



Office of Inspector General

Illinois Department of
Healthcare and
Family Services

2010 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
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John C. Allen IV
Inspector General

June 20, 2011

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 2010. 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 2010 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 2010**

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 2010, the OIG had an authorized staffing of 181 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 2010, 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 2010, the OIG established \$18,010,444 in provider overpayments, which were identified through post-payment compliance audits conducted on providers enrolled in the Illinois Medical Assistance Program. The majority of these audits were conducted by a combination of OIG Bureau of Medicaid Integrity (BMI) staff auditors and vendors who were contracted by the Department to conduct audits on its behalf. BMI staff auditors performed audits on all types of providers, while the contractors were only utilized to conduct audits of Long Term Care facilities and Inpatient Hospitals.

In 2010, the OIG completed 302 audits of various medical providers participating in the Medicaid program. This total number included both desk audits and traditional field audits where auditors physically visited the providers' facilities.

DRG Inpatient Audits

The Inpatient Hospital Audit Program (IHAP) was implemented during 2010 to identify and recoup erroneous inpatient billings and to help hospitals understand proper billing practices. Contracts were finalized with two vendors to conduct the IHAP audits. As of the close of 2010, ten of these audits had been approved and distributed. It was anticipated that these full-scale reviews of hospital Medicaid billings would result in significantly increased collections of overpayments. The ten IHAP audits completed identified a potential recoupment of over \$4 million.

Client Prosecution Cases

During 2010, the Bureau of Investigations (BOI) referred 25 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 Department of Education
Unreported Income / Use of False SSN

An investigation found that the client assumed various names and identities for herself and her family members to apply for and receive cash and medical assistance, Supplemental Nutrition Assistance Program (SNAP) benefits and childcare payments. She reported false information, used numerous fictitious identities and had multiple sources of unreported income. The case was combined with the OIG – U.S. Department of Education and referred for federal criminal prosecution. The case was referred to the U.S. Attorney's Office – Northern District Illinois (NDI) in August 2007. The BOI referral included an overpayment totaling \$92,170.91 comprised of the following: \$20,418 financial assistance; \$25,908 SNAP benefits; \$3,485.72 medical benefits; and \$42,359.19 child care benefits. On January 15, 2010, the client was convicted of one count of Mail Fraud for her fraudulent receipt of Child Care benefits. As a result, she was sentenced to 90 days in the U.S. Bureau of Prisons; two years supervised release; five months home confinement with electronic monitoring; \$100 assessment fees and \$45,902 in restitution (\$42,358 to the Department of Human Services (DHS) Bureau of Child Care and Development, \$2,531 to the U.S. Department of Education and \$1,013 to the Illinois Student Assistance Commission). The U.S. Attorney's Office did

not include the public assistance benefits in the prosecution case and that overpayment was referred to DHS for collection activity.

- Prosecution Investigation—Joint Investigation with HHS and IRS
Child Care Provider Fraud

The DHS Bureau of Child Care and Development (BCCD) referred an allegation of fraud to BOI regarding a child care provider in St. Clair County. The director and owner of the child care facility was also a SNAP and Medicaid recipient in St. Clair County and allegedly did not report income from her business to DHS.

Additional agencies which investigated this case with BOI were the U.S. Department of Health and Human Services Office of Inspector General (HHS – OIG) and the Internal Revenue Service Criminal Investigations (IRS). The Illinois Department of Children and Family Services Office of Inspector General (DCFS-OIG), the U.S. Department of Agriculture Office of Inspector General (USDA-OIG), the U.S. Postal Inspector and the Federal Bureau of Investigation (FBI) also assisted in the investigation.

The investigation found a total of \$26,427 in SNAP fraud and \$169,263 in child care fraud. Additional losses to the government allegedly occurred in bankruptcy fraud and tax losses. The subject pled guilty to a three count Indictment in the U.S. District Court – Southern District Illinois (SDI) in East St. Louis. The day care center, represented by the husband also pled guilty to a one count Indictment by falsely billing for \$150,652.84 in child care funds.

Sentencing hearings for these cases were held on March 18, 2010 in the U.S. District Court – SDI. The subject was sentenced to 25 months incarceration with the U.S. Bureau of Prisons followed by three years of supervised release. She was also ordered to pay a total of \$452,254.86 in restitution and \$300 in special assessments. Restitution was ordered to be paid to DHS for \$169,263.11 for child care; \$26,427 for SNAP and \$7,367.75 for Medicaid. The day care center was also ordered to pay \$169,263.11 in restitution to DHS along with a \$400 special assessment.

- Prosecution Investigation
Unreported Income / Child Care Recipient Fraud

This case was referred to BOI from the Social Security Administration Office of Inspector General (SSA-OIG) and the U.S. Department of Veterans Affairs Office of Inspector General (VA-OIG). The subject allegedly resided with her spouse in Madison and St. Clair Counties, and he had income from VA and SSA disability benefits. There was a SNAP overpayment of \$1,803 in St. Clair County, Illinois from April 2007 through March 2008 and a child care overpayment of \$2,890 in Madison County, Illinois from November 2007 through March 2008.

The criminal prosecution investigation report was completed and presented to the U.S. Attorney's office – SDI. In addition to SNAP and Child Care overpayments, both subjects received overpayments of \$107,857 from the VA and \$28,730 from SSA. They were charged in a six count indictment by the U.S. District Court – SDI. According to the indictment, the

husband was a member of the U.S. Army who was about to be deployed when he had a one car vehicle accident. He allegedly faked his paralysis, defrauded the VA and the SSA and filed a bogus personal injury lawsuit.

Both defendants pled guilty to all counts at the U.S. District Court – SDI. The husband was sentenced on April 23, 2010 to 78 months of imprisonment; three years supervised release and \$314,806 in restitution. The wife was sentenced on April 26, 2010 to 24 months of imprisonment; three years supervised release and ordered to pay \$241,244.02 in restitution.

- Prosecution Investigation
Child Care Recipient Fraud

This case was referred to BOI from an anonymous caller to the DHS fraud hotline and investigated jointly by BOI and SSA – OIG. The subject allegedly received SSI benefits and SNAP benefits in Randolph County for a child who did not live with her.

The investigation resulted in a SNAP overpayment of \$8,844 from October 2005 through August 2008, and an SSI overpayment of \$35,164 from May 2004 through February 2009. This subject was indicted by the U.S. District Court – SDI on five counts of making false statements to receive SSI and SNAP benefits.

While on bond a second investigation was initiated by BOI alleging that the subject had a child care recipient overpayment of \$8,982.86 from November 2005 through March 2010.

The subject pled guilty on June 23, 2010 to the original counts and to the additional indictment charge of making false statements to receive child care assistance. On July 16, 2010 she was sentenced to 21 months of incarceration in the U.S. Bureau of Prisons with 36 months of supervised release to follow concurrently and she was ordered to pay \$27,836.86 restitution.

- Prosecution Investigation
Child Care Fraud

An investigation found that a child care provider created a false household including three children to receive child care payments. The Attorney General's Office requested BOI's assistance in determining the validity of the Social Security numbers assigned to household members for which child care benefits were being paid by DHS. In September 2010, the investigation was referred to the Assistant Attorney General because none of the Social Security numbers were assigned to the reported persons in the child care household. The Attorney General's Office will use the information to prosecute the provider whose overpayment was originally referred to them for civil action.

- Prosecution Investigation
Child Care Fraud

This case was referred to BOI by the U.S. Probation Office. A St. Clair County resident allegedly received Child Care assistance with her husband named as the

provider. She did not report her marriage to DHS Bureau of Child Care and Development. Her husband was also convicted of a felony which made him ineligible to be a child care provider.

This case was referred by BOI to the St. Clair County State's Attorney in October 2010. A guilty plea was entered on November 19, 2010. The defendant was ordered to serve 30 months probation including twelve months of intensive probation and to pay \$6,601.69 in restitution and all court costs and fees.

- Prosecution Investigation
Child Care Fraud / Household Composition

This case was referred from DHS on April 7, 2009. The subject was receiving child care assistance and SNAP benefits from DHS. The subject failed to report that her husband was residing in her household and his income was not being budgeted on her assistance case. Tax records, Secretary of State records, employment records, bank records and interviews with neighbors verified the subject's husband in the household.

The total SNAP overpayment for the period of August 2008 through March 2009 was \$3,576, and the total child care overpayment for the period February 2003 through February 2009, was \$76,474.74. BOI prepared a prosecution report and referred it to the Sangamon County State's Attorney on November 10, 2010. The case is pending review with the Sangamon County State's Attorney.

- Prosecution Investigation
Household Composition / Responsible Relative in the Home

The OIG received an anonymous referral alleging that a recipient in Peoria County failed to report to DHS that the father of her child was living in the assistance unit. The investigation found the recipient failed to report that from July 2008 through September 2009 the father of the recipient's child lived in the recipient's home, during which time the father of the child had income from employment. The SNAP overpayment for this case totaled \$6,365, and in February 2010 the recipient was indicted in Peoria County on one count of State Benefits Fraud (Class 3 Felony).

- Prosecution Investigation
Household Composition / Unreported Income

An investigation found the client failed to report her marriage or the earned income of her spouse. Additionally, she used her married name and a second Social Security number to conceal her own employment and their joint assets. The case was combined with the SSA-OIG's investigation and referred for federal criminal prosecution. The case was referred to the U.S. Attorney's Office – NDI in August 2007. BOI's referral included a \$27,260.17 overpayment which was comprised of; \$2,408.17 in financial assistance and \$24,852 in SNAP benefits. On March 9, 2010, the client pled guilty to one (1) count of Wire Fraud and was sentenced to 3 years probation and \$119,125 in restitution; \$26,795 for her public assistance benefits and \$92,330 for her Social Security benefits.

- Prosecution Investigation—Joint Investigation with SSA
Unreported Income

This case was referred to BOI by the SSA and was jointly investigated by BOI with SSA – OIG. The subject allegedly received SSA benefits for her mother after her mother passed away. She also received SNAP benefits in St. Clair County and did not report the receipt of that income to DHS. She received a total SNAP overpayment of \$4,899 from August 2001 through December 2007. She also received an SSA overpayment of \$56,176.

