence of Fraud

89 Ill. Adm. Code, Ch. I, Section 140.44, promulgated to implement the statutory provision 305 ILCS 5/12-4.25 (K), strengthens the OIG's ability to prevent fraud. The rule permits the OIG to withhold (stop) payments, in whole or in part, to a provider or alternate payee upon receipt of credible evidence that the payments may involve fraud or willful misrepresentation in billings of program services. Notice to the provider, setting forth the general allegations as to the nature of the withholding, is required within 5 days of the placement of withhold. A provider may request full or partial release of payments from the Department. This rule is an important tool in eliminating continued fraud or abuse of the Medical Assistance Program. It permits the OIG to hold payments that would otherwise be released during an ongoing investigation, even after credible evidence of fraud has been identified. This rule creates a method by which, when evidence of fraud has been identified, the State can respond immediately and thereby prevent future losses. This Rule became effective on April 15, 2009.

89 Ill. Adm. Code, Ch. I, Section 140.16 (a)(11) – Denial, Suspension, or Termination of Eligibility based upon Conviction of Murder and Class X Felony

89 Ill. Adm. Code, Ch. I, Section 140.16(a)(11), implements statutory provision 305 ILCS 5/12-4.25 (A-10) and permits OIG to ensure that only appropriate providers are rendering services to recipients of the Medical Assistance Program. Pursuant to this rule the Department may deny, suspend, or terminate the eligibility of any person, firm, corporation, or other entity to participate as a provider, if after notice and opportunity for a hearing, the Department finds the provider, a person with management responsibility of a provider, an officer or person owning 5% or more of the shares of stock in a corporation, an owner of a sole proprietorship, or a partner in a partnership has been convicted of a felony offense related to murder or a class X felony under the Criminal Code of 1961. This Rule became effective on August 17, 2009.

89 Ill. Adm. Code, Ch I. Section 140.13 (a)(4) - Limitations on Psychiatric Services for Group Psychotherapy

In the last several years OIG has focused, through its provider quality of care reviews, provider financial audits and other fraud detection methods, on identifying potential vulnerabilities relating to billings associated with group psychotherapy services. OIG Bureau of Information Technology (BIT) staff performed a three-pronged analysis to identify areas of improvement in the fiscal integrity of psychotherapy services paid for under the Medical Assistance program – (1) analyzed claims for group psychotherapy, (2) surveyed other state program integrity offices to better understand how other states pay for psychotherapy services, and (3) reviewed published studies and other payer's guidelines on group therapy size and consulted with physician experts to identify a recommended group size and related requirements. Based on this research, the OIG and other members of the Department's executive-level program integrity oversight workgroup developed a report for the Medicaid Director that identified a number of the Department's vulnerabilities in this area and proposed recommendations to strengthen the Department's billing and payment policies. The OIG and the Division of Medical Programs began working on rules that would implement these recommendations.

While new rules were being promulgated, the OIG continued its program integrity efforts to identify and prevent fraud and abuse identified with psychotherapy billings. New BIT fraud detection routines identified an increase in the numbers of physicians, without a psychiatric specialty, billing for Group Psychotherapy services. BIT targeted psychotherapy services in the Predictive Modeling System development effort, which is highlighted in another section of this report. BMI, through their financial compliance audits, identified and sought recoupment of payments for instances where providers billed improperly for group psychotherapy services.

In addition, the BMI Peer Review Section identified problems with the quality of care being provided, including instances where medical records for group psychotherapy services lacked documentation of either the psychiatric service provided or the medical necessity for such services. In other instances, OIG identified medical records that did not include specific psychiatric diagnoses or treatment plans. In cases such as these, where serious deficiencies led OIG to have concern for the quality of group psychiatric care being provided to Program recipients, administrative action against the providers was aggressively pursued.

