



Office of Inspector General

Illinois Department of
Healthcare and Family Services

2011 Annual Report

Pat Quinn
Governor

Bradley K. Hart
Inspector General



Office of Inspector General
Illinois Department of Healthcare and Family Services

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Pat Quinn
Governor

Bradley K. Hart
Inspector General

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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 2011.

The achievements depicted within this report are the results of the hard work and dedication of OIG staff members as well as the commitment of those within the Departments of Healthcare and Family Services and Human Services. Due to the efforts of these employees, the OIG has made great strides in the pursuit of its integrity mission.

This report describes many of the activities and results of OIG staff over the past year that enhances the integrity of the programs operated by both Departments. As required by Public Act 88-554, this report provides information on recoupments, sanctions, investigations and specifically highlights our newly operational predictive modeling system, more colloquially called the Dynamic Network Analysis (DNA) system. The DNA system has already been cited by the Centers for Medicare and Medicaid Services as a "Best Practice;" in and of itself, a notable commendation for the OIG staff.

It is with great pride that I provide you with the accomplishments of the Office of Inspector General for 2011.

Sincerely,

Bradley K. Hart
Inspector General
Healthcare and Family Services

Mission

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

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**Office of Inspector General
Illinois Department of Healthcare and Family Services
Annual Report
Calendar Year 2011**

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 2011, the OIG had an authorized staffing of 185 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 2011, with Bradley K. Hart serving as the Inspector General, with his tenure beginning on November 1, 2011. 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 2011, the OIG established \$14,843,505 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 2011, the OIG completed 287 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.

Diagnosis-Related Group (DRG) Inpatient Audits

Audits performed as part of the Inpatient Hospital Audit Program (IHAP) began in the latter part of fiscal year 2010. All IHAP audits are conducted by vendors under contract with the state. Ten (10) IHAP audits were completed in Calendar Year 2010, and the findings were subsequently distributed to providers during Calendar Year 2011. The combined potential recoupment of these audits was over \$4 million.

In Calendar Year 2011, the number of completed IHAP audits increased by over 100%, to 21. The identified potential recoupment of these audits is over \$17 million. It is anticipated that the number of audits completed in Calendar Year 2012 will increase, and the Department will continue to collect significantly increased recoupment year over year.

Local Education Agency (LEA) - Technical Assistance Reviews

A federal Payment Error Rate Measurement (PERM) review of Illinois resulted in a determination that the records submitted for PERM review by the LEAs were not in compliance with the policies of the Medical Assistance Program. In response, the OIG conducted a Technical Assistance Review pilot study of LEAs. For those LEAs included in the pilot, a small sample of records was reviewed to verify whether billed services were eligible for reimbursement and had been submitted in accordance with state and federal requirements. The goal of the review was to identify inappropriate billings and documentation deficiencies, and educate each school district on covered/non-covered services and proper documentation requirements.

The pilot study was completed in 2011, and in 2012, the OIG will be expanding its review to include the approximately 900 LEAs that were not included in the pilot study. It is anticipated that by conducting these reviews and providing education to the LEAs, they will come into compliance with state and federal requirements, and the quality of services provided to students may improve.

Improvements to Preservation of Program Integrity

In 2011, in an effort to improve both program integrity and the efficiency of our audit and re-audit process, the OIG decided to more strictly enforce the record-keeping requirements of the Illinois Administrative Code. Pursuant to 89 Ill. Adm. Code, Ch. I, Section 140.28, when the

Department requests records for an audit, enrolled providers have a limited amount of time to satisfy the request. Previously, if a provider failed to turn over the requested documents at audit, the Department allowed providers a second chance to satisfy the record request at re-audit. The result was lengthy re-audits, significant reductions in identified overpayments, and the possibility that a provider might fabricate documentation that did not previously exist.

Beginning in late 2011, except in limited circumstances, providers found to have missing records as a result of failure to comply with the requirements of Section 140.28 will no longer be able to present those records as part of a re-audit request. We anticipate that this will significantly limit the number of re-audits performed as well as reduce the amount of time required to conduct a re-audit. By reducing the amount of time spent conducting re-audits, our auditors will be able to conduct and complete an increased number of new audits. In addition, the overpayments identified at audit will be reduced far less often than in years past, leading to greater potential recoupment.

Finally, program integrity will be preserved because those providers who might otherwise have fabricated records in an attempt to reduce the audit findings will no longer have the opportunity to do so.

Client Prosecution Cases

During 2011, the Bureau of Investigations (BOI) referred 19 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
Child Care Recipient Fraud /Unreported Income

This case was referred to BOI by Department of Human Services (DHS), Bureau of Child Care and Development (BCCD). A Madison County resident allegedly received child care assistance program (CCAP) funds after naming her husband as the provider without telling the Child Care Resource and Referral (CCR&R) agency that he was her husband and that he was employed during the hours that child care was allegedly being provided. The subject also falsified employment verifications that were provided to the CCR&R by reporting that she was working for a disabled adult after that person had died.

The investigation report was completed by BOI on July 29, 2011 showing that the subject received a total overpayment of \$31,384.31 in CCAP funds from February 2007 through June 2009. A Criminal Information was filed in the Circuit Court of Madison County on August 23, 2011. The defendant was charged with one count of State Benefits Fraud and this case is currently pending with the Madison County Circuit Court.

- Prosecution Investigation
Child Care Recipient Fraud /Household Composition

A BOI child care investigation found that a client and child care provider falsified their child care arrangement to obtain childcare monies. The investigation found that the unemployed father of the youngest children was residing in the client's home and watched the children. The investigation was completed in September 2011 and referred to

the Lake County State's Attorney for criminal prosecution. The investigation estimated a \$27,929.82 child care overpayment. In December 2011, the client entered a Not Guilty plea. The next court date is scheduled for April 2012.

- Prosecution Investigation
Child Care Recipient Fraud /Household Composition

A referral from BCCD alleged that a client was inappropriately receiving child care assistance and food stamp benefits from DHS. The BOI investigation revealed that 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 reported the subject's husband in the household.

The total Supplemental Nutrition Assistance Program (SNAP) overpayment for the period of August 2008 through March 2009 is \$3,576.00, and the total child care overpayment for the period February 2003 through February 2009 is \$76,474.74. BOI referred this case to the Sangamon County State's Attorney. On November 9, 2011 the subject was sentenced to 30 hours of public service and two years probation. No restitution was ordered in this case.

- Prosecution Investigation
Employment

A BOI investigation found that a client failed to report the income of her husband who was included in her case. The case was referred to the LaSalle County State's Attorney for criminal prosecution on July 22, 2010. The Bureau of Investigations identified a SNAP overpayment of \$13,305.00. On January 20, 2011, the client pled guilty to State Benefits Fraud. She received a sentence of 120 days in jail, two years probation, a fine of \$600.00 and court ordered restitution of \$13,305.00.

- Prosecution Investigation – Joint Investigation with U.S. 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 receiving SNAP benefits allegedly failed to report to DHS that she had income from employment and resided with her husband who had Social Security Administration income. 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 for the Southern District of Illinois (SDI), the U.S. Postal Inspector, the U.S. Department of Agriculture (USDA) -Office of Inspector General (OIG), and the Social Security Administration (SSA) – OIG. The subject received a SNAP overpayment of \$11,280.00 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 and was sentenced on February 11, 2011 to 21 months of incarceration with the U.S. Bureau of Prisons, three years of supervised release and was ordered to pay \$31,093.67 in restitution, including \$11,280.00 in SNAP restitution, and \$900.00 in special assessments.

- Prosecution Investigation – Joint Investigation with SSA
Multiple Assistance / Employment / SSN Misuse or Discrepancy

A BOI investigation found that a client failed to report her employment with the Chicago Public Schools system. She had been employed using another name and SSN. Additionally, it was determined that she received public assistance under both names and SSNs. The investigation was worked with the Social Security Administration – OIG. BOI's completed case was referred to SSA on March 24, 2011 for prosecution. Upon completion of the SSA investigation, the cases will be combined and referred to the US Attorney's Office – Northern District of Illinois. The BOI referral included a \$28,578.00 SNAP overpayment.

- Prosecution Investigation – Joint Investigation with HUD
Unreported Income / Assets

This case was referred to BOI by an anonymous caller and was jointly investigated with the U.S. Department of Housing and Urban Development (HUD) – OIG. A St. Clair County resident allegedly had more income from self-employment and excess assets in bank accounts that were not reported to DHS. The client received a total SNAP overpayment of \$17,607.00 from January 2007 through August 2009 and also fraudulently received \$14,226.00 in HUD funds.

The subject was charged in a three count indictment by the US District Court – SDI and pled guilty. She was sentenced on April 1, 2011 to six months of home confinement with electronic monitoring, and five years of probation. She was also ordered to pay \$31,833.00 in restitution, including \$17,607.00 for SNAP and \$14,226.00 in HUD benefits and a \$100.00 special assessment, along with the costs of electronic monitoring.

- Prosecution Investigation
Employment

The OIG received a referral that a recipient was not reporting employment income to DHS. The BOI investigation found that from June 2009 through April 2010 the recipient had unreported income. The SNAP overpayment for this case totaled \$3,307.00 and on January 31, 2011 the recipient was charged in Knox County with one count of State Benefits Fraud (Class 3 Felony). On June 29, 2011 as part of a negotiated plea, the defendant pled guilty to the charge and was placed on 24-months of Conditional Discharge and ordered to pay \$3,307.00 in restitution.

- Prosecution Investigation
Employment / Unemployment Insurance Benefits

An investigation found that a client failed to report income and unemployment insurance benefits received by his children who were included in his case. BOI identified a SNAP overpayment of \$4,053.00. The case was referred to the LaSalle County State's Attorney for criminal prosecution. Grand jury testimony was provided by the BOI investigator on April 12, 2011. On June 24, 2011, the client pled guilty to State Benefits Fraud and received a sentence of 30-months Conditional Discharge and ordered to pay \$4,053.00 in restitution.

- Prosecution Investigation
Employment

BOI received a referral that a recipient in Peoria County was not reporting employment income from employment to DHS. The investigation found that from April 2008 through May 2009 the recipient had unreported income, with a SNAP overpayment of \$7,903.00. In August 2010 the recipient was indicted in Peoria County on one count of State Benefits Fraud (Class 3 Felony). On July 1, 2011 as part of a negotiated plea, the defendant pled guilty to the charge and was placed on 30-months probation and ordered to pay \$7,903.00 in restitution.

- Prosecution Investigation
Employment

A BOI investigation found that a client was intercepting the employment verifications and returning them to the local DHS office stating that she was not employed when she actually was employed full time. The client failed to report her income from employment to DHS and took steps to deliberately mislead the Department as to her actual earned income. BOI identified a SNAP overpayment of \$14,531.00 from June 2008 through June 2010. This case was presented to the State's Attorney in May 2011 and an arrest warrant was issued in September 2011.

- Prosecution Investigation – Joint Investigation with SSA
Household Composition / Other Income

A BOI investigation was initially completed in August 2011 as a client eligibility investigation, and was referred for criminal prosecution in October 2011. The investigation found that a client failed to report her marriage, her husband's employment, their household income and assets. Additionally, the client received benefits for a nephew who was actually residing with his mother in a neighboring city. The investigation was worked with the Social Security Administration - OIG and combined with their investigation for criminal prosecution. The case was referred to the US Attorney's Office – Northern District of Illinois in October 2011. The BOI referral included a \$22,578.00 SNAP overpayment. The case is currently pending review by the prosecution attorneys.

- Prosecution Investigation – Joint Investigation with SSA and HUD
Unreported Income – Alias Name and Social Security Number

A BOI investigation found that a client failed to report income she earned while using an alias name and Social Security number and she failed to report the retirement benefits she received under her alias. The client also received income under the alias identity from the U.S. Department of Housing and Urban Development (HUD) for payments as a landlord. The investigation was worked with the Social Security Administration - OIG and HUD – OIG. The joint investigative results were referred to the US Attorney's Office – Northern District of Illinois on March 18, 2010. The BOI referral included a \$6,231.00 SNAP overpayment. On December 19, 2011, the defendant pled guilty to Embezzlement and Theft: Public money, property or records. She is scheduled for a sentencing hearing at the U.S. District Court – NDI on March 7, 2012.

- Prosecution Investigation – Joint Investigation with IRS, FBI, and Postal Inspector
Unreported Income / Assets

This case was referred to BOI by the U.S. Attorney - SDI. The subject of the investigation and her husband allegedly owned their own business and purchased a new home and did not report their income and assets to the DHS local office while receiving SNAP and Medicaid in St. Clair County. This case was jointly investigated by BOI with the IRS Criminal Investigations, the FBI, and the U.S. Postal Inspector.

The investigation showed that the subject and her husband received SNAP and Medicaid at three different addresses in St. Clair County from January 2003 through October 2006. They did not report that they purchased a new home in Madison County in October 2005 for \$550,000.00, or that they had income from their family owned business. A total of \$22,488.00 in Food Stamp benefits were received by the subject from January 2003 through October 2006.

The subject and her husband were indicted by the grand jury at the U.S. District Court – SDI on February 24, 2011 in an eleven count indictment. Included in the indictment was a charge of making false statements to the Food Stamp program. They were arraigned on March 11, 2011.

The subject pled guilty to three counts of the indictment, including the charge of making false statements to the Food Stamp program at the U.S. District Court – SDI in East St. Louis on July 29, 2011. She was sentenced on December 21, 2011 to 37-months imprisonment followed by five years of supervised release, and she was ordered to pay restitution of \$22,488.00 to DHS for Food Stamp Fraud.

