Department of Healthcare and Family Services

Office of Inspector General

2012 Annual Report

PAT QUINN, GOVERNOR

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Pat Quinn
Governor

Bradley K. Hart
Inspector General

April 10, 2013

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 for Calendar Year 2012.

The OIG is committed to aggressively carrying out its mission of safeguarding the integrity of the Medical Assistance Programs administered by the Illinois Department of Healthcare and Family Service and related agencies, and maintaining the health and welfare of the system's recipients. **During calendar year 2012, the OIG successfully implemented legislative and enforcement initiatives that resulted in $89.0 million dollars in cost savings and avoidance for the taxpayers of Illinois**. This represents a nearly $20.0 million dollar increase over the previous year's $70.6 million dollars, which included the administrative transition to the current OIG leadership.

As the healthcare system continues to evolve under the auspices of the Affordable Care Act, managed care, and increasing costs, the need for diligent program integrity is invaluable. It is crucial that all levels and branches of government remain vigilant to ensure the system is protected against fraud, waste, abuse, mismanagement and misconduct. To do its part in the fight against fraud, the OIG vision for the future includes:

- Enhanced oversight of provider enrollment and screening to identify high-risk individuals and entities that seek to participate as providers in the program.
- Expand fraud investigations and oversight of providers and recipients to vigilantly monitor related programs using shared data and high tech analytics.
- Expand payment and compliance oversight through education, integrity agreements and pre-and post-payment compliance audits.
- Expand quality of care oversight to ensure that the taxpayers are receiving the services for which they are paying.

The CY 2012 achievements detailed in 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 program integrity mission.

This report describes many of the activities and results of OIG staff over the past year, including the Comprehensive Program Integrity Initiative implemented through the SMART Act (PA 97-0689); increased development and implementation of "analytics" into the OIG business flows; and continued enforcement actions over the Illinois Medicaid system. As required by Public Act 88-554, this report provides information on the composition, recoupments, sanctions and investigations of the OIG.

It is with great pride that I provide you with the accomplishments of the Office of Inspector General for Healthcare and Family Services for CY 2012.

Sincerely,

Bradley K. Hart
Inspector General
Healthcare and Family Services

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Office of Inspector General
Illinois Department of Healthcare and Family Services
Annual Report
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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 (DHS). 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." The OIG 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 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 2012, the OIG had an authorized staffing of 212 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 2012, with Bradley K. Hart serving as the Inspector General. The OIG continues its current fraud fighting efforts while working to expand its integrity activities by researching and developing new programs.

2012 NOTABLE ACCOMPLISHMENTS AND INITIATIVES

$89 million - OIG Total Cost Savings and Avoidance

In CY 2012, the Office of Inspector General ("OIG") for the Illinois Department of Healthcare and Family Services implemented a comprehensive program integrity work plan, which included an aggressive regulatory framework, expansion of audits, investigations and quality of care reviews. This aggressive work plan resulted in a cost savings and avoidance of over $89 million dollars. This represents nearly a $20.0 million increase from CY 2011.

...cost savings and avoidance of over $89 million dollars.

$16 million in Savings – Program Integrity Oversight of Long Term Care Applications and Asset Evaluation

Through the OIG's Long Term Care-Asset Discovery Investigations (LTC-ADI), the OIG completed 938 investigations during 2012, incurring penalty periods on 182 of those cases resulting in $16,042,828 in savings. This includes a return on investment (ROI) of $7.26:1.

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$34 million in Established Overpayments due to Expansion of Program Integrity Audits

During Fiscal Year 2012, OIG began the expansion of its internal audit capabilities, completing 1,281 audits of providers, including both desk audits and traditional field audits. These audits were developed using the DNA predictive modeling system. Overall, the audit bureau established over $34 million in overpayments.

SMART Act Increases Program Integrity "Tools"

On June 14, 2012, the Save Medicaid Access and Resources Together Act ("SMART Act") was signed into law. In 2012, the Office of Inspector General ("OIG") for the Illinois Department of Healthcare and Family Services drafted the Program Integrity Initiative to implement a comprehensive regulatory framework to identify, prevent, and eliminate fraud, waste, and abuse in the Illinois Medical Assistance Program. As a result, Illinois now has one of the most aggressive and expansive regulatory systems in place for combating provider and recipient fraud. This regulatory framework encompasses the strict Program Integrity measures found in the Affordable Care Act ("ACA") and builds on the successful OIG internal initiatives to ensure that public resources are properly utilized.