In 2009, 89 Ill. Adm. Code, Ch. I, Section 140.413, Limitation on Physician Services, was implemented. Section 140.413 sets forth specific limitations on, and requirements for, Department reimbursement for group psychotherapy services. Reimbursement is restricted to two group sessions per week and only one session per day is allowed. Further, in order to ensure the quality of psychiatric services and to prevent potential abuses, payment for group

psychotherapy will only be made after specific conditions are met. Specifically, the patient's medical record must contain documentation of the patient's mental health diagnosis, and such diagnosis must comply with a mental illness defined in either the International Classification of Diseases (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Further, the group psychotherapy must be directly performed by a physician who has completed an approved general psychiatry residency program or is providing the service as a resident or attending physician at an approved or accredited residency program. This rule also mandates that the size of the group may not exceed 12 patients, and each group session must last a minimum of 45 minutes.

Section 140.413 increases the Department's ability to ensure that a high-level quality of group psychotherapy care is rendered to Program recipients. The rule requires that the physicians utilize acceptable group treatment models, methods, and subject content that have been selected on evidence-based criteria for the target population of the group and that the physician follows recognized practice guidelines for psychiatric services. Importantly, all group sessions must be provided in accordance with a clear written description of goals, methods and referral criteria. Additionally, the new rule mandates the inclusion of proper documentation by the rendering physician in order to verify the services performed, including information pertaining to the session's primary focus, the level of patient participation, and the beginning and ending times of each session. For patients or residents of a long term care facility receiving group psychotherapy, additional documentation requirements exist. The patient's medical record must demonstrate that the physician rendering care and the long term care facility are sharing information and coordinating services to effectively implement the patient's plan of care based upon the patient's needs. All of these requirements are aimed at increasing the quality of care provided to recipients while eliminating fraud and abuse of group psychiatric services. This rule was effective October 1, 2009.

COOPERATIVE EFFORTS

Federal Program Participation

As part of its ongoing program integrity efforts, the OIG works closely with the federal Centers for Medicare & Medicaid Services (CMS) whose mission is to monitor effectiveness within the federally funded medical programs.

Medicaid Integrity Group - Provider Audits

The federal CMS Medicaid Integrity Group (MIG), whose responsibilities include provider auditing and providing effective support and assistance to states in their efforts to combat Medicaid provider fraud and abuse, initiated their audit program in Illinois during 2009. As required by the Deficit Reduction Act of 2005, MIG has awarded umbrella contracts to Medicaid Integrity Contractors (MIC) to perform the various audit components. In August 2009, AdvanceMed Corporation was awarded the Review MIC contract for Illinois to analyze Medicaid Statistical Information System (MSIS) claim data to identify aberrant claims and potential billing vulnerabilities, and provide leads to the Audit MICs of Medicaid providers to be audited. Health Integrity, LLC was awarded the Audit MIC contract in November 2009 and will conduct post-payment audits of all types of Medicaid providers and, where appropriate, identify overpayments. Once overpayments have been identified, OIG will be responsible for recovery of the overpayments and handling the administrative hearing process for MIC audits contested

by providers. This will be an ongoing relationship with OIG working closely and coordinating the various audit activities with MIG and its contractors.

Payment Error Rate Measurement (PERM)

Federal CMS implemented the PERM program in FFY 2006 to measure improper payments in the Medicaid program and the Children's Health Insurance Program (CHIP). Illinois began its second PERM cycle in October 2008 with the OIG continuing to be the Illinois PERM liaison.

CMS suspended review of CHIP payments and client eligibility in April 2009 due to Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requiring a new PERM rule and delaying calculation of a PERM error rate for CHIP until six months after the new PERM rule is in effect. CHIPRA mandates for PERM also included: harmonization between the Medical Eligibility Quality Control (MEQC) program and PERM; clearly defined errors for states and providers; clearly defined processes for appealing error determinations; state specific sample sizes; and clearly defined responsibilities and deadlines for states implementing corrective action plans. The new proposed PERM rules were released by federal CMS in May 2009 with comments due in August 2009. Since that time federal CMS has been reviewing comments to the proposed rule and soliciting opinions from states on various topics.