- Prosecution Investigation
Impersonation / Multiple Assistance

A BOI investigation found that a client failed to report his receipt of public assistance in his name and multiple identities. The case was worked with the Cook County State's Attorney's Office and originally referred to them on December 13, 2010. The original referral included a \$53,039.00 SNAP overpayment in five public assistance cases. The

final investigation determined that the client assumed the identities of five people to receive SNAP benefits in six cases; in his name and five other public assistance cases. The BOI investigation found a total SNAP overpayment of \$63,405.00. On December 19, 2011, the client pled guilty to State Benefits Fraud. He was sentenced to two years in the Illinois Department of Corrections.

- Child Care Recipient Fraud / Provider Fraud
Referral to the OEIG

BOI received a referral from the DHS Bureau of Child Care and Development (BCCD), alleging that an Alexander County resident received child care benefits and the provider was her sister. An audit by BCCD found that the provider was a State employee and worked the same hours that the recipient worked. Because the provider was a State employee, BOI referred the case to the Office of the Executive Inspector General (OEIG). The OEIG requested that BOI complete their fraud investigation. The BOI investigation report was completed showing a child care overpayment from November 2003 through August 2008.

The investigation report was provided to the OEIG and the case was referred to the Attorney General for criminal prosecution. Criminal charges were filed in the Circuit Court of Alexander County against both subjects on January 18, 2011. The preliminary hearings for both defendants were held on February 15, 2011.

The recipient pled guilty on May 26, 2011 to State Benefits Fraud, a Class 3 Felony in Alexander Circuit Court and was ordered to pay \$27,159.45 in restitution and to also pay fees and costs and sentenced to serve 24-months probation. The provider pled guilty to State Benefits Fraud on August 30, 2011 in Alexander Circuit Court and was sentenced to 24-months probation and ordered to pay \$27,159.45 in restitution and court costs and fees.

- Client Eligibility Investigation, Potential Civil Recovery
Household Composition / Absent Children

A BOI investigation completed in April 2011 found that a client continued to claim her only child in her household although the child moved to Texas in 2009. The investigation estimated a SNAP overpayment of \$4,043.00. The results of the investigation were also submitted to the local DHS office to calculate the actual overpayment. The case was referred for possible consideration for civil recovery of a \$37,103.39 medical overpayment.

- Client Eligibility Investigation
Ineligible Fugitive Felon

BOI was contacted by the U.S. Marshal's office for assistance in locating a fugitive felon who was receiving SNAP benefits. The SNAP recipient was wanted on a felony warrant issue in October 2010 for drug charges stemming from a drug ring investigation in Rockford. The investigation tracked the usage of the Link card every month to a store in Chicago. The U.S. Marshal's office picked up the recipient's mother using the Link card,

and she told the officer where the recipient could be located. The recipient was subsequently arrested on May 4, 2011. Because the recipient was a fugitive felon since October 2010 BOI identified a SNAP overpayment of \$1,225.00 from December 2010 through June 2011.

- Client Eligibility Investigation
Employment / Falsified Pay Information

A BOI client eligibility investigation completed in March 2011 found that a client provided false earning verifications from her employment in order to receive public assistance during times when she was income ineligible. The results of the investigation were submitted to the local DHS office, which calculated that the client had received an overpayment of \$30,792.00 in SNAP benefits.

- Client Eligibility / Child Care Investigation
Income / Assets / Household Composition

A client eligibility investigation by BOI found that a client failed to report her spouse who was residing in the house, as well as her true household income. The investigation was completed in March 2011 and referred to the DHS local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of \$5,658.00. The client eligibility investigation led to a child care investigation. The BOI child care investigation estimated a \$16,854.25 child care overpayment. That information has been referred to DHS Bureau of Child Care and Development for collection activity.

- Client Eligibility and Child Care Investigation
Income / Assets / Household Composition

A BOI client eligibility investigation found that a client falsified his household composition by claiming children (his own children and his niece/nephews) resided with him. The investigation determined that his children resided with their mother and that the alleged niece and nephews actually had no familial relationship to him so he was not eligible to receive assistance for them. Additionally, a Short Term Legal Guardianship Form submitted to the DHS local office was found to be fraudulent. The client was found to be receiving monies from the State for employment as a personal assistant and he owned six vehicles and three properties.

The investigation was completed in December 2011 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of \$5,249.00.

The client eligibility investigation also led to a child care investigation as child care benefits were paid for children who were not in his household. The BOI child care investigation estimated a \$17,519.12 child care overpayment and that information was referred to BCCD for collection activity.

- Client Eligibility Investigation
Household Composition / Absent Children

An investigation by BOI found that a client continued to claim two children in her household although she had relinquished her full custodial rights to them in 2002. Court records were obtained to confirm the appointment of guardianship of the minors. The investigation was completed in March 2011. The results of the investigation were submitted to the local DHS office, which calculated that the client had received an overpayment of \$11,950.00 in SNAP benefits.

- Client Eligibility Investigation
Household Composition

A BOI investigation completed in March 2011 found that a client failed to report her marriage, correct residence, household composition and household income. The investigation found a Las Vegas marriage and spouse who was employed as a stock broker with substantial earnings. The earnings would have made the household income ineligible. The investigation also revealed that the family owned their own home although the client reported that she was paying rent. The results of the investigation were submitted to the local DHS office, which calculated that the client had received an overpayment of \$12,559.00 in SNAP benefits.

- Client Eligibility Investigation
Household Composition

An investigation by BOI staff found that a client failed to report that she and her employed spouse were residing together in the same household. The investigation completed in March 2011 estimated a SNAP overpayment of \$24,602.00. The results of the investigation were submitted to the local DHS office to calculate the actual overpayment.

- Client Eligibility Investigation
Assets / SSN Misuse or Discrepancy

A BOI investigation found that a client used an alias name, date of birth and second SSN to hide numerous investment accounts with substantial balances. The investigation was completed in April 2011 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a total overpayment of \$10,324.12: a cash overpayment of \$1,541.12 and a SNAP overpayment of \$8,783.00.

- Client Eligibility Investigation
Household Composition

An investigation completed in May 2011 by BOI investigators found that a client failed to report her marriage, household composition and income from her spouse, who was employed as a firefighter. The results of the investigation were submitted to the local DHS office which calculated that the client had received an overpayment of \$25,649.00 in SNAP benefits.

- Client Eligibility Investigation
Household Composition

A BOI investigation found that a client failed to report that she and her employed spouse were residing together in the same household. Her spouse subsequently filed for dissolution of marriage which was still pending at the time of the investigation. The investigation was completed in June 2011. The BOI investigation estimated a SNAP overpayment of \$19,436.00 (up through the time of the filing for the dissolution of the marriage). The results of the investigation were submitted to the local DHS office to calculate the actual overpayment.

- Client Eligibility Investigation
Household Composition

BOI received a referral that a recipient in Kankakee County failed to report to DHS that the father of her child was living in the assistance unit and had income from employment. The investigation was completed in July 2011 and showed that the recipient failed to report the father of the recipient's child lived in the home from June 2008 through August 2011 and had income from employment. The results of the investigation, in which BOI identified a SNAP overpayment of \$18,875.00, were referred to the local DHS office for handling.

- Client Eligibility Investigation
Other Income / Assets

A BOI investigation found that a client failed to report his income from a workers' compensation claim and his business income. The investigation also found a workers' compensation settlement and deposits into bank accounts. The investigation, completed in August 2011, estimated a SNAP overpayment of \$12,594.00. The results of the investigation were submitted to the local DHS office to calculate the actual overpayment.

- Client Eligibility Investigation
Employment / Assets

An allegation that a client failed to report his ownership and income from three businesses was referred to BOI. Their investigation substantiated these allegations and also found substantial deposits into bank accounts. In September 2011, BOI's investigation was completed with an estimated SNAP overpayment of \$15,270.00. The results of the investigation were submitted to the local DHS office to calculate the actual overpayment.

- Client Eligibility Investigation
Household Composition

BOI completed an investigation on a Winnebago County recipient in November 2011. The investigation found that the client had been living with her ex-husband since January 2005 and during this time he was employed. The results of the investigation were

submitted to the local DHS office which calculated that the client had received a SNAP overpayment of \$29,606.00.

General Investigations – Referrals to the OEIG

During 2011, BOI referred ten cases to the Office of Executive Inspector General for the Agencies of the Illinois Governor (OEIG). The referrals were completed as the allegations refer to possible employee/vendor misconduct outside the jurisdiction of this office. The cases referred included public assistance investigations completed by BOI that may have involved employee misconduct in another agency and the results were sent to the OEIG for further review/action. Once the investigations are referred to the OEIG, BOI does not receive any further disposition on the cases.

- Child Care Recipient
Household Composition

A child care investigation was referred to BOI from the DHS Bureau of Child Care and Development. A Madison County resident allegedly received child care benefits while her husband resided in the home. Because the recipient was a State University employee, this case was referred to the OEIG. The BOI investigation report was completed in March 2011 showing that this case was Unfounded and a copy of the report was provided to the OIEG.

- Client Eligibility
Household Composition

A referral was received from the Randolph County DHS office alleging that the responsible relative (RR) of a recipient was residing in the home and he is employed by the Illinois Department of Corrections. The evidence in this case showed the RR resided with the assistance unit and received income from employment and unemployment insurance benefits from September 2010 through December 2010. The investigation showed an estimated SNAP overpayment of \$766.00 in November and December 2010. The BOI report was completed in April 2011 and referred to the OEIG.

- Child Care Provider

A BOI investigation found that child care payments paid on behalf of a client were questionable as the provider consistently billed for providing child care services during the same hours she was employed as a licensed practical nurse for the Department of Human Services. The investigation found that child care services were billed on behalf of the state employee's grandchildren (her two daughters' children). The investigation was completed in May 2011 and referred to the OEIG. BOI's investigation estimated a child care overpayment of \$40,384.96. At the time of the OEIG referral, the employee was receiving a pension from the state.

- Client Eligibility
Household Composition

A referral, received from the Division of Child Support Services, alleged that a client failed to report her marriage or correct household composition to the department as her spouse was residing in the home. The evidence confirmed the marriage and the living arrangements. The case was referred back to the local office to re-determine the household's eligibility for medical assistance. The BOI report was completed in June 2011 and sent to the OEIG because the client was a DHS employee.

- Client Eligibility
Impersonation

A BOI investigation implicated three DHS caseworkers in the filing and processing of a false application for medical and Supplement Nutrition and Assistance Program (SNAP) benefits. A client determined that a false application had been made in her name when she went to file an application and learned she was already on assistance. A familial relationship was found between two of the caseworkers and the alleged client. The investigation was completed in July 2011 and referred to the OEIG. BOI's investigation estimated an overpayment of \$5,023.80; an estimated SNAP overpayment of \$4,365.00 and a medical overpayment of \$658.80. At the time of the referral, the case was still active.

- Client Eligibility
Vendor Fraud

A referral, received from a complainant regarding the landlord of a DHS County Office, indicated that the landlord owned several properties and he accepted Link cards as payments towards the rent he charged. BOI opened seven client eligibility investigations and was able to interview four of the seven clients named in the allegation. Two clients confirmed that they were asked to use their Link cards towards their rent payment but when they refused, they were evicted or issued an eviction notice. The other two clients denied being asked for their Link cards for payment for rent. In addition, it was alleged that the landlord ran the apartments' utilities off the same utility box that was used for and paid by the State of Illinois. The complainant also alleged that someone from the DHS County Office provided the landlord with her information and the landlord was trying to contact her and was verbally threatening her for turning him in. The seven BOI client eligibility cases were completed in July 2011 and referred to the OEIG for possible vendor misconduct.

- Child Care Recipient
Child Care Provider

A BOI investigation found that child care payments paid on behalf of a client were questionable as the provider consistently billed for providing child care services during the same hours she was employed as a mental health technician for DHS. The case was originally referred to BOI when the Bureau of Child Care and Development completed an audit for November 2007 and filed a child care overpayment for \$442.26. The

investigation was completed in September 2011 and the additional mis-billings were referred to the OEIG. BOI's investigation estimated an additional child care overpayment of \$33,340.98. At the time of the referral, the employee was still employed by the state.

- Child Care Recipient
Child Care Provider

Upon completion of an audit of a child care provider for November 2007 which determined a child care overpayment for \$792.37, the Bureau of Child Care and Development referred the case to BOI. The investigation found that child care payments paid on behalf of a client were questionable as the provider consistently billed for providing child care services during the same hours she was employed as an office clerk for DHS. The BOI investigation was completed in September 2011 and the additional mis-billings were referred to the OEIG. BOI's investigation estimated an additional child care overpayment of \$7,868.79. At the time of the referral, the employee was still employed by the state.

- Client Eligibility
Household Composition

A referral was received from the Jefferson County DHS office alleging that the husband of a recipient never left the home of the assistance unit and he is employed by the Illinois Department of Transportation. This case was sent to the OEIG because the husband is a State employee. The evidence in this case showed the husband has resided with the assistance unit and has received income from employment and worker's compensation. The BOI report was completed in September 2011 and referred back to the local office to complete the overpayment. DHS calculated a SNAP overpayment of \$6,164.00. A copy of the investigative report was provided to the OEIG.

- Prosecution

BOI received four (4) overpayment referrals from DHS reporting that state employees had incurred SNAP overpayment as they failed to report their employment with the state. Although the cases were rejected for full investigation and possible prosecution as the dollar amount of the overpayments were below the prosecution threshold for Cook County, the information was referred to the OEIG due to possible employee misconduct.