The subject was indicted on four counts of making false statements and theft of government funds by the federal grand jury at the U.S. District Court in East St. Louis on July 21, 2009. Arraignment was held on August 6, 2009 and the subject pled guilty on December 3, 2009. She was sentenced on April 1, 2010 to six months home confinement, five years probation and ordered to pay restitution of \$4,899 to DHS and \$56,176 to SSA.

- Prosecution Investigation
Impersonation / False Identity

An investigation found that a subject used another person's identity to obtain public assistance benefits in Illinois. In this case, the subject fraudulently assumed the identity of another person by using the other person's name, date of birth and Social Security number to apply for and receive public assistance in that person's name. The case was referred to the Cook County State's Attorney's Office in November 2008, for criminal prosecution. BOI identified an overpayment of \$121,091.70; \$39,120 in SNAP benefits and \$81,970.70 in Medicaid assistance. On April 1, 2010, the client pled guilty to one count of Identity Theft and was sentenced to 18 months incarceration in the Illinois Department of Corrections, one year mandatory supervisory release and fines of \$510. The case was also referred to DHS for collection activity.

- Prosecution Investigation
Unreported Income

BOI received a referral that a recipient in Knox County was not reporting to DHS that she had income from employment and that a member of her assistance unit also had income from employment. The investigation found that from April 2006 through September 2008, the client and the client's boyfriend, a reported member of the assistance unit, each had income from employment which the client failed to report to DHS. The SNAP overpayment for this case totaled \$8,701.

On November 24, 2009 the recipient was charged by the Knox County State's Attorney's Office with one count of State Benefits Fraud (Class 3 Felony). On April 16, 2010, the recipient pled guilty to a reduced charge of Theft (Class A Misdemeanor). In court on April 16, 2010 the recipient paid full restitution in the amount of \$8,701 by check and was placed on 12 months of Court Supervision and was also ordered to pay \$300 in court costs.

- Prosecution Investigation
Household Composition / Responsible Relative in the Home

An investigation found that a client failed to report her true household composition, income and assets by failing to report the presence of her husband in her household. The investigation also found unreported assets of real estate and bank accounts. The case was referred to the Cook County State's Attorney's Office for criminal prosecution on June 1, 2010. BOI identified a SNAP overpayment of \$30,640. The case has been assigned to an assistant state's attorney, and information from an asset forfeiture case is being reviewed in conjunction with the prosecution case.

- Prosecution Investigation—Joint Investigation with SSA, HUD and Homeland Security
Unreported Income / SSN Misuse

An investigation found that a client failed to report income she earned while using an alias Social Security number. In addition, it was determined that the client moved to the state of Louisiana, but continued to receive SNAP benefits from Illinois. The investigation was worked with the SSA-OIG, Housing and Urban Development Office of Inspector General (HUD-OIG) and Homeland Security Office of Inspector General (HS-OIG). The case was referred to the U.S. Attorney's Office – NDI on July 22, 2009. BOI identified a SNAP overpayment of \$8,382. Although the client and her mother were indicted on April 22, 2010, the indictment did not include the public assistance benefits. The overpayment was sent to DHS for collection activity.

- Prosecution Investigation
Unreported Income

This case was referred to BOI by an anonymous complainant to the White County DHS Family Community Resource Center. A White County resident allegedly failed to report that she and her husband were employed in Indiana while receiving assistance in Illinois.

This case was investigated by BOI and showed that the subject received a SNAP overpayment of \$14,315 from February 2006 through May 2008. The prosecution investigation report and evidence was presented to the White County State's Attorney in November 2009.

The subject was charged with one count of State Benefits Fraud by the White County Circuit Court in November 2009. She pled guilty to the felony charge on June 28, 2010 and was sentenced to six months incarceration in the White County Jail and two years of probation. She was also ordered to pay restitution of \$14,315 and all court costs and fees.

- Prosecution Investigation—Joint Investigation with SSA and HUD
Household Composition / Unreported Employment

An investigation found that a client failed to report her true marital status, household income and employment. This investigation was working in conjunction with the HUD OIG and the SSA OIG and combined with their investigations for criminal prosecution. The case was referred to the Attorney General's Office in February 2008. BOI's referral included a \$76,021 overpayment comprised of \$36,457 in financial assistance and \$39,564 SNAP benefits. In July 2008, the client was indicted on three counts of Theft and eight counts of Forgery; one count of Theft and two counts of Forgery were specifically related to BOI's

investigation. On August 3, 2010, the client pled guilty to one count of Theft and was sentenced to two years incarceration in the Illinois Department of Corrections and fines of \$535.

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

An investigation found that a client failed to report his receipt of public assistance and Social Security benefits in his name and an alias name. The case was worked with the SSA-OIG and combined with their investigation for federal criminal prosecution. The case was referred to the U.S. Attorney's Office – NDI on November 5, 2009. BOI identified an overpayment of \$28,126; \$1,151 in financial assistance and \$26,975 in SNAP benefits. On August 3, 2010, the client was served with a target letter due to the SSA and public assistance fraud. The SSA investigator has appeared before the Grand Jury and action is pending on the public assistance fraud.

- Prosecution Investigation—Joint Investigation with SSA
Absent Children

This case was referred to BOI by the SSA and was jointly investigated by BOI and SSA – OIG. The subject allegedly received SNAP, Medicaid and Supplemental Security Income (SSI) in St. Clair County for herself and for children who did not live with her. The case resulted in a SNAP overpayment of \$11,712 from September 2004 through April 2008 and a Medicaid overpayment of \$3,374 from September 2004 through June 2009. The subject also received an SSI overpayment of \$26,909.18.

This subject was indicted on four counts of making false statements by the grand jury at the U.S. District Court – SDI. She pled guilty to all four counts on March 8, 2010. She was sentenced on August 31, 2010 to five months of incarceration, five months of home confinement, and three years of supervised release. She was also ordered to pay restitution of \$41,995.18 including \$11,712 in SNAP and \$3,374 in Medicaid.

- Client Eligibility Investigation
Unreported Income

BOI received a referral that a client was submitting falsified pay stubs from her employer, the United States Postal Service (USPS). The investigation found that the client was altering her paycheck stubs from the USPS using a personal computer. The client was underreporting her income to DHS in order to remain eligible for SNAP benefits. The Bureau notified the USPS Office of Inspector General (USPS-OIG) that the client had been submitting falsified check stubs to DHS. The client was terminated from her job with the USPS in August 2010. The results of the investigation were submitted to the local DHS office, which calculated that the client had received an overpayment of \$6,687 in SNAP benefits.

- Prosecution Investigation—Joint Investigation with SSA
Impersonation / Multiple Assistance

An investigation found that a client failed to report his receipt of public assistance and Social Security benefits in his name and another alias name. The investigation determined that the client assumed the identity of his deceased brother to receive benefits in his second public assistance case. The case was worked with the SSA-OIG and combined with their investigation for federal criminal prosecution. The case was referred to the U.S. Attorney's Office – NDI on February 26, 2009. BOI's referral included a \$49,048.51 overpayment comprised of \$10,553.18 in financial assistance, \$16,711 in SNAP benefits and \$21,784.33 in Medicaid benefits. On November 13, 2009, a plea agreement was reached and on September 16, 2010, the client pled guilty to one (1) count of Theft of Government Theft and was sentenced to 3 years probation with the first 9 months in home detention and electronic monitoring, a \$100.00 special assessment fee and \$80,703 in restitution including \$49,049 based on BOI's investigation.

- Prosecution Investigation—Joint Investigation with US Department of Justice Unreported Income

The U.S. Department of Justice, National Center for Disaster Fraud (NCDF) Task Force referred this case to BOI. A St. Clair County resident allegedly failed to report that she received income from employment and resided with her husband who had SSA income while receiving SNAP benefits in St. Clair County. The couple also applied for and received federal disaster relief benefits claiming losses related to hurricane damage.

This case was jointly investigated by BOI for the NCDF with the U.S. Attorney – Southern District of Illinois, the U.S. Postal Inspector, USDA–OIG, and the SSA–OIG. The subject received an overpayment of \$11,280 in food stamps from March 2006 through March 2009.

Both parties were indicted on four counts of disaster relief fraud by the U.S. District Court – SDI on August 18, 2010. The wife was also indicted on five counts of fraud, including four counts of making false statements to the USDA in order to receive SNAP benefits. She pled guilty to the charges on November 10, 2010 at the U.S. District Court – SDI in East St. Louis.

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

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

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

Since the inception of the EBT Program in 1999, SNAP Fraud Unit has received 35,636 referrals from the USDA Food and Nutrition Services (FNS) and 590 referrals from field staff and hotline calls. According to the FNS Midwest Regional Office Director, Illinois is the most active State in the Midwest Region in pursuing clients suspected of EBT fraud.

“Illinois has the longest running EBT client integrity project in the Midwest Region and continues to be a leader in this area. Illinois’ success could not have been achieved without a commitment to integrity and the dedication of your staff and resources to this important project. Illinois staff continues to be a pleasure to work with on these activities.

Illinois has been 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.”

*Trish Solis, MWRO Director
Supplemental Nutrition Assistance Program*

In 2010, SNAP Fraud Unit received a total of 824 SIPV and 1,539 EBT referrals. The Unit, completed 1,877 reviews, participated in 2,571 Administrative Disqualifications Hearings and processed 24 prosecution disqualifications. 799 administrative hearing decisions were rendered of which 748 were positive, resulting in disqualification of the client. Eight of the positive hearing decisions had overpayments of over \$10,000. In addition, FSFU processed 409 signed waivers (client admission of guilt), with 19 of the signed waivers with overpayments over \$10,000. SNAP Fraud Unit efforts in 2010 resulted in cost savings to the State of Illinois of \$2,537,862. Two particular noteworthy cases are:

- SNAP Fraud Unit attained a signed Waiver for a client receiving duplicate assistance in two Illinois counties using a false name. The cost avoidance for this ten year disqualification was \$48,000.
- SNAP Fraud Unit received a positive hearing decision resulting in a ten year disqualification for receiving duplicate assistance in two states. The cost avoidance for this ten year disqualification was \$169,920.