OIG drafted the SMART Act legislation to achieve a comprehensive Program Integrity approach. It eliminates fraud on the front end through prevention methods used to screen and exclude high risk providers prior to enrollment. Under the new provisions of the SMART Act, providers who have been barred or terminated from other federal and state healthcare programs are prevented from entering Illinois and perpetrating similar fraud and abuses. Another goal of the SMART Act legislation is to increase monitoring and enforcement of proper billing practices during enrollment. Smart Act legislation extends the probationary enrollment period to include all provider types. This allows enhanced

monitoring through pre-enrollment on-site visits to verify their business legitimacy and through analysis of their billing patterns to detect aberrant behaviors during the initial year of enrollment. During this time, the Department identifies and removes problem providers whose improper billing and business practices, if undetected, would otherwise result in substantial losses to the State. Finally, the Smart Act provisions increased the Department's ability to enforce Sanctions and to collect debts from Providers who owed to the State due to improper billing practices.

Key SMART Act Program Integrity Tools

- Increases accountability of providers who owe debts to the State and encourages repayment.
- Requires surety bonds for high risk individuals or business seeking to participate as providers.
- Authorizes the Department to immediately suspend a provider who constitutes an immediate public danger.
- Allows the Department to consider a provider's prior conviction for a serious crime in Medicaid program participation determinations.
- Improves inter-agency data sharing to allow greater verification of recipient and provider eligibility.
- Establishes health care providers to disclose an actual or potential violation of Program violation or overpayment, pursuant to a self-referral disclosure protocol.
- Establishes a one-year provisional enrollment period for enhanced oversight and screening, and review based on risk of fraud and abuse.
- Avoids "pay and chase" by authorizing the OIG to conduct both pre-payment and post-payment audits and reviews to verify billings for improper billing practices.
- Requires all providers to submit reimbursement claims to the Department no later than 180 days (as opposed to one year) after the date of service, with certain limited exceptions.
- Provides enhanced OIG quality assurance monitoring of all HFS-administered programs
- Allows the OIG to exclude providers who have been barred or terminated from other federal and state healthcare programs. Broadens the Department's ability to restrict recipient provider choice for recipients who abuse medical care.

$8.6 million - OIG Bureau of Investigation expansion Cost Savings

OIG began expansion of the Bureau of Investigations to increase the number of investigators available to identify and fight fraud, waste and abuse of the Medical Assistance Program. The Bureau's ongoing efforts resulted in 1,845 recipient eligibility fraud investigations and 1,283 investigations that led to the denial or cancellation of medical assistance benefits to individuals who were found not eligible. This resulted in a cost savings of $8.6 million.

Program Integrity Sanctions and Recovery Actions - $7.8 million in Cost Savings and $5.2 million in Cost Avoidance

OIG had continued success in aggressively pursuing Sanctions against high risk individuals and providers that commit fraud and abuse of the Medical Assistance Program. In FY12, OIG brought 153 Termination actions and 45 termination and recovery actions. These Sanction actions generated $5,284,666 in cost avoidance and $7,833,153 in cost savings.

OIG STATUTORY MANDATES

The OIG is authorized by 305 ILCS 5/12-13.1. By statute, the Inspector General reports to the Governor (305 ILCS 5/12-13.1(a)). The OIG statutory mandates are "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct." The OIG must comply with a variety of charges set out by 305 ILCS 5/12-13.1, including the following Program Integrity requirements for the Medical Assistance Program.

- Audits of enrolled Medical Assistance providers
- Monitoring of quality assurance programs
- Quality control measurements of any program administered by HFS
- Administrative actions against Medical providers or contractors
- Serve as primary liaison with law enforcement
- Report all sanctions taken against vendors, contractors, and medical providers
- Public assistance fraud investigations

In addition to the Medical Assistance Program Integrity components, the OIG has several additional duties.

- Employee and contractor misconduct investigations
- Fraudulent and intentional misconduct investigations committed by clients
- Pursue hearings held against professional licenses of delinquent child support obligors
- Prepare an annual report detailing OIG activities over the past year

Federal Mandates and Program Participation

The OIG is also responsible for Program Integrity functions mandated under federal law.