Provider Collusion – Client Eligibility Study

The Bureau of Investigations conducted a special study at the request of Director Hamos in response to several allegations received by the Director's Office. It was alleged that as clients visited certain physicians, information on their applications may have been falsified to make the clients eligible for medical assistance. BOI identified 15 public assistance cases to investigate to determine if each recipient was financially eligible for medical assistance as of the dates of their application.

Two BOI investigators were assigned to determine if there appeared to be a concerted effort by a particular physician's group to qualify their patients for medical assistance, regardless of need.

Additionally, as public assistance applicants are frequently assisted with the completion of their “All Kids” applications by an “All Kids Application Agent” (AKAA) who receives a \$50 fee pursuant to the approval of each application they assisted with, the AKAA role in the application process was also reviewed.

In one of the 15 cases investigated, the client reported on their initial All Kids application that her spouse had income from his employment; however, she failed to report that she was also employed at the time of the application. On the date of that application, the applicant’s income was reducing and her employment ended the following month as a result of her pregnancy, and for an unrelated pending surgical procedure. However, according to DHS policy, the additional income did not make the applicant ineligible for medical assistance because their household income was within the allowable income standard.

In two of the 15 cases investigated, recommendations were made to DHS to re-determine eligibility for continued medical assistance. The recommendation in the first of these cases was made because the client could not be located for an interview. The second recommendation was because the client was found to have a substantial increase in their employment earnings since the date of their original application.

After examining all the information identified during the investigations, BOI determined that no evidence was found showing any improprieties on behalf of doctors, or by any of the five AKAA’s who assisted 11 applicants with their All Kids applications, nor was there an orchestrated effort to “make” applicants eligible on behalf of any of the parties.

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, the SNAP Fraud Unit has received 41,143 referrals from the USDA Food and Nutrition Services (FNS) and 630 referrals from field staff and hotline calls. According to the FNS Midwest Regional Office Director, Illinois continues to be one of the most active states in the Midwest Region in pursuing clients suspected of EBT fraud and is highly regarded by the Department of Agriculture, Food and Nutrition Services.

“Illinois continues to have a successful EBT client integrity project. In FY 2011, the State’s efforts resulted in 909 EBT disqualifications of recipients. Illinois’ success could not have been achieved without a commitment to integrity and the dedication of staff and resources to this important project. Illinois staff continues to be a pleasure to work with on these activities. ”

Illinois is held up nationally by FNS as a model of a successful EBT client integrity project. We know that in this environment of limited resources, tough decisions have to be made on where to expend 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 2011, the SNAP Fraud Unit received a total of 773 SIPV and 5,565 EBT referrals. The Unit completed 2,742 reviews, participated in 2,127 Administrative Disqualification Hearings and processed 17 prosecution disqualifications. There were 904 administrative hearing decisions rendered of which 863 were positive, resulting in disqualification of the client. Thirty-eight of the positive hearing decisions had overpayments of over \$16,000. In addition, 31 of the positive decisions involved second offenses resulting in a two year disqualification and five decisions resulting in permanent disqualifications.

The SNAP Fraud Unit processed 496 signed waivers (client admission of guilt), with 17 of the signed waivers with overpayments over \$16,000. In addition, the Unit obtained signed waivers on 29 second offense cases which resulted in two year disqualifications; three cases with ten year disqualifications; and, four cases with permanent disqualifications.

The Unit’s efforts in 2011, led to the following notable accomplishments:

- SNAP Fraud Unit received a positive hearing decision for a case that had two overpayments totaling \$48,696. The client was disqualified for one year because she did not report employment or assets.
- SNAP Fraud Unit received a positive hearing decision for a case that had a \$42,189 overpayment. The client was disqualified for one year because she received benefits for a child that did not exist and for a granddaughter that was not in her care.
- SNAP Fraud Unit received a positive hearing decision for a case that had a \$41,891 overpayment. The client was disqualified for one year because she received benefits for two children who were not in the home and also did not report spouse in the home or his employment.

- SNAP Fraud Unit received additional positive hearing decisions on cases that had significant high dollar overpayments: \$40,768; \$38,620; \$35,926; \$34,343; \$32,999; \$32,155; \$31,199; \$31,182; and, \$30,276.
- SNAP Fraud Unit attained a signed Waiver from a client who had an overpayment of \$52,493. The client was disqualified for one year because she failed to report spouse in the home and his employment since 1996, and her property assets.
- SNAP Fraud Unit attained a signed Waiver from a client who had two overpayments totaling \$37,544. The client was disqualified because she failed to report the father of her child in the home or his income.
- SNAP Fraud Unit attained a signed Waiver from a client who had an overpayment of \$34,036. The client was disqualified because she failed to report all her bank accounts and assets.
- SNAP Fraud Unit attained additional signed Waivers on cases that had significant high dollar overpayments: \$30,792; \$26,999; \$25,661; and, \$24,326.

HFS Employee Investigations

The OIG Bureau of Internal Affairs (BIA) completed 163 employee and vendor investigations during 2011.

Misuse of Department Resources/Time Abuse/Falsification of Records/Travel Vouchers

- An anonymous complaint was received alleging that two HFS employees, who travel extensively as a part of their jobs, have repeatedly submitted falsified travel logs and travel vouchers that allowed them to receive travel funds for which neither was eligible to receive. The source claimed that the two traveled in one automobile yet each billed the state of Illinois for travel as if they drove separately. In addition, the travel arrival and departure times were questioned for both employees.

The travel and attendance records for the two were reviewed and surveillance was conducted. The surveillance findings along with the information provided by the source established that one of the employees claimed mileage on three occasions that she was not entitled to receive. The same employee also left early on six occasions, arrived late one time, and took an extended lunch on two occasions. The second employee claimed mileage on seven occasions that she was not entitled to receive. The second employee left early on seven occasions, arrived late one time, and took an extended lunch one time. Both employees' travel vouchers were withheld from processing so no financial loss was incurred during our review period. When confronted with our findings, both employees resigned from the Department. Both employees were required to resubmit corrected travel vouchers that reflected legitimate claims for which they were entitled; however, the investigation prevented the employees from receiving state funds to which they had fraudulently submitted and were not entitled.

- Internal Affairs received a handwritten anonymous complaint alleging a management employee was abusing time by extending her lunch period, arriving late for work, and departing early for the day. The complainant documented five dates and times during

December 2010 as periods of time abuse. Subsequently, the complainant called with twelve additional dates of alleged time abuse from January 2011 through March 2011.

Surveillance at the employee's work location disclosed that the employee arrived approximately 30 minutes after her scheduled start time on three occasions. In each instance, the employee misrepresented arrival times on the HFS MC 163 Ethics Time Sheets.

Internal Affairs learned that the employee intended to resign with HFS and seek employment in the private sector. The Office of Labor Relations was pursuing disciplinary action against the employee at the time of the employee's resignation in April 2011.

- An anonymous complaint was received that alleged an HFS employee managed a personal lawn business from his HFS work cubical using a personal cellular telephone and an agency issued desktop telephone. A second anonymous person reiterated the initial complaint and alleged that the employee was also scheduling athletic events, booking sponsors, and negotiating financial transactions during his HFS workday. Interviews with supervisors and co-workers confirmed that the employee spent a considerable amount of time on his personal cellular telephone. The employee's voice was described by co-workers as loud and disruptive.

The investigation concluded that the employee conducted multiple personal business activities throughout the workday and during overtime periods that included his personal lawn care business, organizing a basketball tournament, sending and receiving large volumes of personal text messages, and extensive Internet activity on his personal cellular telephone. Our analysis established that the employee's personal cellular telephone was in use from 15% to 50% of the average workday. The employee also used the Department's email system and agency telephone for personal use. The employee was disciplined for his conduct.

- An HFS employee was suspected of misusing Agency resources. The investigation determined that the employee used the HFS email system, computer and Internet resources for personal use in violation of HFS policies. The employee sent personal email messages to a network of other individuals outside of the Agency, and acknowledged that the Internet was used to research and plan personal activities such as vacations. Forensic evidence substantiated that the employee had downloaded unauthorized software from the Internet onto the agency computer and those of other co-workers. The employee also used the Department's computer resources to store personal documents. The employee was disciplined for his conduct.
- An employee of another state agency filed a complaint with the Office of Executive Inspector General (OEIG) regarding personal emails he received at work from an employee working at HFS. The emails pertained to a child welfare investigation involving the employee's son. The OEIG referred the matter to the HFS OIG for handling.

The investigation determined that the HFS employee used the Agency computer to store personal documents and to send a significant number of personal emails. The employee was discipline for her conduct.

- An anonymous source reported to Internal Affairs that a supervisor departed from her state job early to work a second job in a nearby retail store. The employee allegedly did not use available benefit time (ABT) to account for her absences. The complaint also alleged that this supervisor had directed one of her staff to work on her child support case.

The investigation determined there was no evidence to support the allegation that the supervisor departed from her state job early in order to work a second job. There was also no evidence to support the allegation that the employee failed to use ABT for absences or directed a subordinate to work on her child support case. Our analysis of the employee's time records established there were no overlapping hours between the employee's state employment and her second job. The analysis confirmed that ABT was used to account for any absences from her state job.

Workplace Bullying, Sexual Harassment and Inappropriate Behavior

- Two agency employees reported a conflict with another employee at their work site. The employee allegedly confronted the two co-workers for not holding open the door. The situation escalated into talk of beating up the co-workers. The aggressor told the co-workers he had previously beat up two police officers in another state. One of the co-workers acknowledged challenging the aggressor several times to follow through with his threat.

On another occasion when these same employees were discussing upcoming elections, the aggressor became so irritated at the political conversation that he threatened to choke anyone who did not vote in the election. The employee was disciplined. Management also suggested the employee attend personal enrichment courses offered by the HFS Bureau of Training.

- An investigation was conducted on an employee for alleged inappropriate behavior and a conflict of interest. The employee was suspected of requesting a Medicaid provider prepare a letter of support on his behalf in rebuttal to a personnel matter between the employee and HFS. The employee also allegedly discussed with the provider the Department's decision to re-audit the provider's facility without appropriate permission.

Based upon physical evidence, witness interviews and the employee's own admissions, the employee behaved inappropriately when he discussed his employee performance evaluation and the audit of the provider's facility with the provider. The investigation established that the provider drafted a letter at the employee's behest that was later mailed by the employee to the HFS Director, the HFS Inspector General, and the Office of Executive Inspector General. The employee's intent was to use the letter to rebut his recent performance evaluation. This incident was further aggravated by the fact that employee previously audited this provider then used that professional relationship for personal gain. The employee was disciplined for his conduct.

- An agency supervisor reported that an employee in her area behaved in a threatening and hostile manner towards her. The investigation determined that the employee yelled at his supervisor. The employee admitted he raised his voice at his supervisor because he felt she was being unprofessional when she addressed him as “Hey.” The employee admitted this was not the only occasion when he quarreled with his supervisor.

Several co-workers overheard a verbal exchange between the employee and his supervisor and added that the employee’s disruptive behavior has been ongoing in the workplace for months. The supervisor and the employee were both disciplined for their inappropriate behavior.

- A client reported to HFS that a male employee of the Agency engaged in sexual harassment. The client told an HFS supervisor that while the employee was on a telephone call with her earlier that day, the male employee made unwelcome, unwanted and lascivious remarks.

The investigation determined there was sufficient evidence to support the allegation that the HFS employee violated multiple HFS policies when he made sexually explicit comments to the client during the phone call. The employee's actions were inappropriate for the workplace, were outside the scope of his official work duties, and caused the client to become alarmed, fearing for not only her safety but also that of her children.

A co-worker of the offender revealed that the offender confided in him about a conversation the offender had with a client. The offender told the co-worker that he had engaged in a sexual, flirtatious telephone conversation with a client.

The offending employee failed to cooperate in this investigation with both his supervisor and Internal Affairs investigators. After a pre-disciplinary hearing, the employee elected to resign his position with HFS.

Breach of Confidentiality and Misuse of Computer Systems

- A complaint was filed by an HFS client against an employee for negligence in servicing her case and for discourteous treatment. The client alleged the HFS employee yelled at her for approximately 25 minutes for calling so often. The client stated that when she requested to speak to the employee’s supervisor, she was told the supervisor was not available. The client requested that another employee handle her case in the future.

The client’s statement, internal emails and electronic case notes were sufficient evidence to support the allegation against the employee. Initially, the employee said that she did not see or speak with the client. Later the employee acknowledged she serviced the client’s case but said claimed she acted professionally when dealing with the client. The employee was disciplined.

- A manager reported to Internal Affairs that an employee may be involved in a conflict of interest and may have released confidential client information to an unauthorized source. The employee had earlier recognized her relationship with several clients as a potential concern and alerted management to the situation in 2010.

The client alleged in her complaint to the manager that she told the HFS employee that the father of her children had recently gotten married. The client alleged that the employee told another client who also had children with the same man. The client claimed that within several hours after leaving the office, she received a telephone call from the father of her children who was upset that she reported his marriage to the Agency.

A 30-day monitoring on the two child support cases of interest was established. Despite recognizing these cases as a potential conflict of interest, the employee accessed both cases during the monitoring period and reviewed multiple screens associated with each case.

The employee acknowledged accessing one of the cases but denied accessing the second child support case. She acknowledged accessing the child support case knowing that such behavior was prohibited and recognized as a conflict or potential conflict of interest. The employee was disciplined for her behavior.