Throughout this process, OIG has reviewed and submitted comments to the proposed PERM rule which included recommendations for sample size calculations, universe validation techniques, equitable error assessments, corrective action plan deadlines and monitoring, a national measurement model and alternate methods for performing the PERM reviews.

Both Medicaid payments and client eligibility continued to be reviewed throughout 2009. The data processing reviews began in October 2009 and the medical record reviews began in November 2009. Enhancements were made to the OIG Case Tracking System (CASE) to track and monitor the various PERM activities. This has significantly aided the tracking of the PERM cases and has saved a considerable amount of staff resources.

Medical Assistance Program Prosecutions

The OIG partners with the Illinois State Police, Medicaid Fraud Control Unit (MFCU) and other law enforcement agencies in developing cases for the prosecution of providers, alternate payees, and individuals whose actions under the Medical Assistance Programs violate federal and / or state statutes. OIG provided assistance on these cases by performing data research, providing program related documentation and arranging expert witnesses from within the agency.

OIG worked with both state and federal prosecutors and law enforcement officials in this effort. Prosecutors handled the legal enforcement of statutes as a criminal or civil prosecution. Qui tams, or whistleblower cases, are often handled as multi-state jurisdiction prosecutions. A few of the prosecutions completed during 2009 are described below.

- Dr. Roland Borrasi, an Illinois Medicaid provider, was indicted by a United States District Court, Northern District of Illinois Grand Jury alleging that Rock Creek Center L.P., a licensed inpatient psychiatric facility, was paying bribes to Roland Borrasi for Borrasi to refer patients to Rock Creek Center L.P. and arranging for the furnishing of services. Rock Creek L.P. would pay monies to Borrasi for those services, which he, Borrasi did not provide. In June 2009, Dr. Borrasi was found guilty by a jury of seven (7)

counts of criminal acts, related to the indictment. All counts were for acts to defraud a Federal Healthcare Program.

Upon the indictment of Dr. Borrasi, the OIG under authority of Illinois statute 305 ILCS 5/12-4.25 (F-5) initiated withholding the payment of all bills submitted to the Illinois Medical Assistance Programs by Dr. Borrasi. Resulting from the conviction of Dr. Borrasi and the authority of Illinois statute 305 ILCS 5/12-4.25 (F-5) the Department avoided paying bills totaling \$2,518,234.38.

The Bureau of Administrative Litigation is currently pursuing the termination of this provider.

- On July 2009 Dr. Sukhdarshan Bedi, an Illinois Medicaid provider, was indicted in the United States District Court, Southern District of Illinois and then arrested by MFCU and the Health and Human Services Office of Inspector General. Based on the indictment Dr. Sukhdarshan Bedi, Marion Clinic, Harrisburg Clinic and Galatia Clinic, did knowingly and willfully devise a scheme to defraud the Medical Assistance Programs by submitting or causing to be submitted claims for non-covered services.

Dr. Shan Bedi was the owner/operator of Illinois Health Care Clinic, P.C. d/b/a Marion Family Health Care, M-CFHC Inc. d/b/a Harrisburg Family Health Care and Galatia Medical Center all rural health care facilities. In November 2009, Dr. Bedi was convicted by pleading guilty to four counts in the indictment. Dr. Bedi was convicted on two counts of obstruction of justice, one count of tampering with a witness and one count of illegal dispensing of a schedule II controlled substance, all class C felonies. As part of the criminal guilty plea, Dr. Bedi was ordered to repay \$47,784.31 to the Illinois Medical Assistance Programs.

Upon the July 2009 indictment of Dr. Bedi, the Office of Inspector General under authority of Illinois statute 305 ILCS 5/12-4.25 (F-5) initiated withholding the payment of all bills submitted to the Illinois Medical Assistance Programs by Dr. Bedi as well as all named facilities. Resulting from the conviction of Dr. Bedi and the authority of Illinois statute 305 ILCS 5/12-4.25 (F-5) the Department avoided paying bills totaling \$72,404.45.