- Medicaid fraud detection and investigation program (42 CFR 455)
- CHIP fraud detection and investigation program (42 CFR 457)
- Statewide Surveillance and Utilization Control Subsystem (SURS) which is part of the Medicaid Management Information System (MMIS) (42 CFR 456)
- Lock-in of recipients who over-utilize Medicaid services and Lock-out of providers (42 CFR 431)
- Client fraud investigations (42 CFR 235)
- Food Stamp program investigations (7 CFR 273)
- Medicaid Eligibility Quality Control (MEQC) program (42 CFR 431)
- Fraud and utilization claims post-payment reviews (42 CFR 447)

OIG COMPOSITION

Administrative Functions
The professionals that make up the OIG staff include attorneys, nurses, data analysts, investigators, accountants, quality control reviewers, fraud researchers and information technology specialists. The following is an overview of the OIG composition and the functions and goals of the professional staff.

Administrative Support Unit
The **Administrative Support Unit** (ASU) is responsible for the **Central Verification Unit** (CVU), which processes fraud and abuse referrals from citizens, local DHS offices, other state and federal agencies and law enforcement entities regarding recipients and providers. CVU conducts research on referrals by accessing information from DHS, Secretary of State, Illinois State Police, DPH vital records, employment and unemployment history. ASU is responsible for the process of criminal background fingerprint results for all non-emergency transportation providers enrolling with the agency.

ASU's duties also extend to collections of overpayments and court-ordered restitution from providers, a process that involves establishing accounts on the HFS Accounting System and monitoring those payments. The unit follows-up on delinquent accounts and works with OCIG on provider collection cases, bad debt cases, and cases to be referred to the Attorney General's office. ASU is also responsible for the procurement contracts for the Office of Inspector General. All invoice vouchers are processed through the ASU Budget/Procurement office rendering payment to contractors accordingly.

Personnel and Labor Relations activity for the OIG is coordinated through the Administrative Services Unit; ASU handles the necessary paperwork for all personnel transactions, labor relation issues, deferred compensation, direct deposit and the sick leave bank.

Fraud and Abuse Executive
The **Fraud and Abuse Executive** (FAE) was established to coordinate Federal and state law enforcement activities related to the Illinois Medicaid program. The FAE handles policy issues and clarifications, identifies key HFS and DHS personnel to provide testimony at criminal and civil proceedings and facilitates the disposition of global settlement agreements generated by the National Association of Attorneys General, the Departments of Health and Human Services and U.S. Department of Justice. Policy issues include termination of providers, reinstatement requests of providers, and formulation or assistance in implementation of legislation or rule changes.

FAE is the liaison with the **Illinois State Police Medicaid Fraud Control Unit** (MFCU). This area evaluates and transmits fraud and abuse referrals to MFCU. In addition, the FAE implements payment withholds pursuant to 42 C.F.R. 455.23 and Illinois State law in the event of Program related felony indictments. The FAE also works in conjunction with OCIG

on the implementation of the enhanced payment suspension capabilities authorized by the SMART Act. (PA 97-0689).

The Office of Counsel to the Inspector General

The **Office of Counsel to the Inspector General** (OCIG) provides general legal services to the OIG, rendering advice and opinions on HFS programs and operations and providing all legal support for the OIG's internal operations. OCIG represents the OIG in administrative fraud and abuse cases involving HFS programs. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders program guidance to the OIG Bureaus, as well as to the health care industry as a whole, concerning healthcare statutes and other OIG enforcement activities.

OCIG drafts and monitors legislation and administrative rulemaking that impacts fraud, waste, abuse and the overall integrity of the Medical Assistance Program. OCIG is also responsible for the enforcement of provider sanctions, and represents the Department in provider recovery actions; actions seeking the termination, suspension or denial of a provider's Program eligibility; state income tax delinquency cases; civil remedies to recover unauthorized use of medical assistance; and legal determinations affecting recipient eligibility for the OIG's Long Term Care Asset Discovery Initiative. OCIG also brings joint hearings with the Department of Public Health (DPH) in instances when DPH seeks to decertify a long-term care facility. Finally, OCIG oversees Freedom of Information Act and subpoena requests.

OCIG's administrative actions and strategic initiatives have proven to be powerful tools in eliminating losses due to fraud, waste and abuse perpetrated by high-risk providers. In the past year, OCIG initiated 213 hearings. As a result of OCIG actions, 155 high-risk providers were either excluded or terminated from the Program. The total dollars established through Final Administrative Determinations and settlements totaled $5.1 million. Currently, OCIG has initiated administrative actions on behalf of the Department to recover over $24 million dollars.