- A non-custodial parent (NCP) claimed during a court hearing that he made two child support payments at a child support office. The NCP alleged that neither payment was properly processed and credited to his child support case.

The investigation determined that on October 20, 2010, the NCP presented two false receipts in court claiming that the Division of Child Support Services (DCSS) failed to properly process both payments. In January 2011, the NCP was asked under oath to provide the court with additional details regarding the two receipts he submitted to the court. The NCP testified he made each of the payments via a money order and that he made the payments in person at the DCSS office. By comparing these two receipts with an authenticated receipt and the DCSS receipt books, numerous discrepancies were noted by the Cook County State's Attorney's Office (CCSAO) including the size of the receipts and their serial numbers. The CCSAO determined the NCP lied in court and that both receipts were fabricated false documents. The NCP was prosecuted, found guilty of criminal contempt in Cook County court and was sentenced to six months in jail.

- A guardian for a child in an HFS case reported to the Agency that she received an income tax refund in the name of the child's deceased mother. The check was allegedly given to an employee who was supposed to provide the guardian with guidance on what to do with the check. Allegedly, the employee did not contact the guardian or return the check to her.

According to the Comptroller's website, the \$2,486.00 check was collected on behalf of the deceased client and the check in question had not been cashed.

When the employee was questioned, he immediately produced the check from a desk drawer. The employee recalled the child's grandmother (who was the guardian) presenting the check at the end of the workday and then placing it in a drawer in his desk. The employee said he told his supervisor about the check and then forgot to forward it to the Bureau of Fiscal Operations. The supervisor told investigators he had no recollection of the employee discussing this particular check with him.

The check was secured by an investigator and then forwarded for appropriate processing. During the employee's interview, investigators determined the employee was scheduled to retire in less than two weeks. Due to the timing of the employee's departure, no disciplinary action was pursued.

- The OEIG forwarded a complaint that alleged an employee had accessed and released confidential case information about a Supplemental Nutrition Assistance Program (SNAP) recipient. The SNAP recipient said she was in an intimate relationship with the employee's son and with whom she shares two children. The employee has custody of her two grandchildren. According to the SNAP recipient, the employee said she could have the SNAP benefits and unemployment benefits canceled with "the click of a button."

The employee admitted that she accessed the system database in an effort to provide the non-custodial parent's address to child support staff. The employee violated HFS policy when she allowed private and personal interest to conflict with work-related job duties and responsibilities. The employee was issued discipline.

- An email inquiry to child support staff contained "verbatim" information from a child support case notes screen from the Key Information Delivery System (KIDS). Either the individual making the inquiry or an employee had accessed the child support case and released confidential DCSS case notes and agency information.

It was determined that the individual that sent the email inquiry was a contractual employee with the Department of Human Services (DHS). The individual's organization was contracted to administer social services programs and had access to the DHS client database and KIDS. Evidence showed the contractual employee accessed information related to her own child support case on at least 41 occasions. In addition, she accessed her biological father's closed child support case, on at least one occasion.

Because of the findings in the investigation, the contracting agency will be conducting periodic training on the conditions under which their staff is to access HFS/DHS computer resources. Any violation of the system security will result in immediate termination.

Following the Internal Affairs interview, the contractual employee was immediately dismissed from work and subsequently terminated.

- A client alleged that during an interview with an HFS employee, the employee revealed that she had a social relationship with the mother of the alleged father in the client's case. The complainant said the employee telephoned her friend and informed the friend that the client had applied for child support naming her friend's deceased son as the father of the child.

While trying to determine whether the employee called her social acquaintance to tell her a client came into the office naming the friend's deceased son as a father of a child and applying for child support assistance, we discovered the employee's telephone abuse.

The employee admitted to using her assigned Department telephone during work hours to engage in long and frequent unauthorized telephone calls to family members.

The employee was issued discipline and was directed to make restitution to the State of Illinois for the unauthorized telephone calls to family members.

- Internal Affairs received a complaint that a Department employee breached confidentiality by telling an individual that a client had applied for assistance. The employee is the uncle of the alleged father in the assistance case. The client asserted that within two hours of leaving the office, the alleged father was at her home screaming at her for filing for support. The police were called in an effort to get the alleged father to leave.

The employee admitted to investigators and our monitoring verified that the specific child support case was accessed for personal reasons. The employee was discipline for his behavior.

- An HFS client alleged that two State of Illinois workers, one an HFS employee and the other a DHS employee, tampered with her HFS case. The investigators established a 45-day monitoring on the case in question, reviewed the case with the liaison and made several unsuccessful attempts to contact the complainant by telephone and by mail, to include sending a certified letter. They also spoke with the caseworker who fielded the complaint in an effort to establish additional details about the allegations.

The investigation determined that the DHS employee is the complainant's mother-in-law and worked at a local office and the HFS employee also worked in the same county as the DHS employee. The 45-day monitoring of the case established that neither accessed the case. Furthermore, the review of the case did not determine any activity that would be considered unusual, constitute tampering or be considered intentional undermining of services.

- An OEIG referral regarding the State Disbursement Unit (SDU) and a non-custodial parent alleged that the NCP mailed "at least ten" child support payments to the SDU for which she has not been credited nor has the custodial parent (CP) received. She also claimed the SDU refused to assist her in locating these payments.

SDU records confirmed they received a total of six payments from the complainant. Five of the six payments had been negotiated by the custodial parent. The most recent payment the complainant sent was disbursed by the SDU in December 2011. SDU staff confirmed there were no case notes or service requests in the case in question. Furthermore, our office was unable to contact the complainant via the telephone number or email address she provided in her OEIG complaint. The investigators sent a certified letter to the complainant providing details of her child support payment information. The investigation found no evidence of negligence on the part of the Department or the SDU.

- Internal Affairs received a report from an HFS contractor that a contractual employee had been terminated in January 2011 after it was discovered the individual had used a supervisor's company issued credit card to make a non-work related purchase. Because

the terminated employee had access to the HFS child support data base, a computer forensic examination was conducted to rule out a breach of confidentiality.

The computer forensic examination established there was no evidence the employee took social security numbers from the child support database and placed them in a file or transferred HFS client personal data to a USB drive. The investigators discovered the employee used the agency computer for personal email and to access several banking Internet sites for personal reasons. The computer also contained sexually graphic images that were housed in a zip file.

Miscellaneous Investigations

- In September 2011, Illinois State Police, Division of Internal Investigation reported that they had received a complaint from a hospital in Springfield. The complaint alleged an HFS employee attempted to secure (through Medicaid funding) a specialized piece of equipment on behalf of her teenage profoundly disabled son.

According to hospital officials, the employee has secured two similar pieces of equipment previously on behalf of her son. The employee allegedly told hospital staff that while hospital records may reflect her son has previously received specialized equipment, Medicaid shows only one. Based upon past remarks made to hospital staff by the HFS employee, a co-worker had expedited the Medicaid related purchases. It was confirmed that this specific co-worker retired in August 2011.

The investigation determined that the HFS employee did not have the system access to manipulate the Medicaid system. A complete analysis was performed regarding the employee's claims for medical equipment, processing and approval times for all similar Medicaid claims. There was no evidence that the employee in question received services to which they were not entitled nor was there any data that indicated claims were expedited. The processing time for similar equipment totaled 640 claims and ranged from one day to 483 days from receipt to approval times. The investigators validated the claim in question request took only four days; however, there were 218 claims processed ahead of the employee's request. In addition, the first equipment claim from the employee for specialized equipment made in 2004 was paid for through a private insurance carrier. Therefore, only one specialized piece of equipment was funded through Medicaid. The ISP was notified of the findings.

- An employee of HFS alleged her HFS co-workers intentionally failed to record significant issues that were uncovered during a care facility review. The issues include missing documents, medication errors, invalidated programs and, on one occasion, an alleged sexual abuse that may not have been properly reported.

The investigation determined that the allegations against HFS staff were unsubstantiated. Many of the claims the complainant made against her co-workers were also recorded in her six-month performance evaluation and her evaluation rebuttal. The complainant filed a grievance in response to her evaluation; however, the grievance was closed by the Office of Labor Relations after the employee failed to respond to a request for additional documentation.

The investigation determined that the complainant was having work performance issues that included the inability to fulfill her duties, conflicts with co-workers, inadequate report writing skills, poor resident interviewing and follow up skills and a failure to follow supervisory instructions.

The most serious allegation alleged by the complainant was that a female resident at the care facility claimed a physician made her fondle him and that the matter was not properly reported or properly handled by the bureau. The investigators determined that immediately following an anonymous call to the complainant's bureau regarding this incident, a supervisor called the care facility manager with instructions to contact the local police department. The local police conducted an investigation and filed a police report. The complainant's bureau also conducted an administrative investigation. The bureau cited the facility for failing to notify local law enforcement immediately after being alerted to suspected sexual abuse of a resident. Our investigation concluded the complainant's bureau handled the allegation of a sexual abuse matter involving a care facility resident in a timely and appropriate manner.

Administrative Litigation Initiatives

Attorneys from the Bureau of Administrative Litigation (BAL) represent the Department in provider 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) in instances when DPH seeks to decertify a long term care facility. In Calendar Year 2011, BAL achieved continued success in expediting hearings and resolving administrative cases. As a result of improved efficiency and overall management of cases, the recoveries achieved through BAL administrative actions totaled over \$6.8 million dollars in 2011. Currently, BAL has initiated administrative actions on behalf of the Department to recover over \$37 million dollars.

Over the past several years, BAL commenced several new initiatives aimed at strengthening program integrity efforts in the State of Illinois and expediting sanctions against high risk providers perpetrating fraud, waste, and abuse on the Illinois Medical Assistance Program. Certain initiatives have more recently been recognized as "Best Practices" and "Effective Practices" by the Department of Health and Human Services Centers for Medicare & Medicaid Services Medicaid Integrity Program.

Ongoing BAL Initiatives Strengthen Program Integrity Efforts

BAL's *Integrity Initiative* was created to provide a more effective method of ensuring provider compliance with Department policies and rules during the post settlement period. As part of that initiative, BAL staff negotiate and monitor compliance with comprehensive provider integrity agreements. After commencement of an administrative action by BAL to terminate a provider from Program participation, BAL may determine that, in order for a provider to continue participation in the program, a comprehensive integrity agreement in lieu of a more streamlined settlement agreement is necessary. Under these integrity agreements, providers agree to perform specific obligations that ensure correction of past deficiencies related to Program participation. Such agreements result in enhanced provider monitoring and accountability.

The Department of Health and Human Services Centers for Medicare & Medicaid Services Medicaid Integrity Program conducted a comprehensive review of the State of Illinois's

Medicaid Integrity Program and identified practices that merited consideration as a noteworthy or “best” practices. In its Illinois Comprehensive Program Integrity Review and Final Report, CMS recognized BAL’s wide range of administrative sanctions, including the ability to impose CIA’s as a “*Best Practice*” recommended to be emulated by other States. Specifically, CMS noted the following:

The HFS-OIG utilizes a wide range of sanctions to foster provider compliance from provider education up to and including termination. Its flexible provider lock-in programs include limiting provider participation for varying periods of time, disallowing the use of alternate payees or granting power of attorney to anyone else, requiring submission of tax returns, limiting a provider’s practice to one site, and the use of individual CIAs.

By requiring certain providers to sign CIAs as a condition of their continued participation in Medicaid, the HFS-OIG is able to commit providers to such program integrity obligations as adherence to a code of conduct and full compliance with all the statutes, regulations, directives, provider notices, and guidelines that are applicable to the State Medicaid Assistance Program. The CIA can also be used to require specific forms of training and education and compliance with relevant certification and reporting requirements.

(Department of Health and Human Services Centers for Medicare & Medicaid Services Medicaid Integrity Program. Illinois Comprehensive Program Integrity Review Final Report January 2012)

Preliminary Call and Expedited Recoupment Initiatives

Two additional BAL initiatives were recognized by CMS in their final report as “Effective Practices.” The Expedited Recoupment and Preliminary Call were established to streamline and expedite case management, and have proven essential to the efficient resolution of cases. In its Final Report, CMS noted the following:

As part of the initiatives, half of the BAL’s cases were reassigned to the Preliminary Call, a single extended monthly call in which hearings are streamlined to allow expedited prosecution of cases. Management of the Preliminary Call is assigned to one BAL attorney, leaving other BAL attorneys available to focus on the prosecution of more complicated and high priority termination and recoupment cases. the State to devote more resources to priority cases involving administrative actions against high risk providers. ”

As a result of these initiatives, BAL’s case management process has become significantly more efficient, doubling the number of resolved cases and monetary recoupment each year. The BAL’s focus on NET and group psychotherapy providers, which comprised 70 percent of all cases referred for administrative action, alone yielded over 43 provider terminations and 90 debarments of owners and managers of NET and group psychotherapy

companies over the course of the last three years. Additionally, through final administrative decisions and settlements during this time period, BAL recovered over \$20 million in overpayments.

(Department of Health and Human Services Centers for Medicare & Medicaid Services Medicaid Integrity Program. Illinois Comprehensive Program Integrity Review Final Report January 2012)

OIG Sanction Initiatives

One key program integrity function of BAL is the oversight and enforcement of Program provider sanctions. In 2011, in effort to strengthen program integrity, BAL undertook a new and aggressive initiative to expedite Department sanction actions. As part of this initiative, BAL initiated over 170 sanction actions, and successfully terminated 122 high risk providers from eligibility in the Program. In addition to enforcing Illinois Program sanctions, BAL reviews provider exclusion databases to identify providers who have been excluded from federal or other state healthcare programs. In instances where a provider who is excluded from federal or another state's healthcare program is identified, BAL takes action to exclude the provider from eligibility in the Illinois Program.