HFS Employee Investigations

The OIG Bureau of Internal Affairs (BIA) completed 205 employee and vendor investigations during 2010. Several of these cases are described below:

Workplace Bullying and Other Inappropriate Behavior

Bullying is something we tend to associate with schoolyards and playgrounds. An aggressive child picking on a classmate is the vision that often comes to mind. Unfortunately, bullies also exist in the workplace and workplace bullying may be considered one of the foremost job stressors for many Americans. The *Workplace Bullying Institute* defines workplace bullying as repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators that take one or more of the following forms:

- Verbal
- Offensive conduct/behaviors (including non-verbal) which are threatening, humiliating, or intimidating
- Work interferences

According to the *Workplace Bullying Institute's* latest annual survey, 35 percent of the U.S. workforce report being bullied at work. This percentage represents an estimated 53.5 million workers who experienced bullying firsthand in 2010. Victims of workplace bullying experience distress, humiliation, anxiety, lower levels of job satisfaction and turnover. Numerous states including Illinois are considering legislation that addresses bullying in the workplace.

Additionally, an Illinois Task Force on Workplace Bullying was created in 2009 to study workplace bullying and the impact of that conduct.

HFS offers excellent training programs that address professionalism at work, temperament, appropriate communication and attitude as well as management and leadership skills related courses. Also, the Bureau of Training publishes a monthly e-mail newsletter for managers and supervisors that focus on coping with workplace negativity and other relevant workplace subjects. Lastly, HFS has policies in place that address inappropriate behavior, discourteous treatment of co-workers and hostile work environment. However, despite training and policies available, a number of HFS employees choose to engage in workplace bullying and other forms of inappropriate work behavior.

- While conducting an investigation into a single allegation of sexual harassment, investigators uncovered evidence that established a widespread practice of workplace bullying, sexual harassment and inappropriate behavior within a unit overseen by three male supervisors. Some culpability for the supervisors' behavior going unaddressed was traced to higher levels of the management staff. Investigators interviewed a large number of current and former staff, and an overwhelming majority of them described the unit's environment as stressful and intolerable. One individual commented that working in the unit was more stressful than a previous job working in a correctional center and yet another described his experience in the military as less stressful. Former and current employees of the unit were clear when they explained to investigators that it was not the work, but the workplace, that was intolerable. Employees reported they started taking prescription medications, using available benefit time as it became available, becoming physically ill and using family medical leave time due to the conditions in the unit. Employees took demotions, transfers and several even quit to escape the working conditions.

Some of the more egregious behavior of the supervisors included regularly threatening male and female employees with non-certification, discipline up to and including discharge, and prosecution if they provided incorrect information to clients. Incidents of inappropriate staring, unwanted touching, kissing, hugging and fondling; standing in one's personal space, yelling at staff in front of co-workers and making condescending and demeaning remarks to subordinates were recounted. Female staff reported intentionally avoiding their male supervisors. One female would back her chair up to the wall to avoid having her supervisor approach her from behind; another female would use her straight-arm to maintain a distance from her supervisor in order to avoid his unwanted hugging and touching.

Based on evidence developed during the investigation, one of the supervisors and his manager were determined to have engaged in national origin discrimination. A Hispanic female employee was told by her male supervisor to "lose her accent" or be fired. The remark was repeatedly made to the employee. The unit manager also admitted culpability by condoning some of the supervisor's actions. Because of the bullying behavior of her supervisor, the employee quit her job to avoid the anticipated discharge. The affected employee was later reinstated to the Department after investigators brought the incident to the attention of the Department's personnel office.

Two of the male supervisors resigned during their Internal Affairs interviews; the third supervisor received a 29-day suspension. A manager who was responsible for the supervisors was cited for numerous HFS policy violations including negligence in the performance of her job duties. While the investigation remains underway, the manager has accepted a reassignment and disciplinary action is currently pending against her.

- In another division, a unit supervisor was reportedly becoming increasingly aggressive, confrontational and threatening towards his staff and other workers in the area. The conduct had been gradually escalating over several months and was documented as cursing, screaming, shouting, fists clinching and arm waving in an aggressive manner. Because of the bullying-style behavior exhibited by the supervisor, staff told investigators they were concerned for their emotional and physical safety. Nineteen employees and one non-employee were interviewed. In addition to establishing a pattern of intimidating and threatening behavior, it was discovered that the supervisor made sexual innuendoes to staff and a non-employee and behaved in a stalking and harassing manner towards a female subordinate employee. The employee described her supervisor's behavior towards her as a "fixation." When interviewed, the supervisor admitted his behavior was unprofessional and inappropriate. The supervisor was previously disciplined for similar behavior in 2008 that led to a five-day suspension and a Last Change Agreement which gave the agency the right to random drug/alcohol testing. The Department was in the process of issuing the employee a suspension pending discharge action, for his more recent unprofessional conduct; however, in November 2010, the employee submitted to a random drug test, which resulted in a positive finding for illegal drugs. The employee voluntarily resigned in lieu of discharge in December 2010 based on the results of that test and the pending charges.

- An office coordinator allegedly made threatening, profane and sexual orientation remarks to a co-worker after the co-worker removed the office coordinator's bowl of oatmeal from the office microwave. On the following day, the office coordinator continued to refer to the co-worker in a profane and demeaning manner and was allegedly overheard threatening to kill the co-worker. The investigation determined there was sufficient evidence to support the allegations contained in the initial complaint. The office coordinator admitted that she was upset with her co-worker for removing her unattended oatmeal from the office microwave. According to witnesses, the office coordinator's profane and demeaning manner towards the co-worker went on for nearly two days. The alleged threat to kill comment was overheard by another worker while the office coordinator was on the telephone. The witness could not confirm that the threat was directed towards the co-worker who removed the bowl of oatmeal. The office coordinator denied making any sexual slurs and denied threatening her co-worker. The office coordinator was issued a five-day suspension.

Falsification of Official Agency Records

The scope of these investigations run the entire gamut of paperwork submitted through official channels for official documentation for employment, fiscal, payroll, and attendance purposes. Sometimes other areas of misconduct are discovered during one of these investigations. There is a multiplicity of investigative tools and techniques that are employed, usually involving intense analysis of large amounts of data. Some cases require surveillance while other cases benefit from computer forensic examinations. If the employee travels in the course of their job duties, travel vouchers have to be scrutinized. If the case involves a secondary employment issue, then the secondary employer's records may have to be obtained and examined. Computer forensics may also have to be performed on an employee's hard drive to ascertain if false documents were created on the employee's computer.

- It was reported that an Office Coordinator (OC) was on a Leave of Absence, Non-Service Disability and had applied for and received SNAP benefits. When she returned to work, she failed to notify DHS to cancel her SNAP case. Her failure to request cancellation of her case resulted in a \$2630 overpayment. The employee then ignored DHS's efforts to recoup this amount.

The investigation determined the OC committed Public Assistance Recipient Fraud when she received SNAP benefits between December 2008 and January 2009 to which she was not entitled. The initial overpayment for \$2630 covered the period from April 2009 to August 2009. When investigators examined her reported earnings from December 2008 to January 2009, it was determined that she had not truthfully reported all of her earnings for this period. Since she had not reported all her earnings between December 2008 and January 2009, her overpayment increased from the initial \$2630 amount to \$3,313 for the final overpayment period from December 2008 to August 2009.

A review of a Family Medical Eligibility Redetermination Form, dated March 13, 2009, indicated that she was still on a leave of absence but she had already returned to full employment on March 2, 2009. When the employee was interviewed, she was allowed an opportunity to explain why she failed to disclose all her available earnings/income when she applied for SNAP and medical assistance. She admitted to submitting false

information regarding her employment status and earned income so she could continue to receive public assistance.

The Office Coordinator was discharged for cause in July 2010.

- Human Resources staff advised Internal Affairs that a Division's Trainee had told her that he had not reported all of his prior criminal convictions on his CMS 100 application. He provided an addendum to the staff person stating that in January 1993 he was convicted of Aggravated Criminal Sexual Assault in Madison County, Illinois and was sentenced to four years probation.

We reviewed the CSST's application documents which showed that he had also reported convictions in November 1999 for DUI in Green County, Illinois; March 2002 a second degree felony conviction for possession of cocaine and sentenced to five years imprisonment in Texas; and in June 2006 a conviction for manufacturing and delivery of cannabis and was sentenced to 4 years incarceration at the Department of Corrections in Taylorville.

Illinois State Police, Division of Internal Investigation, verified the trainee's Illinois convictions for DUI, Criminal Sexual Assault, and the Manufacture and Delivery of Cannabis, and Threatening a Public Official in Madison County, Illinois, which he had omitted from his state employment application (CMS 100). Internal Affairs investigative resources revealed that the trainee failed to report on his CMS 100 drug and weapons convictions in 1989 in Florida, unlawfully carrying of a weapon and DUI in Texas in 1991, and two counts of Threatening a Public Official in Madison County, Illinois in 1994.

During the interview, the employee acknowledged his unreported Illinois and out-of-state convictions. Further, when questioned about his work history, he volunteered that in 1982 he enlisted in the United States Navy and went Absent Without Leave (AWOL) for 29 days in 1982 following an alleged rape committed on him. He further claimed that he was subsequently honorably discharged from the Navy.

After the trainee admitted he had failed to report his true and accurate criminal convictions and work history, he resigned his position with the agency in May 2010, waiving all reinstatement rights to the State of Illinois and agreed not to seek or accept employment with HFS or the State of Illinois in the future.

- An agency-wide check of attendance records on all Health Facilities Surveillance Nurses (HFSN) revealed an inordinate amount of secondary employment income from three separate employers for one HFSN. Records were obtained by subpoenas from all three employers seeking the work schedules, payroll, times and locations of the HFSN's home visits while working for the three secondary employers for the previous three years. The investigation disclosed overlapping employment over a three-year period wherein she traveled to home healthcare assignments either from her office or while on Department surveys during Agency work hours to perform her visits to secondary employer's patients at the patient's homes.