Bureau of Fraud Science and Technology

The **Bureau of Fraud Science and Technology** (BFST) uses sophisticated computer technology to analyze, detect and prevent fraud, waste and abuse by providers and recipients. BFST is responsible for maintenance and enhancement of the DNA Predictive Modeling System, a CMS "Best Practice" put into production in September of 2011 and CASE, a highly sophisticated case tracking and document management system developed specifically for OIG. BFST also responds to referrals from within and outside HFS. The bureau is also responsible for the introduction, development, maintenance and training of staff on new technologies and maintenance of the OIG website.

The Bureau's **Provider and Recipient Analysis Section** (PRAS) researches, develops and implements selection criteria to identify providers with potentially fraudulent behavior. PRAS selects and conducts monthly analyses of providers who have "excepted out" of the Surveillance Utilization and Review System (SURS). SURS compares a provider's billing

patterns against his peers and produces outliers. The section conducts new provider monitoring analysis of transportation and durable medical equipment providers. PRAS also manages the **Recipient Restriction Program** (RRP). It identifies clients who are inappropriately utilizing Medicaid services and locks them into a single provider type, in order to control over-utilization.

The Bureau's **Fraud Science Team** (FST) develops fraud detection routines to prevent and detect health care fraud, abuse, overpayments and billing errors. FST works with HFS to identify vulnerabilities and solutions in HFS's payment system. FST's routines are analytical computer programs written in SAS, Teradata SQL and DataFlux, utilizing the HFS Data Warehouse along with other third-party data sources. FST also identifies program integrity solutions, pre-payment claims processing edits, policy innovations, operational innovations, fraud referrals, desk reviews, field audits and self-audit reviews.

The Bureau's **Technology Management Unit** (TMU) is responsible for all OIG Local Area Network (LAN) coordination activities, which include hardware and software. TMS handles all database design and development within the OIG; provides data in electronic or paper format to ISP, FBI, the Illinois Attorney General, the U.S. Department of Justice and other state OIGs; provides data within the OIG; and validating Data Warehouse queries. TMS also maintains the OIG website.

Bureau of Investigations

The **Bureau of Investigations** (BOI) provides professional investigative services and support to HFS and DHS and in an effort to prevent, identify, investigate and eliminate fraud, waste and abuse by recipients in all programs administered by these departments. The Bureau attempts to promptly investigate any suspect person or entity and vigorously pursue criminal prosecution and/or recovery of overpayments. The Bureau cultivates and nurtures a professional working relationship with state and federal prosecutors, members of the law enforcement community and other state and federal agencies.

The goal of the Bureau is to ensure the integrity of the Temporary Assistance to Needy Families (TANF), Food Stamp, Medicaid and other assistance programs through **Supplemental Nutrition Assistance Program** (SNAP). The functions of BOI include client eligibility, prosecution, medical, food stamp/EBT disqualifications/investigations and child care investigations. BOI also manages the **Fraud Prevention Investigations** (FPI) program, and oversees the **Long Term Care Asset Discovery Investigations** (LTC-ADI) program.

Bureau of Medicaid Integrity

The Bureau of Medicaid Integrity (BMI) performs post-payment compliance audits of providers, provider quality of care reviews and quality control reviews. In addition, the Bureau conducts Medicaid eligibility quality control reviews and special project reviews.

The Bureau's **Audit Section** performs audits on Medicaid providers to ensure compliance with HFS policies. This Section audits hospitals, pharmacies, nursing homes, laboratories,

physicians, transportation providers, durable medical equipment suppliers and other types of providers. Contractual CPA firms do additional nursing home audits. Other contractual vendors perform audits of hospital inpatient DRG services. The Section reviews various records and documentation, including patient records, billing documentation and financial records. Deficiencies noted as a result of these audits may result in recoupment of any identified overpayments. The OIG collects the overpayment in full or establishes a credit against future claims received from the provider. The provider may contest the findings through HFS's administrative hearing process. The Audit Section is also responsible for the newly implemented Recovery Audit Contractor (RAC) program, required by the Affordable Care Act.