OIG systematically update the HFS-OIG Provider Sanction Database, available online at <http://www.state.il.us/agency/oig/search.asp>. This database, which is publically available and searchable, alerts Illinois employers, healthcare providers and the public about the exclusion status of Program providers. State and federal law prohibits Program payment for items and services ordered, furnished or prescribed by an excluded individual, as well as to entities in which an excluded individual is serving as an employee, administrator, operator or in another key capacities. Also, no payment may be made to any business or facility that submits bills for payment of items or services provided by such an individual or entity. Entities participating in the Program are obligated to check the HFS-OIG Provider Sanction Database, as well as federal sanction websites, prior to employment or utilization of an individual or entity and periodically thereafter.

New State Laws and Rules to Combat Recipient Abuse of the Medical Assistance Program

BAL is responsible for drafting legislative initiatives and rules to ensure OIG's program integrity mission of identifying and eliminating fraud and abuse of the Program. The Illinois Medicaid Reform Law was signed into law in January 2011 (P.A. 096-1501). This law allows the OIG to aggressively pursue actions against individuals or entities that fraudulently obtain unauthorized medical benefits, among other features. The program integrity section of the Medicaid Reform Law, located at 305 ILCS 5/8A-2.5, authorizes HFS to seek to recover state and federal monies expended for improper and erroneously paid benefits as a result of fraudulent actions of Program recipients. This law also allows OIG to take action against individuals or others who obtain medical benefits through the unauthorized use of a medical card. The statute authorizes the Department to recover civil penalties and interest on overpayments to recipients. Prior to the recovery of any amount paid for benefits allegedly obtained by fraudulent means, the recipient of such benefits is afforded the opportunity for a hearing.

The OIG is actively investigating recipients who may have fraudulently obtained unauthorized medical benefits. BAL is preparing to utilize the civil remedies hearing processes for unauthorized medical benefit use, once pending administrative rules establishing the civil

remedies hearing process receive final approval. In September 2011, the Department filed proposed rules amending 89 Ill. Adm. Code Sections 104 and 140 and creating Sections 104.900 et seq. and 140.1300 et seq. The rulemaking will establish a procedural framework for HFS hearings for recipients alleged to have received unauthorized medical assistance benefits, enforcement of Final Administrative Decisions, and collection of repayment and penalty amounts.

The OIG also proposed a rule to amend 89 Ill. Adm. Code Section 120.80 pursuant to the Medicaid Reform Law amendments at 305 ILCS 5/11-26 which will expand the Department's ability to restrict a recipient to a Department-designated "primary provider type" when the recipient is abusing the Program. The rule is pending final approval.

Notable Final Administrative Decisions and Recoveries

The OIG is responsible for ensuring the integrity of the Program through the prevention, detection and elimination of Program fraud and abuse. This function is achieved largely through financial auditing of Medicaid providers. Audits ensure that payments made to providers for services rendered were appropriate. If overpayments or improper payments are identified, the Department takes action to recover the overpayment from the provider, and to terminate the provider from Program participation where warranted. The BAL team that represents the Department in provider recovery and termination actions is extremely adept at reaching successful resolution of cases through both settlement and administrative hearing. In 2011, monetary recoveries achieved through BAL administrative actions amounted to over \$6.8 million. The following are some of the notable Final Administrative Decisions and Settlement Recoveries achieved.

- **Institutional Provider – Settlement Recovery in the amount of \$2,903,100.29**

The Bureau of Medicaid Integrity (BMI) conducted an audit of an institutional provider and referred its findings to BAL. The findings included 15 instances of overpayment due to improper simultaneous billings; 15 instances of overpayment due to billing for improper procedure codes; 2 instances of overpayment due to erroneously billed emergency room services; 83 instances of overpayment due to missing medical records of specific services; and 12 instances of overpayment due to billing for off-site clinic services. The provider disputed the OIG's findings, but ultimately conceded and entered into a settlement agreement prior to the commencement of formal administrative proceedings. The recovery amount was \$2,903,100.29.

- **Institutional Provider – Final Administrative Decision for Recovery in the amount of \$924,451.00**

BAL initiated a recovery action against approximately 20 long-term care and developmentally disabled care facilities seeking penalties for late payment of assessments. This matter was brought before the Administrative Law Judge (ALJ) on remand to determine whether the facilities' request for waiver of penalties and interest under the financial hardship standard at 89 Ill. Adm. Code, Section 140.84(h)(2) should have been granted. The ALJ concluded that the Department had met its burden of proof and that the penalties levied against all of the facilities were not affected by waiver. The

ALJ determined that the facilities were responsible for payment of penalties totaling \$924,451.00. The Director issued a final administrative decision adopting the ALJ's recommended decision.

- **Institutional Provider – Settlement Recovery in the amount of \$611,000.00**

BMI conducted an audit of an institutional provider and referred its findings to BAL. The findings included 7 instances of overpayment due to billing for missing general claims, emergency room, and ambulatory procedure records; 255 instances of overpayment due to missing records of specific services, including general and ambulatory claims; and 33 instances of erroneously billed emergency room and unique outpatient services. The provider disputed BMI's conclusions but ultimately conceded and entered into a settlement agreement prior to the commencement of formal administrative proceedings. The recovery amount was \$611,000.00.

- **Individual Provider – Final Administrative Decision for Recovery in the Amount of \$533,828.38**

BMI conducted an audit of an individual provider and referred its findings to BAL. The audit findings against the provider included 22 instances of overpayment due to billing for missing records; 5,881 instances of overpayment due to billing for missing records of specific services; 55 instances of overpayment due to improper procedure code billing; 283 instances of overpayment due to billing for non-covered services; and 8 instances of overpayment due to billing for services performed by another provider. The Administrative Law Judge recommended a recoupment for the full amount of the audit findings totaling \$533,828.38. The Director of the Department adopted the ALJ's recommendation.

- **Non-Emergency Transportation Provider - Final Administrative Decision for Termination and Recovery in the amount of \$335,039.68**

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 extrapolated overpayments in the amount of \$335,039.68. Specifically, the audit identified 149 instances of overpayment due to missing transportation records, 317 instances of overpayment due to failure to produce trip tickets and/or dispatcher logs, 527 instances of overpayment due to billing for unauthorized services, 192 instances of overpayment due to billing for excess mileage; and 165 instances of overpayment due to billing for improper procedure codes. In addition to seeking recovery of funds, OIG sought to terminate the provider from Program participation and to bar the provider's owners from continued participation. The ALJ issued a recommended decision terminating the provider, barring its owners and also recommending that the Department recover \$335,039.68. In May of 2011, the Director issued a final administrative decision, adopting the ALJ's recommendation.

- **Non-Emergency Transportation Provider – Final Administrative Decision for Termination and Recovery in the amount of \$249,347.40**

BAL filed an action against a provider based upon a BMI post-payment compliance audit that found 5,575 instances of overpayment due to billing for missing records. In addition, to seeking recovery of the overpayment, the OIG sought to terminate the provider's eligibility to participate as a Program provider. The ALJ recommended that the Department recoup \$249,347.40 and further recommended the termination of the provider's eligibility to participate in the Program. The Director issued a final administrative decision adopting the ALJ's recommended decision in full.

- **Pharmacy Provider – Recovery in the amount of \$214,385.00**

BMI conducted an audit of a pharmacy provider and referred its findings to BAL. The findings included 5 instances of overpayment due to billing for missing records, 2 instances of overpayment due to billing for missing prescriptions; and 37 instances of overpayment due to billing for missing dispensing records. The provider disputed OIG's findings but ultimately conceded and entered into a settlement agreement prior to the commencement of formal administrative proceedings. The recovery amount was \$214,385.00.

- **Non-Emergency Transportation Provider – Final Administrative Decision for Recovery in the amount of \$203,966.75**

BAL brought a recovery action against a non-emergency transportation provider after a post-payment compliance audit determined that the provider had received extrapolated overpayments in the amount of \$203,966.75. Specifically, the audit identified 4 instances of overpayment due to failure to provide trip tickets and dispatcher log and 242 instances of overpayment due to billing for non-allowable loaded mileage. The ALJ issued a recommended decision finding that the Department was entitled to recover \$203,966.75. The Director adopted the ALJ's decision.

- **Audiologist Provider – Settlement of Voluntary Withdrawal and Recovery in the amount of \$171,609.95**

BMI conducted an audit of an audiologist. The audit identified 34 instances of overpayment due to billing for missing records; 114 instances of overpayment due to billing for missing records of specific services; 366 instances of overpayment due billing for unauthorized services; and 10 instances of overpayment due to billing for non-covered services. After receiving a referral from BMI, BAL initiated an action to recoup the overpayment amount and to terminate the provider from the Program. The provider disputed OIG's findings but ultimately conceded and entered into a settlement agreement, agreeing to pay \$171,609.95 and to voluntarily withdraw from the Program.

- **Non-Emergency Transportation Provider -- Final Administrative Decision for Termination and Recovery of \$109,756.60**

BAL brought a termination and recovery action against a non-emergency transportation provider whom BMI had determined, through a compliance audit, owed the Department \$109,756.60 in extrapolated overpayments. Specifically, the audit found 321 instances of overpayment due to billing for non-covered 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 \$109,756.60 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 of recoupment and termination.

- **Physician Provider - Settlement Recovery in the amount of \$107,945.90**

BAL brought a termination and recovery action against a physician provider, whom BMI had determined, after a compliance audit, owed the Department \$107,945.90 in overpayments. Specifically, the audit found 2,868 instances of overpayment due to billing for missing records. In addition to seeking recovery of the overpayment, the OIG sought to terminate the provider's eligibility to participate as a Program provider. The provider entered into a settlement agreement with a recovery amount of \$107,945.90.

- **Non-Emergency Transportation Provider – Final Administrative Decision for Termination and Recovery in the amount of \$47,921.48**

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 \$47,921.48. Specifically, the audit identified 166 instances of overpayment due to missing trip tickets and prior approvals; 518 instances of overpayment due to missing trip tickets or dispatch logs; and other overpayments due to missing prior approvals. In addition to seeking recovery of funds, the OIG sought the provider's termination from the Program and barrment of the provider's owner. The ALJ issued a recommended decision terminating the provider, barring its owner and also recommending that the Department recover \$47,921.48. The Director issued a final administrative decision adopting the ALJ's recommendation.

- **Physician Provider - Settlement Recovery in the amount of \$35,987.25**

BMI conducted an audit of an optometrist provider. The audit identified overpayments in the amount of \$35,987.25, arising out of 188 instances of overpayment due to failure to produce patient medical records; 6 instances of overpayment due to billing for services provided by another provider; and 1 instance of overpayment due to billing for a non-covered service. After receiving this referral from BMI, BAL initiated attempts to recoup the overpayment. The provider entered into a settlement agreement with a recovery amount of \$35,987.25.

BAL Actions to Ensure Integrity and Quality of the Medical Assistance Programs

One of the integrity functions of the OIG is to monitor and ensure Program quality. BAL takes administrative action to suspend, terminate or deny the Program eligibility of healthcare professionals who fail to meet Department quality standards, who provide care in excess or needs or who place recipients at risk of harm. The following Final Administrative Decisions represent cases aimed at ensuring the quality of programs administered by the Medical Assistance Program.

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

BAL filed a four-count termination action against a physician, alleging that the care rendered by the physician to Program recipients was of grossly inferior quality and placed recipients at an unacceptable risk of harm. In particular, BAL alleged that the physician had inappropriately assessed and managed diabetes mellitus, Hepatitis C and urinary tract infections; failed to properly address positive H. Pylori results and abnormal hemoglobin levels; and failed to provide routine preventive health care and screenings. The ALJ recommended the physician's termination from the Program. The Director adopted the ALJ's recommendation and terminated the physician from the Program.

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

BAL filed a three-count termination complaint against a physician, alleging that the care the physician rendered to Program recipients was of grossly inferior quality, placed recipients at an unacceptable risk of harm and was in excess of patient need. In particular, OIG alleged that the physician: failed to document current medication lists or medication allergies; failed to document vital signs; failed to document evidence of pre-operative and post-operative hearing tests when performing myringotomy and tube placements; failed to document immunotherapy vaccine maintenance level, informed consent for immunotherapy; failed to document allergy vaccine content, dose and concentrations; failed to document indication for prescribed medications, including dose and frequency of treatment; and tested for food allergies without relevant patient histories. The ALJ recommended that the physician be terminated from the Program. The Director issued a final administrative decision terminating the provider from the Program.

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

BAL filed a six-count termination complaint against a physician, alleging that the care rendered to Program recipients was of grossly inferior quality, placed the recipients at an unacceptable risk of harm and was in excess of patient need. Specifically, OIG alleged that the physician: failed to adequately evaluate and manage patients with signs and symptoms of congestive heart failure; failed to adequately manage a patient with diabetes mellitus; prescribed narcotics without clinical indication; failed to properly evaluate a patient with urethral discharge; prescribed improper medications; and failed to address abnormal lab results. At the hearing, BAL presented extensive medical expert testimony relating to the quality of care rendered by the physician to Program recipients. At the conclusion of the hearing, the ALJ recommended that the physician be terminated from the Program. The Director adopted the ALJ's recommendation. Subsequently, the

physician filed an administrative review, appealing the Department's decision in circuit court. The circuit court judge reversed the Department's decision to terminate the physician and remanded the case back to the Department. The ALJ subsequently issued a recommended decision that again recommended that the physician be terminated. The Director adopted the ALJ's recommendation and terminated the physician as Program provider.