The Bureau of Administrative Litigation is currently working on the termination of this provider.

- In January 2009 Dr. Sushil Sheth, an Illinois Medicaid provider, was indicted by the United States District Court, Northern District of Illinois alleging that beginning January 2002 to about June 2007 that Dr. Sheth did knowingly and intentionally devise and participate in a scheme to defraud the Federal and Illinois healthcare benefit programs by submitting fraudulent reimbursement claims.

Upon the January 2009 indictment of Dr. Sheth, the Office of Inspector General under authority of Illinois statute 305 ILCS 5/12-4.25 (F-5) initiated withholding the payment of all bills submitted to the Illinois Medical Assistance Programs by Dr. Sheth. Resulting from the conviction of Dr. Bedi and the authority of Illinois statute 305 ILCS 5/12-4.25

(F-5) the Department avoided paying bills totaling \$11,550.00. In August 2009 Dr. Sheth was convicted by pleading to health care fraud, in violation of Title 18, United States Code, Section 1347.

The Bureau of Administrative Litigation is currently pursuing the Termination of this provider.

Restitution

OIG procedures were instituted during 2008 to notify and assist courts in the enforcement of their orders relating to State of Illinois restitution payments. The restitutions are all determined on the courts' findings that an individual or company had either abused or committed fraud within the Illinois Medical Assistance Programs. The restitution determined by the local courts is based on information provided by the OIG through the Illinois Attorney General or the United States Attorney's Office.

The OIG Fraud and Abuse Executive (FAE) closely monitors all the varying parameters in these 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 by the subject, the FAE in turn notifies and works with the responsible courts seeking remedy. During 2009, FAE monitoring resulted in the following actions.

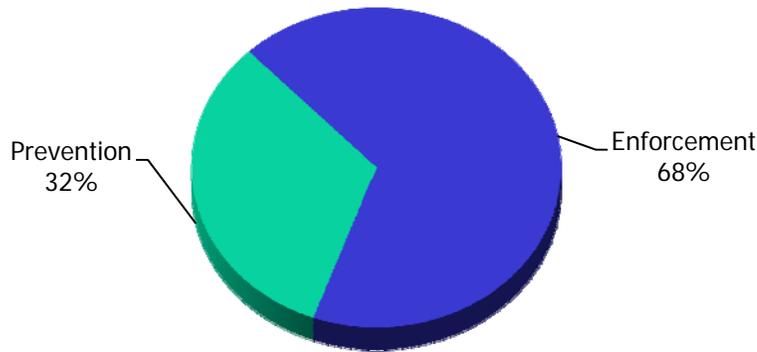
- Irit Gutman, past owner and operator of Universal Public Transportation, a Medicaid Non Emergency Transportation provider was convicted October 2007 of Vendor Fraud, Theft and Money Laundering. Irit Gutman was sentenced to 66 months in the Illinois Department of Corrections and ordered to pay restitution to the State of Illinois Medicaid Program in the amount of \$2,000,000.00. Prior to the FAE communicating with the Illinois Attorney General's Office in early 2009 the Department had only received \$27,000.00 on the court ordered restitution from Irit Gutman. The Illinois Attorney General's Office in pursuit of this conviction restitution located a house owned by Irit Gutman and filed an asset forfeiture hearing which was held in Cook County. The courts agreed with the forfeiture and in August 2009 the Department received a check in the amount of \$107,287.99 from the Illinois Attorney General's Office. The OIG supporting the Illinois Attorney General's Office will continue to pursue any future assets discovered until this restitution is paid in full.
- Dr. William Johnson, a terminated Illinois Medicaid provider, on September 2008 was convicted in Cook County for Vendor Fraud, a Class C misdemeanor and court order to pay restitution to the Illinois Medical Assistance Programs in the amount of \$146,000.00. In December 2008, the FAE contacted the Cook County Adult Probation office to inform them that the OIG had not yet received any restitution, as court ordered, and inquired on their ability to advise the courts. Dr. Johnson was brought back in front of the Cook County Circuit Court and was admonished on his non-payment. In October 2009, the Cook County Courts adjusted Dr. Johnson's restitution payments to \$500 per month until paid in full. Dr. Johnson to date has consistently paid his restitution on the latest order.