The Bureau's **Peer Review Section** conducts provider quality of care reviews by sampling patient records. If the section identifies potential quality of care issues, the case is assigned to a physician consultant of like specialty who examines additional patient records. A letter is sent to the provider outlining formal findings and recommendations when minor concerns are noted. Any necessary follow-up action is then discussed and implemented. More serious concerns result in an appearance in front of the OIG's Medical Quality Review Committee (MQRC). Results of MQRC actions may result in recommendations of termination or sanctions or to the Audit Section if potential compliance issues are suspected. In addition, the referral may be sent to the Departments of Public Health and Financial and Professional Regulation for related regulatory actions.

The Bureau's **Central Analysis Section (CAS),** in conjunction with the **Quality Control (QC) Review Section,** operates the federally mandated Medicaid Eligibility Quality Control (MEQC) program. Federal regulations require the state to perform targeted Medicaid eligibility reviews and report the findings to the federal CMS.

CAS plans and designs the sample selection. QC conducts the eligibility reviews for each of the sampled cases to ensure compliance with federal and/or state policies. CAS completes a review of the Medicaid claims as related to each eligibility review case and coordinates individual case corrective action with the appropriate local administrating office. CAS analyzes the data, evaluates the findings, makes recommendations and coordinates global corrective action to address program deficiencies, as well as to ensure compliance with federal and state auditing standards. Every three years, CAS and QC conduct eligibility and payment reviews, coordinate individual case corrective action and ensure accuracy of findings for the federally mandated Payment Error Rate Measurement (PERM) initiative.

Bureau of Internal Affairs

The Bureau of Internal Affairs (BIA) investigates misconduct of employees and contractors and engages in diligent efforts to identify fraudulent staff activity and security weaknesses. The Bureau prepares investigative reports and shares the findings with the agency's division administrators. The Bureau also follows investigations to determine if appropriate actions have been taken, and coordinates investigations of employees and contractors with state or federal authorities. The Bureau has the responsibility for monitoring the safety of

employees, visitors and HFS buildings. The Bureau also monitors HFS's security services contracts, in order to assure compliance with contractual obligations.

BIA conducts assessments for HFS involving threats from employees, non-custodial parents, clients and civilians and conducts annual fire and storm drills.

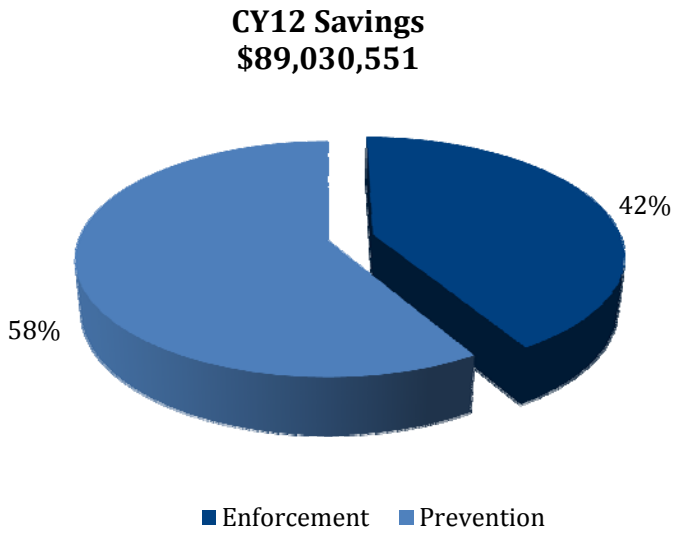
Lastly, the Bureau is responsibility for monitoring employee Internet traffic and monitoring of state resources. BIA conducts computer forensic examinations of department PCs using surveillance and forensic software.

OIG PROGRAM INTEGRITY COST SAVINGS AND AVOIDANCE AND RETURN ON INVESTMENT

During 2012, 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, waste and abuse in HFS programs. 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 generating cost savings, as well as in raising awareness of the importance of Program Integrity among clients, providers and the citizens of Illinois.

OIG CALENDAR YEAR SAVINGS

During Calendar Year 2012, the OIG realized a savings of approximately $89 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings.