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

BAL filed an action seeking to deny a previously terminated provider's second application for reinstatement into the Program. The applicant had previously been terminated from the Program because his license had been indefinitely suspended by the Illinois Department of Financial and Professional Regulation (DFPR). The Department alleged in its complaint that the applicant could not reasonably be expected to meet the written requirements of the Department and sought denial of the application. The ALJ recommended that the applicant's reinstatement application be denied, and the Director adopted the ALJ's recommendation.

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

BAL filed an action seeking to deny a previously terminated provider's application for reinstatement into the Program. The applicant had previously been terminated from the Program because his license had been indefinitely suspended by the DFPR for sexually assaulting a patient. His medical license had been subsequently restored. The provider had previously reapplied for admission to the Program and his application had been denied. The Department, in its complaint, alleged that the applicant could not reasonably be expected to meet the written requirements of the Department and that, after reviewing the activities which served as the basis for the termination, the application should be denied. The ALJ recommended that the applicant's reinstatement application be denied. The Director adopted the ALJ's recommendation and denied the application.

- **Physician Provider - 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 Department sought to deny the applicant's second request for reinstatement because he had an outstanding debt owed to the Department and because his medical license had not been restored by DFPR. The applicant had previously been terminated from the Program because his license had been indefinitely suspended by DFPR. At the hearing, the applicant testified that he should be reinstated to the Program as a medical technician. The ALJ recommended that the applicant's reinstatement application be denied. The Director adopted the ALJ's recommendation.

- **Barred Individual - Final Administrative Decision for Denial of Reinstatement**

BAL filed an action seeking to deny a previously barred individual's application for reinstatement into the Program. The applicant was previously barred because she was the president of a medical facility that was terminated by the Department. The Department alleged that the applicant could not reasonably be expected to meet the written

requirements of the Department and that, after reviewing the activities which served as a basis for the barrment, the application should be denied. The applicant testified at the hearing that she was unaware that she had been the president of a terminated entity or that she was previously barred. The Department introduced evidence to impeach the applicant's credibility. The ALJ recommended that the application be denied and the Director adopted the ALJ's recommendation.

- **Physician Provider - Voluntary Withdrawal**

BAL filed a three-count complaint against a physician, alleging that the care he rendered to Program recipients was of grossly inferior quality, placed the recipients at an unacceptable risk of harm and was in excess of patient need. In particular, OIG alleged that the physician: inappropriately administered and documented ultraviolet light therapy; inadequately trained and supervised personnel administering ultraviolet light therapy; inappropriately prescribed minocycline; inappropriately prescribed potent topical steroids; failed to evaluate and manage patients for major adverse effects of potent topical steroids; inappropriately performed multiple surgeries and lesion excisions without documentation of need; inappropriately prescribed antibiotics without clinical indication; failed to obtain patient histories and physical examination; failed to properly document referral issues and diagnoses; failed to obtain cultures; inappropriately prescribed Clobestal ointment; and failed to make the correct diagnoses. After initiation of BAL's action to terminate the provider from Program participation through filing of a notice of hearing, the provider agreed to settle the case by withdrawing from the Program for 12 months and agreeing to appear before a medical quality review committee upon reapplication, if any. Additionally, the provider agreed to forfeit all the monies that he had billed the Department from the date that he received the notice through the date the Director approved the settlement agreement.

- **Physician Provider - Voluntary Withdrawal**

BAL filed a three-count complaint against a physician, alleging that the care he rendered to Program recipients was of grossly inferior quality, placed the recipients at an unacceptable risk of harm and was in excess of patient need. In particular, OIG alleged that the physician: improperly diagnosed and treated patients for urinary tract infections; failed to adequately evaluate chest pain; failed to adequately treat hypertension; failed to measure and record accurate head circumference; improperly prescribed penicillin; failed to treat abnormal lipid profiles; failed to address domestic violence; improperly prescribed antibiotics; and improperly administered IM Lincocin and Benadryl. After initiation of BAL's termination by sending a notice to the provider, the provider agreed to settle the case by withdrawing from the Program for 12 months and agreeing to appear before a medical quality review committee upon reapplication, if any. Additionally, the provider agreed to forfeit all the monies that he had billed the Department from the date that he received the notice through the date the Director approved the settlement agreement.

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 sixteen fiscal years, the FPI program has provided an estimated average savings of \$12.64 for each \$1.00 spent by the state. FPI has averaged a 64% denial, reduction or cancellation rate of benefits for the 50,020 referrals investigated since fiscal year 1996. In addition, the program's estimated total gross savings has reached over \$140.7 million since the inception of the program.

During Calendar Year 2011, the program generated 3087 total investigations, of which 1263 cases led to reduced benefits, denials or cancellation of public assistance. The overall denial rate for this period was 41%. BOI calculated an estimated gross savings for Calendar Year 2011 of \$8.9 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and SNAP. The program estimated cost savings for Calendar Year 2011, was \$8.19 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 419 investigations during Calendar Year 2011. Of the investigations completed, unallowable asset transfers were identified and penalty periods imposed in 117 of these investigations. The gross savings realized in 2011, based on the identified penalty periods

of the 117 cases was \$12,264,830.00. For every \$1 spent on administration costs relevant to the LTC-ADI program, \$8.83 of savings was realized.

This saving and return on investment does not include the other adverse actions that resulted from the LTC-ADI investigations. 161 of the 419 cases investigated resulted in the client paying for some of their long term care expenses through monthly spend down. In addition, 75 of the applications sent to LTC-ADI were denied because the client either withdrew their application or they failed to cooperate with the investigation.

Throughout 2011, LTC-ADI worked closely with the Division of Medical Programs, the Office of General Counsel and our sister agency DHS to strengthen the program integrity with long term care assistance.

- 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. Decisions on cases that are brought before the court that have originated from a Long Term Care Asset Discovery Investigation are cited as case law to support arguments on other cases with applicable circumstances.

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 court's argument and ruling for this case has been used as supporting case law in other cases with similar issues.

- New Medicaid rules for Long Term Care were adopted by Illinois in 2011 implementing changes proposed by the federal government in the Deficit Reduction Act of 2005; included additional rule changes to tighten loop-holes and bring an end to these schemes that LTC-ADI has uncovered in their investigations.
- Over a period of many years, a scheme had been allowed to develop as a result of a practice of misinterpreting Illinois Medicaid Policy going unchallenged. This practice was discovered during a LTC-ADI Investigation. With the support of Federal and State law the Department argued against the practice during the appeal process. With the Bureau of Administrative Hearings' decision to uphold the Departments decision, the issue was taken to the courts. The Department's decision was upheld throughout.

Implementation of the new Medicaid rules will ensure that the practice will no longer be a viable scheme. The policy that allowed the scheme to develop has been defined to allow no further misinterpretation and is a part of the rule changes adopted by Illinois in 2011.

- The integrity of the LTC-ADI program has been built on high standards of thoroughness, accuracy, knowledge and professionalism. As a result of the program's success, the Long

Term Care Asset Discovery program has been selected to play a significant role in the implementation of new Medicaid rules for long term care that were adopted in 2011. Implementation to begin in early 2012.

Information Technology Initiatives

Predictive Modeling System

The OIG achieved full implementation of an in-house predictive modeling system which was federally funded by a Medicaid Transformation Grant (MTG) awarded in February 2007. This Federal project grant enabled OIG to transform its Medicaid program integrity efforts by developing a predictive modeling system. To date, the Fraud Science Team of the OIG has led a team of medical experts, information technologists, researchers and statisticians in developing an information system that features data mining and reporting capacities for predictive modeling analysis, provider profiling and routine construction.

The Medicaid Transformation Grant project created predictive modeling techniques along with profiling capacities that revolutionize Illinois Medicaid fraud, waste and abuse detection processes of the past. Traditionally Medicaid fraud was a “pay and chase” model (Lazenby, 2009, p.18) where claims were honored in a timely fashion and reviewed for potential fraud at a later date. That has now changed to a proactive, prevention-based, model. The system can now pull from historical claim data, build an evidence-based knowledge base, calculate large amounts of data from multiple resources, cross-reference various data sources, increase the capacity to target providers who render substandard care based on peer review, detect fraud patterns or specific problem areas, all while having the ability for further customization as legislation or other external factors need to be incorporated. The newly developed system supports efficient and effective decision-making processes to detect and deter fraudulent activity.

Through the use of the Predictive Modeling System, the system has provided a much richer look at provider service patterns and their networks. The system identified some known and unknown providers engaging in fraudulent activities. For example, there has been a concern about the rising cost of non-emergency medical transportation (NET) (see figure 1). The figure shows a 128% payment increase from 1997 to 2007. The common fraudulent services for the NET providers were in the form of duplicated billing, services rendered during an inpatient stay, and no corresponding medical service to justify the transportation service. The traditional referral-based audit mechanisms were not precise, nor effective enough to identify these activities. Using the risk score indicator, the

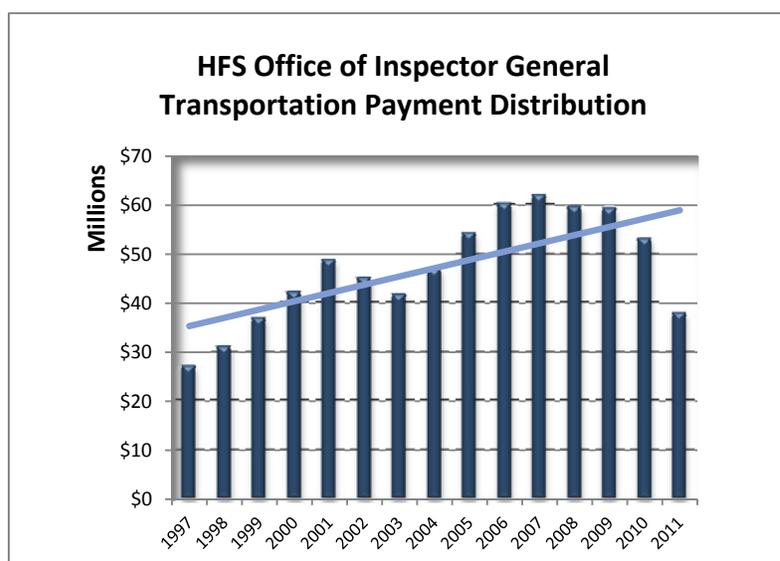


Figure 1

predictive modeling has been deployed to flag transportation providers suspected of these types of activity for further review.

Among these findings, transportation services billed without a corresponding medical claim has shown great potential for fraudulent billing activity within targeted providers. In fact, recent audit processes using the Predictive Model, auditors were able to identify 95% of these claims. In addition, the transportation service during inpatient stay, duplicate billing, and the loaded mileage routines can now be desk-auditable without sending auditors to conduct a field audit. These processes alone increase efficiencies on desk-audit tasks by flagging thirteen million in recoupable dollars from 2009-2011. There is the potential for twenty-three million dollars flagged as potential recoupment from the no corresponding medical service payments.

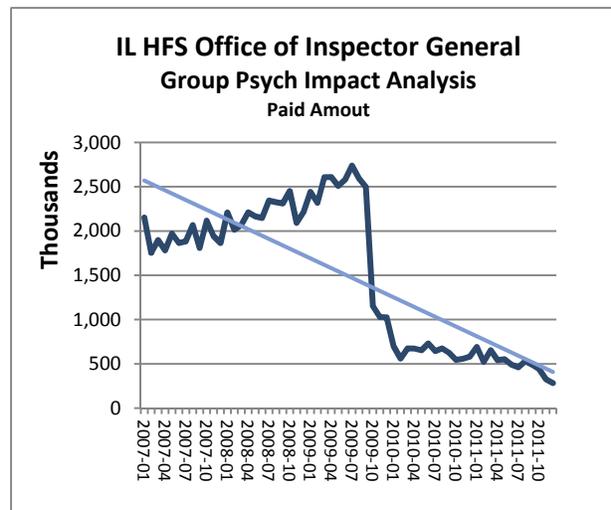


Figure 2

In terms of cross-referencing databases, the information delivery system now successfully utilizes several routines, which address issues of provider established networks through common recipients. It has been known that some psychotherapy providers were working together in fraudulent activity. The technology was not available to effectively identify who and how.

The initial effort in the MTG project was to improve the quality of care for fragile, institutionalized Medicaid recipients. Those that are being moved from a nursing home to inappropriate day care in psychotherapy centers were not acceptable. The system now links transportation services with psychotherapy services and long term care providers. When recipients are being transported to day care facilities for five to seven days per week, the providers involved can be identified as problematic and subsequently flagged for sanction or removal from the Medicaid program.

In the fall of 2009, the Illinois Administrative Rules relating to Group Psychotherapy services, 89 Ill. Adm. Code 140.413(a)(4)(C), were changed based on an analysis produced by the Predictive Modeling System. After these changes, Group Psychotherapy services rendered by a physician were limited to two services (round trips) in a 7-day period, with a maximum of one session per day. Patients in a group were limited to 12 with a minimum of 45 minute sessions. The legislation included requirements that the rendering physician must directly provide the services. The licensing must include the ability to practice medicine in all branches and have completed an approved general psychiatric residency program or is providing the services as a resident or attending physician at an approved or accredited residency program. Another requirement was for the physicians to define the necessity and the goals of the Psychotherapy Services. Figure 2 shows that the total amount being paid for Medicaid Psychiatric services has dropped 70% and per patient cost has dropped almost 35%, translating into savings of almost thirty-five million dollars from 2009 to 2011. A routine that identifies physicians providing improper group psychotherapy practices has been implemented in the information delivery system funded by MTG project.