FISCAL IMPACT

Fiscal Year Savings

During Fiscal Year 2009, the OIG realized a savings of approximately \$100 million through collections and cost avoidances. This savings was almost five times the OIG FY2009 budget of \$20.3 million.

FY09 Savings



Total = \$99,994,475



Prevention Activities:

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

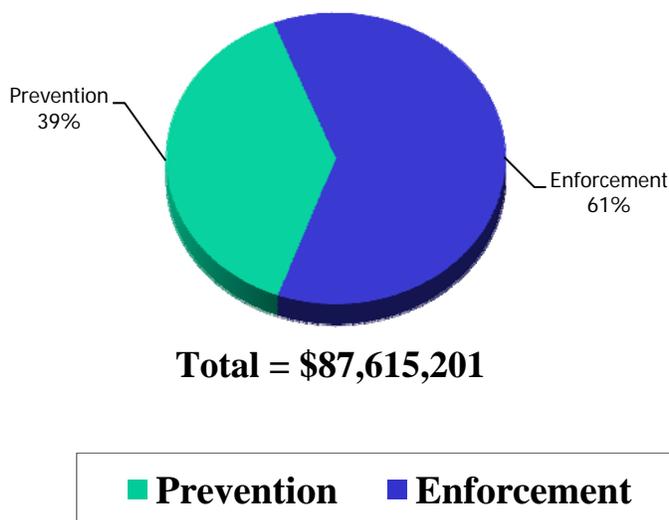
Enforcement Activities:

- 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 2009, the OIG realized a savings of over \$87.6 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 *2009 OIG Savings and Cost Avoidance Tables* portion of this report on the page numbers indicated in parentheses next to the activities listed below.

CY09 Savings



Prevention Activities:

Provider Sanctions Cost Avoidance (*refer to page 48*)
 Food Stamp Cost Avoidance (*refer to page 49*)
 Fraud Prevention Investigations (*refer to page 51*)
 Long Term Care - Asset Discovery Investigations (*refer to page 51*)
 Recipient Restrictions (*refer to page 52*)
 New Provider Verification (*refer to page 53*)

Enforcement Activities:

Provider Audit Collections (*refer to page 46*)
 Fraud Science Team Overpayments (*refer to page 46*)
 Restitution (*refer to page 46*)
 Global Settlements (*refer to page 46*)
 Provider Sanctions Cost Savings (*refer to page 48*)
 Client Overpayments (*refer to page 50*)
 Food Stamp Overpayments (*refer to page 49*)
 Child Care Overpayments (*refer to page 50*)

CONCLUSION

During 2009, 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.

2009 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

Type of Audit	# Recoupments Established	Total Dollars Established
Field	197	\$19,456,333
Desk	130	
Self	9	

Medical Provider Collections

Monies collected are from fraud convictions, provider criminal investigations, civil settlements and global settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or by installments, and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

Medical Provider Collections

Type of Collection	# Cases	Total Dollars Collected
Provider Audits (includes Fraud Science Team Overpayments)	469	\$47,462,913
Restitution	30	
Global Settlements	10	

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

Peer Review Outcomes	# Cases
Letter to Provider with Concerns	92
Letter to Provider without Concerns	28
Referral for Sanction	3
Referral for Audit	26

Sanctions

The OIG acts as the Department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