In addition to the HFSN conducting secondary employment during regular hours at her HFS job, we determined that she had, on 33 separate occasions, utilized sick leave to conduct her secondary employment. Because of the overlapping employment hours between HFS and the secondary employers, the HFSN had falsified numerous payroll, travel vouchers and attendance records.

During the interview in March 2010, when confronted with the evidence, the employee resigned her position with the agency and agreed to no reinstatement rights and to not seek or accept employment with the State of Illinois in the future.

- During July 2009 Internet monitoring, investigators discovered a user, who because of the sites being visited and the frequency of the visits to a certain website, may be using HFS resources to peruse personal interests. Based upon these results, Internal Affairs launched a more in-depth review of this user's activities.

The most egregious of those activities revolved around her secondary employment. The employee had taught for years as an adjunct professor at two separate institutions of higher education. From an examination of her available tax records and cross-referenced to data on attendance records, investigators discovered she has had these employment relationships since at least 2005.

Although HFS was aware of her status as an adjunct professor, it was agreed that the duties and times of her teaching responsibilities would not conflict with her regular duties with HFS. Unfortunately, there were discrepancies noted on her time sheets. The hours that were recorded did not reflect her early departures or late arrivals attributed to conflicts with her secondary employment.

Also, since January 2009, she had signed off as the Reconciler for Time Roll reports and forwarded them to payroll. Most of these reports contain false information regarding the actual time she was at work. Thus, she received payroll funds that she was not entitled, fraudulently obtained and signed off on as reconciler verifying the accuracy of the payroll report.

Intermittent surveillance was conducted on this employee between September 18, 2009 and February 26, 2010. The surveillance afforded us the opportunity to make two basic observations. First, we were able to establish a pattern for her computer logon times and logoff times in relation to her actual departures and arrivals to work. We found that she logged in shortly after she was observed arriving and logged off shortly before she departed her office.

Secondly, we were able to confirm from the surveillance that on days she had scheduled classes, she either arrived late in the mornings to accommodate teaching in the mornings or left early from work to teach her evening class. By factoring the travel time between her office and the locations of her secondary employment located out of area work sites, we determined that in order for her to be "on time" for any of her classes, she would have to take time away from her state employment in commensurate travel time. With the exception of our surveillance where we actually observed the employee's late arrivals and early departures, we were able to deduce all the potential time abuse and

tardiness issues based upon the data we collected. The potential time abuse totaled over 900 hours. This conduct resulted in falsification of Agency records that corresponded to only those dates she taught classes at her secondary employers and early departures on dates when there was no evening class scheduled.

We discovered that one of the colleges was also paying travel compensation as if she were traveling from her home to the college work site. We secured all 2005 through 2009 travel vouchers from the college in order to cross-index self-reported attendance at the classes and computer log on/log off times at her office. Likewise, we reviewed her completed HFS C-10 Travel Vouchers for accuracy of data on the dates she had taught classes for either of her secondary employers. There were several irregularities and apparent falsified data noted on the travel vouchers.

We learned that in December 2009, because of inclement weather, the employee sent email to her students from her state computer providing an access number and passcode to a conference call to be conducted at the regularly scheduled class time at 6:00 p.m. We identified the number as belonging to the Agency with the gateway registered to another employee. Surveillance confirmed that a call was placed and a number of students connected into the call and participated in an abbreviated class. The call was placed from the employee's state telephone in her office. In addition, telephone call logs from her office telephone also confirmed that she initiated multiple calls to her students and secondary employer throughout the day as she had done on other dates we discovered from call detail records and had failed to record any of the calls on official Agency records.

During the employee's Internal Affairs interview in March 2010, she resigned her position with the Department, agreed to no reinstatement rights with HFS and to not seek or accept future employment with the state of Illinois. In addition, she signed a voluntary repayment agreement to reimburse the Department a total of \$6,584.42 for compensation she and was not entitled to receive. She further agreed to waive any appeal of an involuntary withholding process in the event she fails to abide by the voluntary repayment agreement.

- An Administrative Assistant 1 was suspected of leaving work early without taking Available Benefit Time (ABT). Internal Affairs conducted surveillance, examined ABT records, Employee Daily Time Logs (HFS 163) and computer audit reports that captured the employee's computer log-in/log-out times. The investigation established a pattern of time abuse and falsification of time keeping records. The employee had entered false arrival and departure times on twenty-three HFS 163s. We calculated that her tardiness and unauthorized absences totaled 39 hours and 21 minutes. HFS' Payroll Unit determined that her unauthorized absences equated to \$976.44. The Administrative Assistant 1 was discharged for cause in November 2009.

During this investigation additional misconduct came to light involving a Public Service Administrator who was the employee's supervisor. The supervisor failed to properly follow established department policy and procedures when she was aware of her subordinate's habitual misconduct and failed to take appropriate action in the performance of her duties of a supervisor. By this inaction, the supervisor violated

multiple HFS policies. She was negligent, and her negligent behavior facilitated the employee bad behavior.

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

The supervisor was issued a Written Reprimand in January 2010.

- Internal Affairs was contacted to investigate concerns a Division had about potential time abuse and record falsification by an Executive Secretary 2 (ES2). The employee had allegedly been arriving late for work and signing in at her scheduled start time. She also is suspected of leaving early and failing to use available benefit time. In addition, investigators reviewed the employee's email and discovered evidence of what appeared to be a secondary business operated being operated during work hours using Agency resources.

In October 2010, Internal Affairs investigators interviewed the employee. She admitted violating agency policies and procedures when she used the agency's equipment and resources for her personal use.

The ES2 acknowledged she did not obtain agency approval to display booklets advertising sale of retail items at her worksite. She conceded it was inappropriate to promote or discuss her business while at work. She admitted using her state telephone and email to contact employees regarding items purchased from the business, in addition to receiving compensation for the sale of these items.

The employee also stated she was habitually late to work and took extended lunches. She further admitted to falsifying time records on official Agency forms (HFS 163) by not recording time away from the worksite and actual arrival and departure times. She acknowledged these fraudulent and deceptive actions allowed her to receive wages from the State of Illinois, when in fact she was not entitled to these wages. At the conclusion of the interview, she was offered an opportunity to resign.

In November 2010, the employee and her union representative returned to the Internal Affairs office. The employee stated that after considering all that had transpired; she wanted to voluntarily resign from HFS. She waived all reinstatement rights to HFS and further agreed not to seek or accept employment with the State of Illinois at any time in the future.

Other HFS Employee Investigations

- Routine monthly Internet monitoring review discovered evidence that an employee was engaged in an inordinate amount of personal use of the Internet, some of which was also inappropriate. The investigation determined that the employee violated multiple HFS

policies when he used the HFS Internet system for personal use. Some of the sites he accessed were also inappropriate. He admitted to using the Department's computer to purchase football tickets, view game schedules and access pornographic web sites.

The employee was issued a 15-day suspension in July 2010.

- Staff from the CMS BCCS-Infrastructure-Wintel Unit contacted Internal Affairs to report that an Information Systems Analyst 1 may have a large volume of personal data on his "F" drive which may have contributed to the server's instability.

The investigation determined that the employee utilized the HFS Internet system for personal use in violation of HFS policy when he accessed the HFS network to store 918 personal music files taking up 3.75 GB of drive space. He also had 7 picture files and 2 video files on his network drive. He admitted to using the Department's computer to keep copies of his personal music collection, pictures and videos.

In July 2010, the Information Systems Analyst 1 was issued an Oral Reprimand.

- In a similar instance, staff from the CMS BCCS-Infrastructure-Wintel Unit contacted Internal Affairs to report that an Information Systems Analyst 1 may have a large volume of personal data on his "F" drive which may have contributed to the a server's instability.

The investigation determined that the employee utilized the HFS Internet system for personal use in violation of HFS policy when he used the HFS network to store 709 personal music files taking up 3.61 GB of drive space. He admitted to using the Department's computer to keep copies of his personal music collection and used regular work hours to do so.

In July 2010, the employee was issued an Oral Reprimand.

- Division staff notified Internal Affairs that they received a complaint from an Administrative Assistant 1, who reported that an Office Associate asked a co-worker if she could read his paper which was on the floor. He responded, "Yes, but you'll have to bend over to pick it up." The female OA squatted to pick up the paper instead of bending over. As she turned to leave the male co-worker's cubicle, he hit her on her behind. She immediately went to a supervisor's office to file a complaint.

Internal Affairs launched an investigation and conducted interviews with numerous staff who worked in the area of the alleged incident. The Interview Sheets were turned over to the Office of Labor Relations for review and determination if any action would be appropriate or necessary.

The employee was issued a 5-day suspension in June 2010.

- An American Federation of State, County and Municipal Employees representative advised one of our investigators that an Executive Secretary 2 (ES2) released confidential information regarding another employee within the bureau. The union representative provided two statements he obtained outlining the release of confidential information.

Also, after the union representative reported this information to our office, the OIG received two anonymous complaints through the HFS website, regarding the ES2. One involved this specific allegation and the other alleged that she spends an excessive amount of time on the telephone and her personal cellular telephone. Internal Affairs referred the latter complaint back to the division to handle as an administrative matter.

The investigation determined the ES2 violated HFS policies, when she released confidential personnel information to two colleagues about another employee's misconduct.

The Executive Secretary 2 was issued a 7-Day suspension in April 2010.

- Division staff reported that a Child Support Specialist Trainee fielded a telephone complaint from a non-custodial parent (NCP). The NCP alleged the custodial parent's sister, an Office Coordinator (OC), had shared information from his child support case with the custodial parent. He also alleged that the employee may be "sabotaging" his child support case.

The investigation determined that the OC violated multiple HFS policies when, by her own admission, she viewed her sister's child support case in the child support database. This was for purely personal reasons not associated with her job duties as an OC. She also allowed her private and personal interest to conflict with her work-related job duties and responsibilities. By accessing her sister's child support case through the child support database in order to obtain personal information on the status of her sister's case, she created a prohibited conflict of interest.

The OC also provided false or misleading information to investigators during her Internal Affairs interview when she denied having access to the PACIS database. Investigators confirmed with DCSE technical services staff that she does have full access to PACIS and Wage Verification information through the "Jump Key" in the Key Information Delivery System (KIDS).