As a result of the aforementioned changes, the Psychiatric Services Treatment Plan Form for Group Psychotherapy was developed. This form must be signed by the referring physician and direct service provider using an original signature. An illegible, incomplete, inaccurate, or conflicting treatment plan may cause the participant's transportation request to be denied. NET providers are not allowed to complete this form. Figure 3 shows the impact of the PSTP policy. The number of received PSTP forms has drastically decreased since the policy was implemented in 2009. The policy has successfully discouraged a great number of improper NET services. In brief, the predictive modeling system and the information distribution system developed through MTG funding can provide information for future policy changes as well as summarize reports that depict the impact of policies.

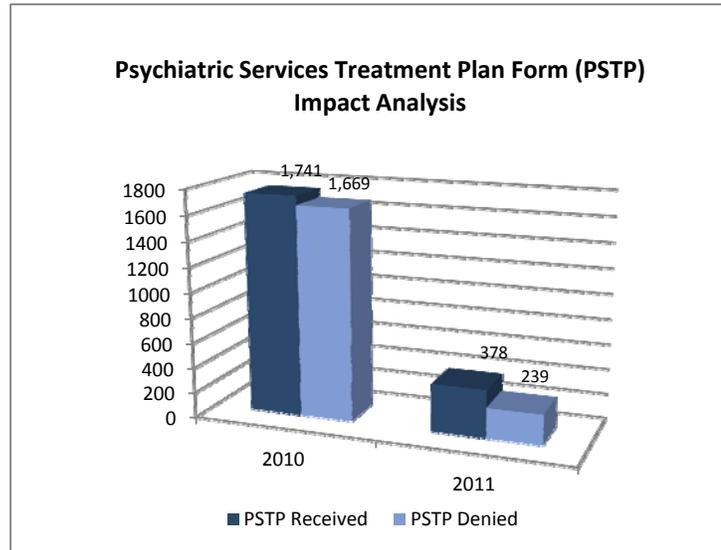


Figure 3

In the case of predictive modeling for Asthma quality of care, OIG and the expert panel agreed on targeting providers who failed to follow recognized standards of care pertaining to emergency room visits, inpatient stays, and medications dispensed. The model was built on a selection of variables associated with Asthma diagnosis and treatment. So far, the model has been completed, implemented in the information system and awaits testing. Yet, the model is invaluable in such ways that 1) the research-based indices selected for the measurement can provide OIG administration, auditors and researchers a more comprehensive perspective in provider assessment, 2) upon testing, the results shall offer recommendations for future policy, and, 3) although the cut-off point for the target providers has not been fully evaluated, the outcome of the Asthma model can serve as an initial sample for audit depending on administrative decisions.

Federally Mandated Medicaid Eligibility Quality Control Program

Post Newborn Pilot

The OIG received approval in August 2011 to target eligibility reviews of children who are at least 15 months old and no more than 23 months old (post newborn) receiving benefits under the State's Moms and Babies program for newborns. Per State policy, "for all newborns, eligibility must be redetermined when the newborn reaches age one year." Previous reviews have revealed children continuing to receive coverage under the Moms and Babies newborn program following one year of age.

The OIG began the reviews in December 2011 and will continue throughout FFY12. A Summary of Findings will be submitted to CMS no later than July 2013.

Illinois Healthy Women (IHW)

For the FFY10 MEQC pilot, the OIG targeted Illinois Healthy Women cases to fulfill the requirements for MEQC and to satisfy the Special Terms and Conditions for the renewal of the IHW waiver. The IHW program provides family planning services to women between the ages of 19 and 44. The reviews were 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.

The results of the reviews were provided to CMS in July 2011 and were as follows:

- A total of 1321 cases were reviewed, of which 81 (6.13%) contained eligibility errors. Of the 81 cases with eligibility errors, 19 had payment errors totaling \$1,831 of the total paid claims for cases reviewed \$26,903, resulting in a 6.81% payment error rate.
- The majority (2.50%) of the 6.13% case error rate was attributed to the initial auto-enrollment cases (cases auto-enrolled when Medicaid ended), representing a small portion (0.84%) of the 6.81% payment error rate. The majority (3.91%) of the 6.81% payment error rate (\$'s) was attributed to the re-enrollments. These cases represented the second highest portion (2.04%) of the 6.13% case error rate.
- Eighty percent (80%) of the cases reviewed (mostly auto-enrolled cases) did not have any paid claims. Redeterminations from both auto-enrolled and applications represented 37% of the claims paid of which 10.55% were paid in error. Applications represented 32% of the claims paid with 3.51% in error.
- The majority of the errors (70 of the 81 case errors and 18 of the 19 payment errors) were due to the recipient's failure to report earned income.
- Case records could not be located for 47% of the cases with eligibility errors and 63% of the cases with payment errors.

With the assistance of staff from the department's Medical Programs, a corrective action plan (CAP) was developed that identified each error type along with target dates by which to implement recommended corrective actions. The CAP is designed to reduce incorrect eligibility determinations that lead to improper payments. The plan was submitted to CMS in November 2011.

Moms and Babies Pilot

Throughout FY 2011, the OIG conducted reviews of the Moms and Babies program to satisfy the MEQC requirement. The pilot targeted the eligibility of women who received benefits under the State'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.

The OIG conducted 945 of these reviews in 2011. Case reviews will continue in 2012 and a Summary of Findings will be submitted to CMS no later than July 2012.

Negative Case Action Reviews

Negative Case Action Reviews (NCAR) also known as Medicaid negative reviews are reviews of cases that have been terminated or denied from the Medicaid program. These reviews are federally mandated and are conducted by the OIG every federal fiscal year (FFY).

FFY 10 In July 2011, the OIG submitted the results of the FFY10 negative case action reviews to CMS. The results were as follows:

- The OIG sampled 228 negative case actions and completed reviews on 223. Of the five cases not reviewed, two were due to the inability to verify the validity of the negative action by either the case record or from the client, two were sampled in error and one was under an appeal.
- Six error cases were discovered, resulting in a 2.69% case error rate. The six error cases were all denials of which four applicants were denied medical assistance with a reason of applicant failed to appear for an eligibility interview, one applicant failed to give information (verification of earned income for a 17 year old) needed to decide eligibility and one applicant was denied for already receiving assistance (GA). However, an interview is not required for medical assistance, verification of earned income is not required for individuals under 19 and the applicant was not already receiving medical assistance on another case. Individual case corrective action was completed on all error and drop cases when appropriate.

A CAP was developed that identified root causes and recommended corrective actions on the error cases designed to minimize incorrect negative actions. The plan was submitted to CMS in November 2011.

FFY 11 The reviews for this sample period began in November 2010 and continued throughout 2011. A total of 204 MEQC negative reviews were completed in 2011. The results of the reviews will be submitted to CMS as a “Summary of Findings” no later than July 2012.

COOPERATIVE EFFORTS

Federal Program Participation

Payment Error Rate Measurement (PERM)

Each year, a different group of state Medicaid and CHIP programs are measured as part of the federally mandated Payment Error Rate Measurement (PERM) program. PERM is a requirement of the Improper Payment Information Act of 2002 and is designed to measure payment errors in the Medicaid and CHIP programs by reviewing claim payments and client eligibility.

Illinois began its third PERM cycle in October 2011 which measures both Medicaid and CHIP payments and client eligibility. The OIG continues to serve as the Department liaison on this

effort. Eligibility reviews began in October 2011 and will continue throughout FFY 2012. These reviews are in addition to the ongoing MEQC reviews and are being completed by OIG staff. The claim payment reviews will begin the 2nd Quarter of FFY 2012 and will continue into FFY 2012. The claim reviews are done by federal PERM contractors, however significant OIG and HFS resources are required throughout the PERM lifecycle, which includes: universe and sample creation, medical record collection, data processing reviews, medical record reviews, and dispute resolution. To help meet the PERM requirements and continue with normal program integrity duties, the OIG has designed and is enhancing its Case Tracking System (CASE) to automate the eligibility reviews by capturing and calculating the various review components.

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 seventeen Global Settlement Agreements during 2011 where the State of Illinois Medicaid Program received \$24,889,082.27 as a recovering party. In the following is a brief description of just a few of these settlements.

- Merck Sharp & Dohme Corp. (“Merck”) Merck & Co., Inc. - \$7,888,421.94

Merck Sharp & Dohme Corp. (“Merck”). Merck & Co., Inc. was a New Jersey corporation with its principal place of business in Whitehouse Station, New Jersey, and was the operating company for Merck’s pharmaceutical business in the United States. As a result of a reverse merger in 2009, Merck & Co., Inc. became a wholly-owned subsidiary of the acquiring company and was renamed Merck Sharp & Dohme Corp. The acquiring company was renamed Merck & Co., Inc. The new Merck & Co., Inc. is a holding company for Merck Sharp & Dohme Corp. and other corporate entities. Currently, Merck Sharp & Dohme Corp. is the operating company in the United States for the pharmaceutical business formerly conducted by Merck & Co., Inc.

Merck developed, marketed, sold and distributed pharmaceutical products throughout the United States, including the drug rofecoxib, which was sold and marketed under the trade name Vioxx® from May 1999 until September 30, 2004, when Merck withdrew Vioxx® from the market.

From May 20, 1999 through April 11, 2002, Merck promoted Vioxx® for rheumatoid arthritis, an indication for use not approved by the federal Food and Drug Administration (“FDA”) in violation of the FDCA, 21 U.S.C. §§ 331(a), 333(a)(1) and 352(f)(1); and which, during the period May 20, 1999 through February 28, 2000, was not a medically accepted indication, as defined by 42 U.S.C. § 1396r-8(k)(6), covered by state Medicaid programs.

From April 2000 through September 30, 2004, when Merck withdrew Vioxx® from the market, Merck promoted the cardiovascular safety of Vioxx® with certain statements by representatives and promotional speakers in written materials that were inaccurate, misleading and inconsistent with the approved labeling for the drug, in violation of the FDCA, 21 U.S.C. §§ 331(k), 333(a)(1) and 352(f)(1); and that through the sale and distribution of a misbranded product, Merck obtained proceeds and profits to which it was not entitled.

From April 2000 through September 30, 2004, when Merck withdrew Vioxx® from the market, Merck made false representations concerning the safety of Vioxx® to state Medicaid agencies on which state Medicaid agencies relied to their detriment in making formulary and prior authorization decisions.

- **WellCare Health Plans, Inc. - \$6,198,495.22**

WellCare is a health maintenance organization (“HMO”) headquartered in Tampa, Florida, that services approximately 2.3 million members enrolled in Medicare and Medicaid plans across the country.

The State contends that it has certain civil and administrative causes of action against WellCare for engaging in the following conduct from January 1, 2004 to June 24, 2010, or where a different period is noted below, during that period WellCare had a multitude of alleged violations the following are the few that included Illinois:

1. Manipulated WellCare’s MLR by (a) creating a wholly-owned reinsurance subsidiary that charged higher premiums to WellCare’s affiliates than those paid by WellCare to independent reinsurers in order to maintain WellCare’s premiums at higher levels than justified by WellCare’s actual costs, (b) counting reinsurance profit as a medical expense, (c) underreporting its profit margin and misrepresenting its costs, (d) manipulating its Incurred But Not Reported (“IBNR”) (an actuarial estimate of claims which have not yet been reported or paid, but are likely to be incurred within a certain time frame), and (e) manipulating behavioral health MLR;
2. Between October 1, 2003 and October 2007, knowingly concealed its contractual and statutory obligations to pay monies back to state Medicaid programs, including the Florida Healthy Kids program and the Illinois Medicaid program, by (a) including false and fraudulent expenses in its reported MLR calculations, (b) shifting and misallocating costs, including prepayment of medical expenses for future years, (c) entering improper capitation and payment arrangements, (d) fraudulently increasing per member per month costs for over-the-counter pharmacy benefits, and (e) retaining monies owed to the state Medicaid programs;
3. Falsified encounter data submitted to the state Medicaid programs;
4. Knowingly concealed and retained overpayments received from state Medicaid programs in violation of its contractual obligations to pay monies back to the state Medicaid programs, including (a) overpayments for newborn Medicaid premiums received by WellCare from AHCA between July 1, 2005 to October 31, 2005, (b)

- overpayments received by WellCare due to overstated membership in the New York State Family Health Plus program, and (c) overpayments received by WellCare as a result of data or programming errors;
5. Engaged in sales and marketing abuses by (a) unlawfully disenrolling certain Medicaid patients and by "cherry picking" others, (b) marketing in a manner designed to discriminate among potential enrollees on the basis of such enrollees' health status or need for health services, (c) improperly encouraging dual eligible beneficiaries to change their health plans frequently in order to generate inflated commissions;
 6. Manipulated and falsely reported to the Centers for Medicare and Medicaid Services ("CMS") and to states, the "grades of service" or similar performance metrics of WellCare call centers and falsified appeals documentation;
 7. Operated a sham Special Investigations Unit ("SIU") that (a) failed to perform its oversight responsibilities with respect to claims submitted to Medicare and Medicaid providers and third party administrators, and claims associated with its Medicare Part D Prescription Drug Plan, (b) used an improper methodology to compute overpayments received by providers, thereby allowing WellCare to seek excessive reimbursement from the providers, (c) failed to provide the proper notification of settlements with providers regarding overpayments to government agencies and to remit settlement funds to Medicaid and Medicare programs in Florida, and (d) filing false and misleading fraud prevention plans.
- **Maxim Healthcare Services, Inc. - \$1,605,949.00**

Maxim Healthcare Services, Inc. ("Maxim"), a Maryland corporation with its principal place of business in Columbia, Maryland, provided in-home health and nursing services in Illinois.