Sanctions

Hearings Initiated	# Cases
Termination	32
Termination/Recoupment	39
Recoupment	121
Suspension	4
Denied Application	8
Decertification	17
Child Support License Sanctions	72

Final Actions	# Cases	Total Medical Provider Sanction Dollars
Termination	22	Cost Avoidance: \$1,634,258 Cost Savings: \$1,183,861
Termination/Recoupment	18	
Suspension	3	
Voluntary Withdrawal	9	
Recoupment	111	
Decertification Resolution	17	
* Barment	73	

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

Reinstatement Actions on Sanctioned Providers	# Cases
Denied Application	4
Reinstated	1

Administrative Actions for Other State Programs	# Cases	Total Payment Plan Dollars Established
Child Support Delinquencies	67	\$1,574,073
Certified Arrearages	31	
Payment Compliance	36	
State Income Tax Delinquencies	1	
Payment Compliance	1	

Law Enforcement

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

Law Enforcement

Enforcement Activities	# Cases
Referrals to Law Enforcement	161
Law Enforcement Data Requests	134

Client Eligibility

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. Investigation results are provided to DHS caseworkers to calculate the recoupment of overpayments. In cases with large overpayments or aggravated circumstances, the OIG prepared for criminal prosecution and presented to a state's attorney or a U.S. Attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits.

Client Eligibility

Enforcement Activities	# Cases	Total Overpayments Established
Investigations Completed	732	\$3,809,095
Founded	477	
Unfounded	255	
Convictions	28	
Type of Investigations		Percent
Absent Children		12%
Absent Grantee		2%
Assets		5%
Employment		12%
Family Comp/RR In Home		16%
Family Composition		12%
Food Stamp Trafficking		3%
Impersonation		2%
Interstate Duplicate Assistance		3%
Other Income		11%
Prosecution		8%
Residence Verification		12%
SSN Misuse/Discrepancy		2%

Food Stamp Fraud

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

Food Stamp Fraud

Enforcement Activities	# Cases	Total Dollars Established
Reviews Completed	2,598	Cost Avoidance: \$2,042,384 Food Stamp Overpayments: \$1,131,682
Pending Administrative Disqualification Hearing	7,919	
Disqualifications	958	
Unsubstantiated	51	

Child Care

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care at inappropriate rates. The results of these OIG investigations are provided to DHS' Office of

Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. Attorney, or to DHS Bureau of Collections for possible civil litigation.

Child Care

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	9	\$294,454
Founded	9	
Unfounded	0	
Convictions	0	

Client Medical Card Misuse

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

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

Client Medical Card Misuse

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	41	\$121,795
Founded	16	
Founded In-Part	7	
Unfounded	18	

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 fourteen-year estimated average savings of \$13.23 for each \$1.00 spent by the state. FPI has averaged a 66% denial, reduction or cancellation rate of benefits for the 43,805 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over \$118.9 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 2009, the program generated 3,260 investigations, of which, 1,822 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated gross savings for calendar year

2009 of approximately \$10.3 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps.

Fraud Prevention Investigations

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	3,260	\$10,326,300
Denied Eligibility	89	
Reduced Benefits	1,629	
Cases Canceled	104	
Approved	1,438	

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	607	\$12,895,665
Approved		
Impose Sanction Period/Group Care Spenddown	76	
Impose Sanction Period/Regular Group Care Credit	55	
No Sanction Period/Group Care Spenddown	276	
No Sanction Period/Regular Group Care Credit	108	
Denied		
Client Requested Application be Withdrawn	41	
Client Refused to Cooperate/Failed to Provide Verifications	47	
Other		
Returned to Local Office without Recommendation	4	

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
Client Reviews completed	1,817	\$723,422
12 Month Restrictions		
New Restrictions	237	
Released or Canceled Restrictions	108	
Converted to 24 Month Restrictions	117	
24 Month Restrictions		
New Restrictions and Re-restrictions	153	
Released or Canceled Restrictions	58	
Total clients restricted as of 12/31/09	611	