The Office Coordinator was issued a 7-day suspension in February 2010.

- An anonymous complaint received via the United States Postal Service alleged that an Office Coordinator (OC) provided confidential child support information to her friend.

The investigation determined that the employee violated multiple HFS policies when she misused the Department's equipment and resources for strictly private and personal reasons. Specifically, she used the Agency's KIDS database to seek information regarding her own child support case and that of her personal friend.

In furtherance of the violations, the OC provided case information to a custodial parent and did not adhere to policy when she released the data without first verifying certain

account information. She failed to safeguard the confidentiality of participants and case information when she disclosed case information to her friend for private personal reasons without having followed the established confidentiality requirements.

By viewing her own child support case and failing to safeguard confidential case information, the employee allowed her personal interest to conflict with her duties and responsibilities associated with her position at DCSS; thus, breaching established confidentiality policies and creating a conflict of interest.

In November 2010, the Office Coordinator was issued a 7-day suspension.

Administrative Litigation Initiatives

Attorneys from the Bureau of Administrative Litigation (BAL) represent the Department in post-payment 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 2010, BAL implemented new initiatives aimed at enhanced monitoring and enforcement Department rules, policies and regulations. BAL also 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 overpayments established through BAL administrative actions exceeded \$5.2 million.

The Expedited Recoupment Initiative (ERI) was instituted to expedite cases to hearing and resolution. In calendar year 2010, the initiative continued to prioritize and expedite its administrative prosecutions involving high-risk providers, and in particular, providers rendering non-emergency transportation (NET) and group psychotherapy services. BAL noted that at least 70% of all BAL administrative termination/recoupment actions filed involved non emergency transportation or group psycho therapy providers. Focused efforts to expedite hearings involving non-emergency transportation group psychotherapy providers resulted in substantial increases in sanctions and recoveries against these providers. In the last three years alone this BAL initiative increased hearings initiated and sanctions achieved against these at risk providers by over 100%.

In 2010, BAL implemented an Integrity Agreement Initiative to insure more rigorous provider compliance with Department policies, rules and regulations, as well as provider compliance with settlement agreements. The goals of this initiative will be satisfied through increased post-settlement monitoring and will serve to increase the integrity of the billings submitted by providers and the quality of care rendered to Program recipients.

BAL also saw continued success in its previously implemented Preliminary Call and Closed Door Initiatives, both created to increase efficiency in the management of cases and to aggressively seek recover owed to the State by non-responsive providers. In 2010, over 126 cases were successfully resolved on the Preliminary Call. These resolutions included the recovery of over \$492,000 in child support delinquency actions and past-due income taxes. The Closed Door Initiative saw continued success in 2010 resolving the remaining six cases of the original 89 cases comprising this initiative. Through this initiative, BAL determined the best ways in which to locate and recover from non-responsive or non-operational providers. The

Department will use these lessons going forward as it continues to aggressively pursue recoveries through administrative actions.

Proven Results in BAL actions against at high-risk providers

BAL actions, in concert with legislative initiatives, have proven successful in providing powerful tools to eliminate future potential losses due to fraud perpetrated by high risk providers of non-emergency transportation and group psychotherapy.

BAL administrative actions often serve as the first line of defense against providers who perpetrate fraud against the Medicaid Assistance Programs. The magnitude of BAL results cannot be overstated. In the past five years, BAL had handled more than 226 cases involving non-emergency transportation and group psychotherapy providers. The total dollars recovered against non-emergency transportation and group psychotherapy providers for this period exceeds \$20 million. Equally notable is the number of high-risk providers who have been terminated from the Program and are no longer able to receive payment for improper billings submitted to the State. Over the past five years, BAL actions resulted in the successful sanctioning of over 130 providers and/or owners of these high-risk providers. Specifically, 43 providers were terminated and an additional 90 owners and managers of non-emergency transportation providers were barred from continued Program participation, thereby preventing further expenditure of State dollars based on fraudulent or otherwise improper billings.

Integrity Agreement Initiative

In order to strengthen the monitoring and enforcement of Department rules and policies, to insure the integrity of State health care program claims submitted by the provider, and to improve quality of care rendered to Program recipients, in Calendar Year 2010, OIG increased its use of comprehensive Integrity Agreements. As part of the OIG Integrity Agreement initiative, OIG negotiated compliance obligations for health care providers and other entities as part of a larger settlement of OIG health care program investigations arising under HFS-OIG audits and quality care reviews. As a condition of the integrity agreements, the providers are required to consent to specific obligations that insure correction of past deficiencies as well as the provider's future compliance with Department rules and policies. A provider or entity consents to these obligations as part of the settlement with the Department in exchange for the OIG's agreement not to seek termination of that health care provider or entity from participation in Medicaid programs. OIG integrity agreements improve the integrity and quality of the Medicaid programs by requiring the following provider obligations:

- Written standards and policies
- Education and Training programs
- Corrective action plans to remedy past deficiencies
- Disclosure requirements for ongoing investigations/legal proceedings;
- Reporting requirements on the status of the entity's compliance activities
- Designation of compliance officers to oversee and implement the terms of Integrity Agreement

An integrity agreement is one aspect of a larger settlement agreement constructed for the purpose of requiring resolution of specific deficiencies. While many IAs have common requirements that strengthen the enforcement of existing Department policies and rules, each agreement involves corrective action obligations to ensure conduct at issue is resolved. Additionally, they extend the

post-settlement period from one year to as many as five years, thereby allowing for enhanced monitoring and enforcement during the post-settlement period. Importantly, the integrity agreements reserves the right of the OIG to impose additional sanctions, up to and including immediate termination of the Provider's eligibility to participate in the Medicaid Assistance Program, in instances where the provider fails to comply with the terms of the agreement.

Final Administrative Actions

In calendar year 2010, ninety-seven Final Administrative Decisions were rendered. Notable decisions are described below.

- **Non-Emergency Transportation Provider - Final Administrative Decision for Termination and Recovery in the amount of \$1,046,318.09**

BAL brought a termination and recovery action against a non-emergency transportation provider after a post-payment compliance audit determined that the provider had received overpayments in the amount of \$1,046,318.09. Specifically, the audit identified 48 instances of overpayment due to failure to produce trip tickets or dispatcher's logs, 1,745 instances of overpayment due to missing records of specific services, and 24 instances where the provider's records indicated that the trips for which they had billed had not been taken. 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 terminating the provider's eligibility to participate in the Medical Assistance Program and barring the owner from further participation in the Medical Assistance Program. The ALJ further noted that "the Department's decision to recover the amount of \$1,046,318.09.... should be upheld." In December 2010, the Department Director issued a final administrative decision adopting the ALJ's decision in full.

- **Durable Medical Equipment Provider - Final Administrative Decision for Termination and Recovery in the amount of \$1,039,556.26.**

BAL brought a termination and recovery action against a durable medical equipment provider who was determined to have received \$1,039,556.26 in extrapolated overpayments. In the case of durable medical equipment or prostheses, the provider must be able to provide a copy of the original wholesale purchase invoice for the item and records of any customization performed by the provider. The provider failed to present these records for audit; therefore, the Department found the payments to be unwarranted and sought recovery. On June 3, 2010, the Department Director issued a final administrative decision adopting the ALJ's decision awarding the Department the sum of \$1,039,556.26 and terminating the provider from the Medical Assistance Program.

- **Non-Emergency Transportation Provider - Final Administrative Decision for Termination and Recovery in the amount of \$415,881.09**

Based upon the OIG audit findings that a non-emergency transportation provider had received \$415,881.09 in overpayments due to 604 instances of failure to provide adequate documentation of services provided, BAL brought action to recover the overpayment and terminate the provider. In May 2010, the Administrative Law Judge issued a recommended decision noting, “[T]he Department’s intended action or decision and the grounds asserted as the basis therefore be treated as a final and binding administrative determination. As a consequence, the ALJ recommends that the decision to terminate the Respondent’s eligibility to participate in the Medical Assistance Program..... and the decision to recover \$413,190.37.....be upheld”. In July 2010, the Department Director issued a final administrative decision adopting the ALJ’s decision and allowing the Department to recover 100% of the amount sought and terminates the provider.

- **Physician and Clinic - Final Administrative Decision for Termination and Recovery in the amount of \$167,430.37**

In 2010 a physician and the physician’s corporate healthcare clinic were convicted of federal criminal felonies related to healthcare fraud and to the payment of non-licensed physicians. BAL brought a termination and recoupment action against both the physician and the healthcare clinic. On July 28, 2010, the Director issued a Final Administrative Decision, adopting the Administrative Law Judge’s recommended decision to terminate the clinic’s eligibility to participate in the Medical Assistance Program for a period of 5 years and barring, as well as terminating, the physician’s eligibility to participate in the Program. In addition, the provider agreed to pay the Department the amount of \$167,430.37 in settlement for overpayments established by Department audit.

- **Non-Emergency Transportation Provider - Final Administrative Decision for Termination and Recovery in the amount of \$65,262.70**

BAL brought a termination and recovery action against a non-emergency transportation provider, whom BMI had determined, after a compliance audit, owed the Department \$65,262.70 in extrapolated overpayments. Specifically, the audit found 1,487 instances of overpayment due to billing for missing records of specific services. In addition to seeking recovery of funds, the OIG sought to terminate the provider’s eligibility to participate as a Program provider. The administrative law judge recommended that the Department recoup \$65,262.70 and further recommended the termination of the respondent’s eligibility to participate in the Program. The Director issued a final administrative decision adopting the ALJ’s recommended decision in full.