The State of Illinois contends that Maxim submitted claims for payment to the State's Medicaid Program (Medicaid), 42 U.S.C. §§ 1396-1396(v). The State of Illinois contends that it has certain civil and administrative causes of action against Maxim for engaging in the following conduct:

1. During the period from October 1, 1998 to May 31, 2009, submitting or causing to be submitted false claims to the state Medicaid program for services not rendered;
2. During the period from October 1, 1998 to May 31, 2009, submitting or causing to be submitted false claims to the state Medicaid program, for services not reimbursable by the state Medicaid program because Maxim lacked adequate documentation to support the services purported to have be performed.

- **Mariner Health Care, Inc., Sava Senior Care Administrative Services, LLC and Rubin Schron collectively - \$1,039,069.38**

Mariner is a Delaware corporation with headquarters in Atlanta, Georgia. Mariner through subsidiaries operates nursing homes. Sava is a privately held Delaware limited liability company with headquarters in Atlanta, Georgia. Schron is a resident of New York.

From December 2004 through December 2006, the Defendants knowingly caused false or fraudulent drug reimbursement claims to be submitted to the Medicaid Program because the claims resulted from a payment made by Omnicare in violation of the Federal Anti - Kickback Statute, 42 U.S.C. § 1320a 7b(b) in return for a pharmacy contract with Mariner and Sava.

- **Serono Labs, Inc. Settlement - \$833,885.02**

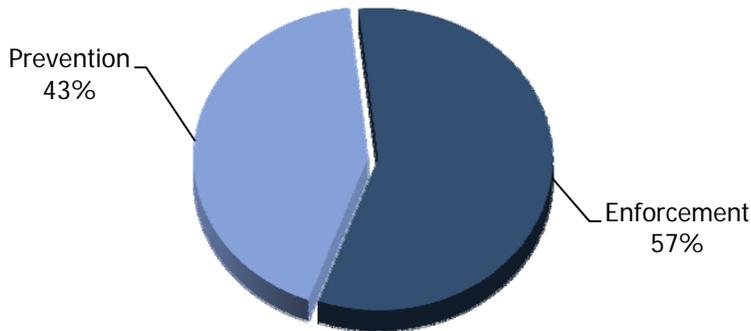
Serono Labs, Inc. is a Massachusetts corporation with a principle place of business in Massachusetts. EMD Serono, Inc. is a Delaware corporation with its principle place of business in Massachusetts. The State of Illinois contends that it has certain civil and administrative causes of actions against Serono for engaging in the following conduct during the period of January 2002 through December 2009, Serono knowingly offered or paid, or caused to be paid, (directly and indirectly through or by third parties) remuneration to health care professionals for the following activities: promotional speaking engagements; speakers' training, and advisory and consultant meetings; expense reimbursement; independent medical grants and educational grants; sponsorships; and charitable contributions. The State contends that at least one purpose of these payments was to induce the recipients to prescribe Rebif and that these prescriptions were paid for or reimbursed by Medicaid, Medicare, or other Federal Health Care Programs.

FISCAL IMPACT

Fiscal Year Savings

During Fiscal Year 2011, the OIG realized a savings of approximately \$71 million through collections and cost avoidances. This savings was four times the OIG FY2011 budget of \$17.6 million.

FY11 Savings



Total = \$70,665,954



Prevention Activities:

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

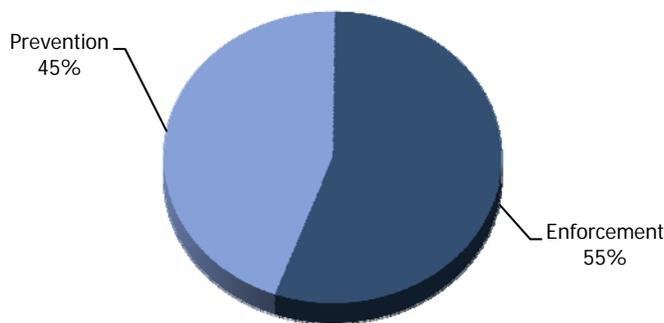
Enforcement Activities:

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

Calendar Year Savings

During Calendar Year 2011, the OIG realized a savings of approximately \$72 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 *2011 OIG Savings and Cost Avoidance Tables* portion of this report on the page numbers indicated in parentheses next to the activities listed below.

CY11 Savings



Total = \$71,533,570

■ **Prevention** ■ **Enforcement**

Prevention Activities:

Provider Sanctions Cost Avoidance (*refer to page 50*)
 SNAP Cost Avoidance (*refer to page 51*)
 Fraud Prevention Investigations (*refer to page 53*)
 Long Term Care-Asset Discovery Investigations
 (*refer to page 53*)
 Recipient Restrictions (*refer to page 54*)
 New Provider Verification (*refer to page 55*)

Enforcement Activities:

Provider Audit Collections (*refer to page 48*)
 Fraud Science Team Overpayments
 (*refer to page 48*)
 Restitution (*refer to page 48*)
 Global Settlements (*refer to page 48*)
 Provider Sanctions Cost Savings (*refer to page 50*)
 Client Overpayments (*refer to page 51*)
 SNAP Overpayments (*refer to page 51*)
 Child Care Overpayments (*refer to page 52*)

CONCLUSION

During 2011, 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.

2011 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	241	\$14,843,505
Desk	45	
Self	1	

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)	251	\$28,155,656
Restitution	34	
Global Settlements	17	

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	85
Letter to Provider without Concerns	10
Referral for Sanction	10
Referral for Audit	11

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	164
Termination/Recoupment	16
Recoupment	13
Suspension	0
Denied Application	9
Decertification	13
Child Support License Sanctions	60

Final Actions	# Cases	Total Medical Provider Sanction Dollars
Termination	122	Cost Avoidance: \$1,047,461 Cost Savings: \$2,104,361
Termination/Recoupment	7	
Suspension	3	
Voluntary Withdrawal	3	
Recoupment	20	
Decertification Resolution	17	
* Barment	1	

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

Reinstatement Actions on Sanctioned Providers	# Cases
Denied Application	5
Reinstated	5

Administrative Actions for Other State Programs	# Cases	Total Payment Plan Dollars Established
Child Support Delinquencies	60	\$1,058,977
Certified Arrearages	40	
Payment Compliance	20	
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	9
Law Enforcement Data Requests	138

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	839	\$3,487,231
Founded	469	
Unfounded	370	
Convictions	24	
Type of Investigations		Percent
Absent Children		15.0%
Absent Grantee		2.0%
Assets		6.0%
Employment		15.0%
Family Comp/RR In Home		14.0%
Family Composition		10.0%
Food Stamp Trafficking		9.0%
Interstate Duplicate Assistance		2.0%
Other Income		11.0%
Residence Verification		13.0%
SSN Misuse/Discrepancy		1.0%
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 food stamp issuances made during the overpayment period times the length of the disqualification period.

SNAP Fraud

Enforcement Activities	# Cases	Total Dollars Established
Reviews Completed	2,742	Cost Avoidance: \$3,370,501 SNAP Overpayments: \$5,503,450
Pending Administrative Disqualification Hearing	2,350	
Disqualifications	1,376	
Unsubstantiated	41	

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	12	\$351,651
Founded	9	
Unfounded	3	
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 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	47	\$29,349
Founded	24	
Founded In-Part	4	
Unfounded	19	

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 sixteen fiscal years, the FPI program has provided an estimated average savings of \$12.64 for each \$1.00 spent by the state. FPI has averaged a 64% denial, reduction or cancellation rate of benefits for the 50,020 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over \$140.7 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 2011, the program generated 3,087 investigations, of which, 1,263 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated gross savings for Calendar Year

2011 of approximately \$8.9 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance (SNAP).

Fraud Prevention Investigations

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	3,087	\$8,864,472
Denied Eligibility	121	
Reduced Benefits	955	
Cases Canceled	187	
Approved	1,824	

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	419	\$12,264,830
Approved		
Impose Sanction Period/Group Care Spenddown	70	
Impose Sanction Period/Regular Group Care Credit	47	
No Sanction Period/Group Care Spenddown	161	
No Sanction Period/Regular Group Care Credit	66	
Denied		
Client Requested Application be Withdrawn	35	
Client Refused to Cooperate/Failed to Provide Verifications	40	

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	733	\$1,249,985
12 Month Restrictions		
New Restrictions	352	
Released or Canceled Restrictions	79	
Converted to 24 Month Restrictions	129	
24 Month Restrictions		
New Restrictions and Re-restrictions	162	
Released or Canceled Restrictions	41	
Total clients restricted as of 12/31/11	1,042	

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	163
Substantiated	60
Unsubstantiated	101
Administratively Closed	2

Types of Allegations Investigated	Percent
Non-Criminal (Work Rules)	72.8%
Discourteous and Inappropriate Behavior	9.8%
Failing to Follow Instructions	1.1%
Negligence in Performing Duties	16.0%
Conflict of Interest	5.1%
Falsification of Records	5.6%
Sexual Harassment	0.8%
Release of Confidential Agency Records	1.7%
Misuse of Computer	10.7%
Work Place Violence	0.6%
Time Abuse and Excessive Tardiness	4.8%
Conduct Unbecoming State Employee	16.6%
Criminal (Work Rules)	7.6%
Theft or Misuse of State Property	2.5%
Commission of or Conviction of a Crime	1.4%
Criminal Code ILCS 720	3.4%
Misappropriation of State Funds	0.3%
Security Issue, Contract Violation	19.0%
Special Project, Background Check, Assist other Agencies	0.6%

Internal investigations often reveal violations of work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension or reprimand. The outcomes for the internal investigations completed during 2010 are listed below.

Misconduct Outcomes	# Actions
Misconduct Identified	24
Employee	21
Vendor	3
Misconduct Resolutions	39
Discharge	3
Resignation	5
Suspension	9
Other, such as reprimands	10
Referred to Other Sources for Resolution	0
Administrative Action Pending at Year End	10
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	185	\$5,133,972
Enrolled	141	
Upgraded	7	
Not Enrolled	37	
Applications Returned	32	
Applications Denied	5	

HMO Marketer Investigations

The OIG monitors marketing practices to ensure clients have the opportunity to make an informed choice when enrolling with an HMO and to prevent HMOs from avoiding the sickest clients. The HFS's Bureau of Managed Care maintains a toll-free complaint hotline from which the majority of referrals are received. HMOs may complete internal investigations on referrals they receive and report their findings. If additional investigation is warranted, the referral is sent to the OIG.

Marketers who have engaged in misconduct or fraudulent marketing practices are removed from the HFS's HMO Marketer Register, which lists HMO marketers from whom the HFS will accept enrollments.

HMO Marketer Investigations

Enforcement Activities	# Cases
Investigations Completed Founded - Fraud	1 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.

Title	Date	Description
<i>Death Notification Project: Identifying the Cause of Delay in Notification</i>	February 2000	Evaluated whether nursing homes or DHS local offices are responsible for case cancellations due to death. The workgroup found that neither party is completely accountable, and made recommendations for improvement in the notification process. The workgroup also proposed increased monitoring of the 26 nursing home's identified as having the highest incidences of overpayments due to late notice of death.
<i>Non-Emergency Medical Transportation Reviews: Focusing on Compliance</i>	December 1999	A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation.
<i>Project Care: Exploring Methods to Proactively Identify Fraud</i>	December 1999	Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.
<i>Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments</i>	December 1999	Recommended methods by which non-institutional post mortem payments could be identified more quickly.
<i>Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century</i>	September 1999	Verified the cost-effectiveness of searching for assets of LTC applicants.
<i>Recipient Services Verification Project: RSVP II-Home Health Care</i>	August 1999	Confirmed receipt by clients of home health care services.
<i>Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues</i>	June 1999	Validated the effectiveness of the project's error-prone criteria and processes.
<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.

Title	Date	Description
<i>Medical Transportation: A Study of Payment and Monitoring Practices</i>	December 1997	Identified policy changes and monitoring strategies.
<i>Funeral and Burial: A Review of Claims Processing Issues</i>	October 1997	Examined policies and procedures of the Department of Human Services in paying for client funeral and burial and made recommendations for improvement.
<i>Maintaining A Safe Workplace: Best Practices in Violence Prevention</i>	June 1997	Identified best practices available to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors.
<i>Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings</i>	May 1997	Recommended a thorough assessment of software systems for prospective review of billings which have the potential to save the State millions.
<i>Fraud Science Team Development Initiative Proposal</i>	April 1997	Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments.
<i>Medicaid Client Satisfaction Survey: April 1996-September 1996</i>	April 1997	Measured client satisfaction with quality and access in both fee-for-services and managed care.
<i>Prior Approval Study</i>	May 1996	Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature.
<i>Clozaril Report</i>	February 1996	Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement.
<i>Hospital Inpatient Project Summary Report</i>	April 1994	Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.

Most of these reports are available on our web site at www.state.il.us/agency/oig. 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
CY2011*

Total Number of Scripts	29,231,208	
Amount Payable		\$1,648,097,750
Scripts Not Subject to RTS	59,097	
Amount Payable		\$6,704,918
Scripts Subject to RTS	29,172,111	
Amount Payable		\$1,641,392,832
Rejected Number of Scripts		1,691,603
Estimated Savings		\$109,611,552

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 2011 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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