Internal Investigations

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

Internal Investigations

Enforcement Activities	# Cases
Investigations Completed	185
Substantiated	55
Unsubstantiated	128
Administratively Closed	2

Types of Allegations Investigated	Percent
Non-Criminal (Work Rules)	66.0%
Discourteous and Inappropriate Behavior	4.7%
Failing to Follow Instructions	2.1%
Negligence in Performing Duties	20.6%
Conflict of Interest	2.7%
Falsification of Records	3.3%
Sexual Harassment	1.1%
Release of Confidential Agency Records	2.7%
Misuse of Computer	5.1%
Work Place Violence	1.7%
Time Abuse and Excessive Tardiness	4.8%
Conduct Unbecoming State Employee	17.2%
Criminal (Work Rules)	9%
Theft or Misuse of State Property	2.6%
Misappropriation of State Funds	0.7%
Commission of or Conviction of a Crime	1.6%
Criminal Code ILCS 720	4.1%
Security Issue, Contract Violation	22.9%
Special Project, Background Check, Assist other Agencies	2.1%

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 2009 are listed below.

Misconduct Outcomes	# Actions
Misconduct Identified	29
Employee	26
Vendor	3
Misconduct Resolutions	46
Discharge	7
Resignation	4
Suspension	15
Other, such as reprimands	8
Referred to Other Sources for Resolution	1
Administrative Action Pending at Year End	9
No Action Taken by Agency	2

New Provider Verification

Monitoring of non-emergency transportation and durable medical equipment providers began in June 2001 by performing pre-enrollment on-site visits to verify their business legitimacy and by performing analysis of their billing patterns to detect aberrant behaviors. 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.

Applications are returned and enrollment is not authorized for 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. Once the applicant has addressed the issue(s) and re-submitted the application, the New Provider Verification process is restarted. An applicant can also be 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.

New Provider Verification

Enforcement Activities	# Cases	Total Cost Avoidance
Reviews Completed	238	
Enrolled	202	
Not Enrolled		
Applications Returned	35	
Applications Denied	1	
		\$6,111,166

APPENDIX A - OIG PUBLISHED REPORTS

Title	Date	Description
<i>Office of Energy Assistance Low Income Home Energy Assistance Program Report</i>	December 2009	Study reviewed Low Income Home Energy Assistance Program (LIHEAP) application and approval processes to determine the eligibility of households that received benefits. Recommended verifying household composition and reported income as part of the LIHEAP application process.
<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.
<i>Non-Emergency Medical Transportation Reviews: Focusing on Compliance</i>	December 1999	A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation.

Title	Date	Description
<i>Project Care: Exploring Methods to Proactively Identify Fraud</i>	December 1999	Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.
<i>Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments</i>	December 1999	Recommended methods by which non-institutional post mortem payments could be identified more quickly.
<i>Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century</i>	September 1999	Verified the cost-effectiveness of searching for assets of LTC applicants.
<i>Recipient Services Verification Project: RSVP II-Home Health Care</i>	August 1999	Confirmed receipt by clients of home health care services.
<i>Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues</i>	June 1999	Validated the effectiveness of the project's error-prone criteria and processes.
<i>Fraud Prevention Investigations: FY98 Cost/Benefit Analysis</i>	December 1998	Identified an estimated \$4 million in net savings with a benefit of \$14.25 for every dollar spent.
<i>Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices</i>	October 1998	Examined weaknesses in the security of the agencies and proposes several recommendations for improvement.
<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.

Title	Date	Description
<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. 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
CY2009*

Total Number of Scripts	28,238,640	
Amount Payable		\$1,529,670,049
Scripts Not Subject to RTS	63,594	
Amount Payable		\$6,772,339
Scripts Subject to RTS	28,175,046	
Amount Payable		\$1,522,897,710
Rejected Number of Scripts		1,401,328
Estimated Savings		\$91,273,944

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 2009 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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