- **Real Estate Broker - Final Administrative Action for Suspension and Recovery of Delinquent Child Support in the amount of \$15,501.25**

BAL brought an action against a licensed Real Estate Broker seeking to collect \$15,501.25 in delinquent child support payments to enforce two separate support orders; one for the amount of \$7,125.25 and the second amount of \$8,378.00. After commencement of the administrative action, the Non-Custodial Parent (NCP) resolved the second amount and the matter was withdrawn as the balance was zero. As to the first amount, the NCP entered into a payment plan in which he made partial payment but

failed to remain in compliance with the payment plan. The hearing was reinstated and, upon completion, the Director adopted the Administrative Law Judge's findings. The Department then certified to the Department of Financial and Professional Regulations that the NCP was delinquent with a support order in the amount of \$7,123.25 through May 2009. Once the Department made this certification, the licensing agency would then be entitled to suspend the NCP's license pursuant to 305 ILCS 5/10-17.6 and 89 Ill. Adm. Code, Ch. I, Section 160.77.

- **Corporate Provider - Final Administrative Decision for Termination and Barring of its Owners**

BAL brought a termination action against a corporate healthcare provider because an owner of 5% or more of the shares of corporate stock had pled guilty to health care fraud in violation of Title 18 of the United States Code. The Administrative Law Judge recommended that the provider be terminated, the convicted individual be barred from further Program participation, and that an additional owner also be barred from further participation in the Medical Assistance Program. The Director adopted the ALJ's recommended decision in full.

- **Physician - Final Administrative Decision for Termination**

BAL brought an action against a physician whose license was suspended for improperly prescribing controlled substances. The Director adopted the Administrative Law Judge recommended decision and the provider's eligibility to participate in the Medical Assistance Program was terminated.

- **Physician - Final Administrative Decision for Denial of Reinstatement**

BAL filed an action seeking to deny a terminated provider's application for reinstatement into the Program. The applicant had previously been terminated because his license was indefinitely suspended by the Illinois Department of Professional Regulation for allegedly fondling numerous female patients. At the hearing, the applicant testified and presented the testimony of a treating psychiatrist and a physician practice monitor. The Department argued that the application should be denied because of the severity of the alleged conduct committed by the applicant, and because the applicant had not presented information that he could reasonably be expected to meet the Department's written requirements for participation. The Administrative Law Judge recommended that the applicant's reinstatement application be denied. The Department Director adopted the ALJ's recommendation and denied the application.

- **Physician - Final Administrative Decision for Termination**

BAL filed a six-count termination action 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, BAL alleged that the physician inappropriately prescribed narcotics, inappropriately prescribed numerous medications concurrently (polypharmacy), failed to obtain appropriate laboratory and/or diagnostic testing, failed to document adequate histories and physical

examinations, and failed to document adequate vital signs. The Administrative Law Judge 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, the Department was able to ensure that the provider would no longer be able to render inadequate care to Program recipients.

- **Institutional Provider – Settlement Recovery in the amount of \$952,695.00**

The Bureau of Medicaid Integrity conducted an audit of an institutional provider and referred its findings to BAL. The findings included 1 instance of overpayment due to missing medical records, 12 instances of overpayment due to missing medical records of specific services, 26 instances of erroneously billed emergency room services and 180 instances of overpayment due to billing for non-covered services. Specifically, the discrepancies related to non-covered services were due to a difference in reimbursement policies between Medicaid and Medicare. The provider disputed the Bureau's findings but, following settlement negotiations in which BAL articulated the State's position that it was not required to provide reimbursement in the same manner as the Federal Government, the provider conceded and entered into a settlement agreement. Ultimately, the provider reimbursed the State \$952,695.00 and the matter was settled prior to commencement of formal administrative proceedings.

- **Physician - Settlement Recovery in the amount of \$144,000.00**

The Bureau of Medicaid Integrity conducted an audit of a medical professional and identified overpayments due to 146 instances of overpayment due to billing for missing records, 23 instances of overpayment due to billing for missing records of specific services, 6 instances of overpayment due to improper procedure code billings, and 809 instances of overpayment due to billing for services performed by another provider. These 809 instances (approximately 82% of the discrepancies) were the result of the doctor's mistaken belief that, as long as he supervised the medical services provided to Program recipients by another provider, who was working under a Federal H-1b visa at the time but has since enrolled in the Program, both doctors could bill under the same provider number. BMI referred its findings to BAL, which initiated formal proceedings. The Department and the provider entered settlement negotiations immediately and, less than five months later, agreed to a settlement of \$144,000. As a result of this expeditious, pre-hearing settlement, the Department avoided incurring the costs of an administrative hearing, including the charges of the Department's expert consultants.

- **Non-Emergency Transportation Provider – Settlement Recovery in the amount of \$181,751.34**

The Bureau of Medicaid Integrity conducted an audit of a non-emergency transportation provider and identified 122 instances of overpayment due to billing for missing records and 1,057 instances of overpayment due to billing for unauthorized services; the transportation company had not provided the Department with the VINs for its vehicles. BMI referred the matter to BAL for recovery of \$181,751.34 in extrapolated overpayments. Prior to initiation of formal proceedings, BAL learned that the company's owner had passed away and ownership had passed to her husband. He wished to transfer

the company's assets and re-enroll under a new provider number. By entering into settlement negotiations, the Department was able to effectuate an agreement under which the Department recovered 100% of the amount it sought, and the new owner agreed to rectify the issues identified at audit. Additionally, by reaching settlement prior to initiation of formal proceedings, the Department avoided incurring the costs of an administrative hearing, including the charges of the Department's expert consultants.

- **Physician Optometrist – Settlement Recovery in the amount of \$48,000.00**

BAL filed a termination and recoupment action against an optometrist after a post-payment compliance audit revealed that in addition to missing records, the provider billed for services that were not rendered. After initiation of BAL's termination and recoupment action, the provider signed a settlement agreement. The provider agreed to repay the Department the amount of \$48,000.00 and, going forward, agreed to submit claims for services only if the services are provided by him personally. If the optometrist fails to comply with any provision of the agreement, he will be immediately terminated from the Program.

- **Home Health Care Provider – Settlement Recovery in the amount of \$48,000.00.**

In July, 2007, the Bureau of Medicaid Integrity conducted an audit of a home health care provider and identified overpayments due to 15 instances of billing for missing records of specific services, 18 instances of improper procedure code billing, and 50 instances of billing for non-covered services. Specifically, the non-covered services were instances in which recipients were cared for by their own adult children, and both the recipient and the caretaker lived in the same home. Although improper at the time services were provided, this arrangement is now permitted under Illinois law. After receiving this referral from BMI, BAL initiated proceedings in February 2010. Following expedited settlement negotiations, after only six months, the Department and the provider reached settlement in the amount of \$48,000.

- **Physician – Settlement Recovery in the amount of \$81,522.00**

BAL filed a termination and recoupment action against a physician after an audit revealed that there were 2,402 instances, totaling \$81,522, where the provider billed for non-covered services. Of these, 2,392 were cases due to billing for psychosocial services where the only documentation was by a facilitator, such as a social worker or a psychologist. Additionally, there were 10 cases of billing for appointments that were cancelled or did not take place. After initiation of BAL's termination and recoupment action, the physician signed an agreement to repay the entire amount of \$81,522. The provider agreed to resolve the deficiencies going forward by complying with the Department's signature requirements in the physician's medical charts for all care rendered. The physician further agreed to review all billing and maintain an accurate list of appointment cancellations and patient absences to ensure that cancelled appointments would not be improperly billed to the Department. As part of the agreement, the physician is required to maintain and make available to the Department a list of cancellations for a period of 3 years. Should the physician fail to comply with the terms

of the agreement, he has agreed that his eligibility to participate in the Program will be terminated.

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

During the past fifteen fiscal years, the FPI program has provided an estimated average savings of \$13.00 for each \$1.00 spent by the state. FPI has averaged a 65% denial, reduction or cancellation rate of benefits for the 47,094 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over \$130.8 million.

During Calendar Year 2010, the program generated 3299 total investigations, of which 1598 cases led to reduced benefits, denials or cancellation of public assistance. The overall denial rate for this period was 50%. BOI calculated an estimated gross savings for calendar year 2010 of \$11.9 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and SNAP. The program estimated cost savings for calendar year 2010, was \$10.91 for each \$1.00 spent on the program.

Long Term Care - Asset Discovery Investigations

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program targets error-prone long term care Medicaid applications. In partnership with OIG, 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 completed 477 investigations during calendar year 2010. Of the investigations completed, unallowable asset transfers were identified in 107 of these investigations. The gross savings realized in 2010, based on the identified penalty periods of the 107 cases was \$10,076,168. For every \$1 spent on administration costs relevant to the LTC-ADI program, \$6.45 of savings was realized. Noteworthy cases:

- An applicant jointly owned a two apartment residential property in the Chicago area. In the month of application for Medicaid, the applicant transferred her half ownership in the property to her son. The applicant was uncompensated for the transfer value of \$215,425. The transfer resulted in the imposition of a forty month penalty period. Savings to the state totaled \$161,700.
- An application was referred to LTC-ADI from Douglas County due to the applicant reporting a transfer of real property to a family member for less than fair market value. The assets reported in the referral packet included a checking account and a prepaid burial contract. Analysis of financial records for the thirty six month look back period revealed that the applicant also owned two certificates of deposit valued at \$50,133 and \$50,000. The undisclosed certificates resulted in excess assets of \$100,000. The OIG was able to confirm the transfer of real property reported on the application. The OIG, also, uncovered three additional parcels that had been transferred. The sum of the transfers resulted in a 53 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 \$142,591 in Medicaid expenditures.
- The applicant also reported closing an investment account during the thirty six month look back period. The Long Term Care - Asset Discovery Investigation exposed fifteen additional assets currently owned by the applicant or transferred by the applicant during the target period. The OIG determined that the applicant received fair market value for the assets that had been transferred, therefore no penalty was assessed. The value of the discovered assets currently owned by the applicant that could be applied towards the cost of her care was in excess of \$72,000.
- Throughout 2010, LTC-ADI continued to support DHS during the administrative hearings process for appeals and beyond to the circuit courts. Evidence presented to administrative hearings officers and attorney generals originated from applications investigated by LTC-ADI.

In early fall of 2010, the OIG assisted the HFS General Counsel's office in negotiations with an appellant's representative relating to a hardship request as a result of a court decision to uphold the Department's decision to impose a penalty period. The imposition of the penalty period was based on a recommendation by LTC-ADI. The negotiations resulted in a settlement with State securing \$55,000 to apply towards the appellants cost of care, lessening the burden to the tax payer.

During December 2010, the efforts of LTC-ADI were affirmed by a decision from the Appellate Court of Illinois Fourth District. LTC-ADI worked closely with HFS General Counsel and the State's Attorney General's office to solidify the Department's position. The decision by the Appellate Court of Illinois Fourth District reversed the circuit court's judgment, not favorable to the Department, and affirmed an administrative decision to impose a penalty period recommended by the OIG as a result of a Long Term Care - Asset Discovery Investigation. The issue in this case was especially relevant to the success of LTC-ADI. The practice under appeal had gone unchallenged for years. The efforts of LTC-ADI have brought an end to a practice that cost the tax payers substantially.

Information Technology Initiatives

Predictive Modeling System

The OIG continued to make great strides in the implementation of an in-house predictive modeling system which was federally funded by a Medicaid Transformation Grant awarded in February 2007. Although full system implementation will not occur until CY 2011, change is already underway to put in place an infrastructure that integrates the analytics with the operational processes which in turn promotes 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. Integration and usage of the fraud routine results generated by the predictive modeling system began in earnest during 2010 which bridged the gap between the predictive modeling analytics and the operational data systems.

Integrating Technology into PI Efforts

Results of the various routines contained within the predictive modeling system were incorporated into existing program integrity efforts dealing with the probationary enrollment of transportation providers and the detection of aberrant and potentially fraudulent transportation providers. One of the early products of the predictive modeling system was the creation of a provider profile report that brought together various routines into a consolidated report that provides a broader snapshot of the transportation providers' patterns and activities which is then used to detect areas of potential abuse and to define target areas for audit. Providers, that might have slipped under the radar because their aberrant billing pattern from a single fraud routine was not exceptionally remarkable, are now bubbling to the top when analyzed across multiple routines. This profiling tool was quickly adopted by the OIG and is now being used in all areas of provider reviews.

Another innovation during 2010 was the redesign of the Non-Corresponding Medical (NCM) Services report for transportation services. The NCM report previously could not identify what type of service or where the service was to be performed that corresponded with a given transportation service. This has been remedied by the inclusion of the transportation prior approval information which identifies the type of service to be performed and the associated medical provider name and address. These report updates are in the early stages of usage, but show great promise in the arsenal of audits performed on transportation providers. Audits of NCM will now incorporate a review of the associated medical provider's medical records to determine if the recipient was seen on the date in question.

Federally Mandated Medicaid Eligibility Quality Control Program

Passive Redeterminations

The passive redetermination process, implemented by the Department in 2006 was designed to simplify the redetermination process for children enrolled in Family Health Plans. To determine the accuracy of this process, the OIG conducted Medicaid Eligibility Quality Control (MEQC) reviews of cases passively renewed during the review period of October 2008 to September 2009. Passive renewals rely on the client to provide up to date correct information.

Of the 1089 cases reviewed, 374 (34%) contained eligibility errors. Of the 374 cases with eligibility errors, 343 had payment errors totaling \$30,996. The total paid claims for cases reviewed was \$198,969, resulting in a 16% payment error rate.

The majority of the errors were discovered in the program area of income, primarily wages and salaries. The program area of basic requirements made up 17% of the errors, mostly due to residency not being met and living arrangement/household composition. The majority of the errors were attributed to the client for the non-reporting of information that affects eligibility.

The results also revealed that information available to the state was not utilized to prevent errors. Failure to use Social Security numbers for identifying income, along with the need to refine reports that assist in identifying unreported income contributed to the errors.

Results of the study were finalized in July 2010 and were submitted to federal CMS as required. An in-depth analysis was completed and distributed to both the HFS and DHS Directors along with recommendations to eliminate and/or prevent errors.

Illinois Healthy Women (IHW)

To fulfill the requirements for FFY10 MEQC and to satisfy the Special Terms and Conditions for the renewal of the IHW waiver, the OIG began MEQC reviews of IHW cases. The IHW program provides family planning services to women between the ages of 19 and 44. The reviews are being conducted on cases auto enrolled into the program as well as those having applied for the program. The review was designed to identify those women not eligible for the program and to correct overall program discrepancies that could impact Medicaid (Title XIX) funds.

A total of 1217 cases were reviewed during 2010 and a summary of findings will be completed in 2011.

Moms and Babies Pilot

The OIG received approval in 2010 to target the Moms and Babies program to satisfy the FFY11 MEQC requirement. The pilot will target the eligibility of women who received benefits under the Department's Moms and Babies program.

The Moms and Babies program is for pregnant women and their babies. The program pays for both outpatient and inpatient hospital services for women while they are pregnant and for 60 days after the baby is born. The program covers prenatal care, labor and delivery and postpartum care. The reviews will identify those women not eligible for the program and correct individual case and overall program discrepancies that could impact Medicaid (Title XIX) funds.

Reviews began in 2010 and will conclude in 2011.

Negative Case Action Reviews

For FFY09, the state was granted approval from federal CMS to substitute the PERM Medicaid Negative reviews for the MEQC Negative Case Action Reviews (NCAR). In July 2010, the OIG submitted the results of the NCAR to CMS. A total of 226 denied and terminated Medicaid cases were sampled and resulted in 204 reviews completed with two errors identified. A case error rate of 0.17% was reported. Individual case corrective action was completed on all error and drop cases, when appropriate.

COOPERATIVE EFFORTS

Federal Program Participation

Payment Error Rate Measurement (PERM)

Both Medicaid client eligibility and claim payment reviews were completed in CY 2010 as part of Illinois' FFY 2009 PERM cycle which only measured improper payments in the Medicaid program. CHIP client eligibility and claim payment reviews were dropped from this cycle as an outcome of the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Illinois will submit its' Corrective Action Plan in February 2011 which will complete the FFY 2009 PERM cycle.

Illinois became a member of the PERM Technical Advisory Group (TAG) in 2010 and also volunteered to participate in a new PERM TAG workgroup to determine harmonization options for the Medical Eligibility Quality Control (MEQC) and PERM programs which was mandated as part of CHIPRA.

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.

There were a total of (16) Global Settlement Agreements during 2010 where the State of Illinois Medicaid Program received \$30,455,254 as a recovering party. In the following is a brief description of just a few of these settlements.

- ***AstraZeneca Settlement - \$9,845,306.31***

Seroquel is one of a newer generation of antipsychotic medications (called atypical antipsychotics) used to treat certain psychological disorders. From January 1, 2001

through December 31, 2006, AstraZeneca promoted the sale and use of Seroquel for certain uses that the Food and Drug Administration had not approved. The settlement resolves a government investigation into promotional activities undertaken by AstraZeneca that were directed not only to psychiatrists but also to primary care physicians and other health care professionals for unapproved uses in the treatment of medical conditions such as aggression, Alzheimer's disorder, anger management, anxiety, attention deficit hyperactivity disorder, dementia and sleeplessness.

- ***Novartis Pharmaceuticals Corporation - \$8,112,729.71***

During the period January 1, 2001 to June 30, 2005, Novartis: (a) knowingly promoted the sale and use of Trileptal® for uses (including, but not limited to, bipolar disorder and neuropathic pain) that were not approved by the Food and Drug Administration (FDA) (i.e. off-label uses) and were not medically accepted indications for which the Medicaid Program provided coverage for Trileptal®; and (b) offered and paid illegal remuneration to health care professionals to induce them to promote and prescribe Trileptal®, in violation of the Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b). As a result of the foregoing conduct, Novartis caused false or fraudulent claims to be submitted to, or caused purchases by, Medicaid.

During the period January 1, 2002 to December 31, 2009, Novartis provided illegal remuneration, through mechanisms such as speaker programs, advisory boards, and gifts, (including entertainment, travel and meals), to healthcare professionals to induce them to promote and prescribe the drugs Diovan®, Zelnorm®, Sandostatin®, Exforge® and Tekturna®, in violation of the Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b). As a result of the foregoing conduct, Novartis caused false or fraudulent claims to be submitted to, or caused purchases by, Medicaid.

- ***GlaxoSmithKline, LLC - \$5,669,534.19***

The settlement covered four drugs manufactured at a Cidra, Puerto Rico, plant that has since been shuttered: Kytril, an anti-nausea medication; Bactroban, a topical anti-infection skin ointment; Paxil CR, a controlled release formulation of the company's antidepressant drug Paxil; and Avandamet, a combination Type II diabetes drug.

GlaxoSmithKline, LLC knowingly manufactured, distributed and sold certain batches, lots, or portions of lots of: (1) Paxil CR that contained some split tablets, causing some consumers to receive either product with no active ingredient and/or product with only the active ingredient layer and no controlled release mechanism; (2) Avandamet that contained some tablets with higher or lower amounts of rosiglitazone than specified; (3) Kytril that was labeled as sterile but was, in some vials, non-sterile; and (4) Bactroban ointments and creams that, in some packages, contained microorganisms.

- ***Forest Laboratories Inc. - \$2,914,955.59***

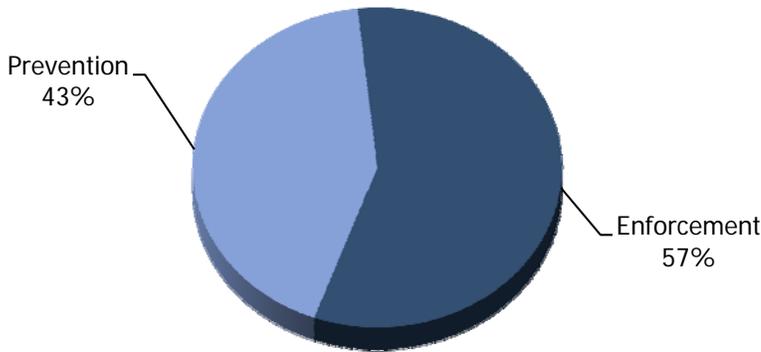
Forest Pharmaceuticals, a subsidiary of Forest Laboratories, agreed to plead guilty to a felony obstruction of justice charge, and two misdemeanor counts related to the distribution of an unapproved drug – Levothroid – and the misbranding or off-label promotion of two anti-depressants, Lexapro and Celexa, which also included paying kickbacks to doctors.

FISCAL IMPACT

Fiscal Year Savings

During Fiscal Year 2010, the OIG realized a savings of approximately \$76.7 million through collections and cost avoidances. This savings was over four times the OIG FY2010 budget of \$19.0 million.

FY10 Savings



Total = \$76,670,931



Prevention Activities:

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

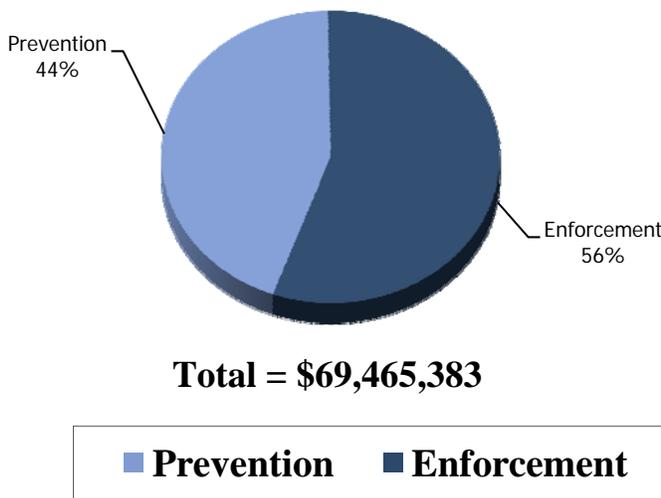
Enforcement Activities:

- 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 2010, the OIG realized a savings of almost \$70 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 *2010 OIG Savings and Cost Avoidance Tables* portion of this report on the page numbers indicated in parentheses next to the activities listed below.

CY10 Savings



Prevention Activities:

- Provider Sanctions Cost Avoidance (refer to page 37)
- Food Stamp Cost Avoidance (refer to page 38)
- Fraud Prevention Investigations (refer to page 40)
- Long Term Care - Asset Discovery Investigations (refer to page 40)
- Recipient Restrictions (refer to page 41)
- New Provider Verification (refer to page 42)

Enforcement Activities:

- Provider Audit Collections (refer to page 35)
- Fraud Science Team Overpayments (refer to page 35)
- Restitution (refer to page 35)
- Global Settlements (refer to page 35)
- Provider Sanctions Cost Savings (refer to page 37)
- Client Overpayments (refer to page 38)
- SNAP Overpayments (refer to page 38)
- Child Care Overpayments (refer to page 39)

CONCLUSION

During 2010, 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.

2010 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	80	\$18,010,444
Desk	191	
Self	4	

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)	278	\$32,421,539
Restitution	26	
Global Settlements	11	

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	133
Letter to Provider without Concerns	40
Referral for Sanction	8
Referral for Audit	14

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	28
Termination/Recoupment	15
Recoupment	44
Suspension	9
Denied Application	11
Decertification	14
Child Support License Sanctions	56

Final Actions	# Cases	Total Medical Provider Sanction Dollars
Termination	32	Cost Avoidance: \$2,932,554 Cost Savings: \$1,162,928
Termination/Recoupment	12	
Suspension	4	
Voluntary Withdrawal	3	
Recoupment	41	
Decertification Resolution	5	
* Barment	22	

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

Reinstatement Actions on Sanctioned Providers	# Cases
Denied Application	10
Reinstated	8

Administrative Actions for Other State Programs	# Cases	Total Payment Plan Dollars Established
Child Support Delinquencies	28	\$492,175
Certified Arrearages	15	
Payment Compliance	13	
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	45
Law Enforcement Data Requests	140

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	787	\$3,368,547
Founded	502	
Unfounded	285	
Convictions	32	
Type of Investigations		Percent
Absent Children		12.0%
Absent Grantee		2.0%
Assets		6.0%
Employment		12.0%
Family Comp/RR In Home		17.0%
Family Composition		9.0%
Food Stamp Trafficking		5.0%
Impersonation		1.0%
Interstate Duplicate Assistance		3.0%
Other Income		11.0%
Prosecution		6.0%
Residence Verification		12.0%
SSN Misuse/Discrepancy		2.0%
TPL		2.0%

SNAP Fraud

Clients who intentionally violate the Supplemental Nutrition Assistance Program (SNAP) are disqualified from the 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 SNAP issuances made during the overpayment period times the length of the disqualification period.

SNAP Fraud

Enforcement Activities	# Cases	Total Dollars Established
Reviews Completed	1,877	Cost Avoidance: \$2,537,862 SNAP Overpayments: \$1,514,671
Pending Administrative Disqualification Hearing	2,219	
Disqualifications	1,181	
Unsubstantiated	59	

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	26	\$318,232
Founded	21	
Unfounded	5	
Convictions	6	

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	44	\$16,660
Founded	22	
Founded In-Part	11	
Unfounded	11	

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 fifteen-year estimated average savings of \$13.00 for each \$1.00 spent by the state. FPI has averaged a 65% denial, reduction or cancellation rate of benefits for the 47,094 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over \$130.8 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 2010, the program generated 3,299 investigations, of which, 1,598 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated gross savings for calendar year

2010 of approximately \$11.9 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	3,299	\$11,899,548
Denied Eligibility	169	
Reduced Benefits	1,263	
Cases Canceled	166	
Approved	1,571	
Pending Local Office Disposition	130	

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	477	\$10,076,168
Approved		
Impose Sanction Period/Group Care Spenddown	62	
Impose Sanction Period/Regular Group Care Credit	45	
No Sanction Period/Group Care Spenddown	222	
No Sanction Period/Regular Group Care Credit	77	
Denied		
Client Requested Application be Withdrawn	40	
Client Refused to Cooperate/Failed to Provide Verifications	31	
Other		
Returned to Local Office without Recommendation	0	

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	1,792	\$820,604
12 Month Restrictions		
New Restrictions	326	
Released or Canceled Restrictions	99	
Converted to 24 Month Restrictions	109	
24 Month Restrictions		
New Restrictions and Re-restrictions	177	
Released or Canceled Restrictions	40	
Total clients restricted as of 12/31/10	782	

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	205
Substantiated	74
Unsubstantiated	131
Administratively Closed	0

Types of Allegations Investigated	Percent
Non-Criminal (Work Rules)	60.4%
Discourteous and Inappropriate Behavior	1.2%
Failing to Follow Instructions	9.4%
Negligence in Performing Duties	10.6%
Conflict of Interest	7.2%
Falsification of Records	3.9%
Sexual Harassment	0.9%
Release of Confidential Agency Records	1.2%
Misuse of Computer	5.5%
Work Place Violence	0.9%
Time Abuse and Excessive Tardiness	3.3%
Conduct Unbecoming State Employee	16.3%
Criminal (Work Rules)	18.3%
Theft or Misuse of State Property	2.6%
Commission of or Conviction of a Crime	0.6%
Criminal Code ILCS 720	15.1%
Security Issue, Contract Violation	20.4%
Special Project, Background Check, Assist other Agencies	0.9%

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 2010 are listed below.

Misconduct Outcomes	# Actions
Misconduct Identified	37
Employee	32
Vendor	5
Misconduct Resolutions	42
Discharge	5
Resignation	8
Suspension	8
Other, such as reprimands	10
Referred to Other Sources for Resolution	1
Administrative Action Pending at Year End	8
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	230	
Enrolled	204	
Not Enrolled	4	
Applications Returned	18	
Applications Denied	4	
		\$2,412,731

HMO Marketer Investigations

The OIG conducts investigations of HMO marketers who are suspected of misrepresentation or fraud while enrolling clients for their health plans.

HMO Marketer Investigations

Enforcement Activities	# Cases
Investigations Completed	2
Unfounded - Fraud / Forgery	1
Unfounded – Misrepresentation	1

APPENDIX A - OIG PUBLISHED REPORTS

Title	Date	Description
<i>Passive Redetermination Analysis</i>	September 2010	The review indicated that the Department cannot rely on information provided by clients to determine eligibility. A 34% case eligibility error rate was calculated, primarily due to incorrect information from clients. Recommended discontinuation of passive re-determination process along with suggesting ways to assist in the identification of unreported income.
<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.

Title	Date	Description
<i>Non-Emergency Medical Transportation Reviews: Focusing on Compliance</i>	December 1999	A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation.
<i>Project Care: Exploring Methods to Proactively Identify Fraud</i>	December 1999	Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.
<i>Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments</i>	December 1999	Recommended methods by which non-institutional post mortem payments could be identified more quickly.
<i>Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 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.

Title	Date	Description
<i>Fraud Science Team Development Initiative Proposal</i>	April 1997	Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments.
<i>Medicaid Client Satisfaction Survey: April 1996-September 1996</i>	April 1997	Measured client satisfaction with quality and access in both fee-for-services and managed care.
<i>Prior Approval Study</i>	May 1996	Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature.
<i>Clozaril Report</i>	February 1996	Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement.
<i>Hospital Inpatient Project Summary Report</i>	April 1994	Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.

Most of these reports are available on our web site at www.state.il.us/agency/oig. 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

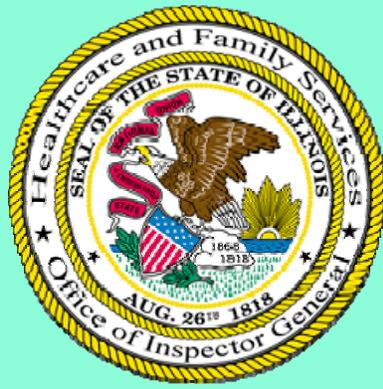
This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid claim. The estimated 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
CY2010*

Total Number of Scripts	29,558,504	
Amount Payable		\$1,621,025,504
Scripts Not Subject to RTS	68,858	
Amount Payable		\$6,186,878
Scripts Subject to RTS	29,489,646	
Amount Payable		\$1,614,838,888
Rejected Number of Scripts		1,633,584
Estimated Savings		\$107,390,470

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 2010 Annual Report/Data on the OIG website identified on the back cover of this report. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type.



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Welfare/Medical Fraud Hotline
1-800-252-8903