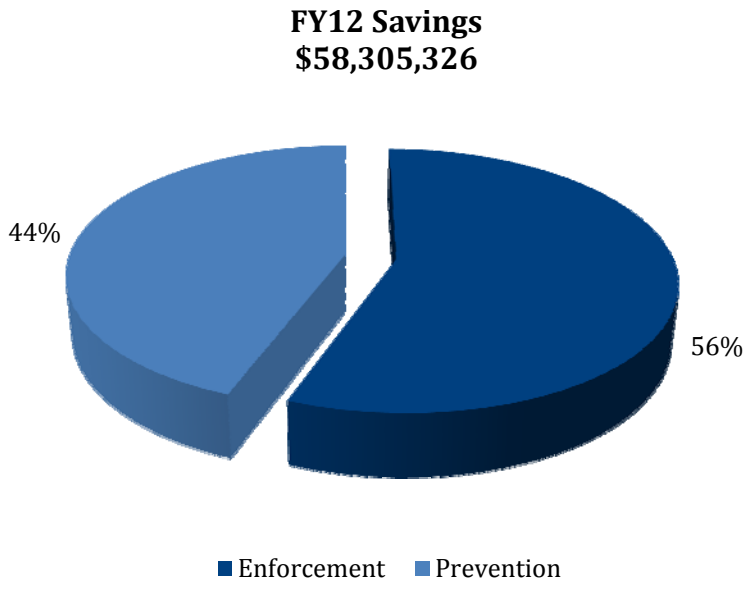


Prevention Activities

Provider Sanctions Cost Avoidance (p. 15)
Snap Cost Avoidance (p. 17)
Fraud Prevention Investigations (p.18)
Long Term Care-Asset Discovery Investigations (p. 18)
Recipient Restrictions (p. 19)
New Provider Verification (p. 21)

Enforcement Activities

Provider Audit Collections (p. 13)
Fraud Science Team Overpayments (p. 13)
Restitution (p. 13)
Global Settlements (p. 13)
Client Overpayments (p. 16)
SNAP Overpayments (p. 17)
Child Care Overpayments (p. 17)



Prevention Activities
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Recipient Restrictions
New Provider Verification

Enforcement Activities
Provider Audit Collections
Fraud Science Team Overpayments
Restitution
Global Settlements
Client Overpayments
SNAP Overpayments
Child Care Overpayments

CONCLUSION

During 2012, the OIG has implemented several new initiatives to expand the depth and breadth of its program integrity mission. Through the hard work of OIG staff, the commitment of those within the Department of Healthcare and Family Services, the cooperation with various government agencies and deployment of new technology and scientific methods, the OIG has continued to fulfill its mandate of preventing and detecting fraud and abuse in HFS programs. The results of these efforts 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.

OIG COMPREHENSIVE PROGRAM INTEGRITY

2012 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	# Recoupments Established	Total Dollars Established
Field	94	$34,850,180
Desk	290	
Self	29	

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)	415	$35,993,583
Restitution	35	
Global Settlements	2	

IMPLEMENTATION OF COST SAVING MEASURES

Following an audit or re-audit, the Department disseminates detailed reports of its findings to those providers who have been audited. Depending upon the size of the audit and the extent of the findings, these detailed reports may be up to 1,000 pages long. In 2012, as a cost saving measure, the Department began disseminating the detailed reports electronically. Letters of findings sent to providers now contain detailed instructions for report retrieval via a secure website. Paper copies remain available for those providers who do not have internet access.

Medical Provider Audits

CPA-LTC (Contract vendors)	147
Inpatient DRG (Contract vendors)	41
Field Audits (In-house staff)	36
Desk Audits, medical practitioners (In-house staff)	4
Desk Audits, transportation fraud science (In-house staff)	1,052
LEA Technical Assistance Reviews	1
Total	1,281

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.

Medical Provider Peer Reviews

Peer Review Outcomes	# Cases
Letter to Provider with Concerns	46
Letter to Provider without Concerns	14
Referral for Sanction	11
Referral for Audit	3

SANCTIONS

The OIG acts as the Department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility or provider status, 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	153
Termination/Recoupment	45
Recoupment	4
Suspension	0
Denied Application	4
Decertification	7

Final Actions	# Cases	Total Medical Provider Sanction Dollars
Termination	141	
Termination/Recoupment	3	Cost Avoidance: $5,284,666
Suspension	2	Cost Savings: $7,833,153
Voluntary Withdrawal	4	
Recoupment	18	
Decertification Resolution	1	
*Barment	4	

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

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

CIVIL REMEDIES

In 2012, OIG has aggressively pursued identification and recovery of improperly and erroneously paid benefits as a result of fraudulent action. The following is a summary of the combined effort:

Civil Remedies

Category	# Cases	Estimated Recovery
Collections	10	$62,606
Pending Administrative Actions	19	$213,163
Cases Referred for Administrative Action	35	$197,527
Total	64	$473,296

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 fraud, the OIG also provides data and data analysis support to MFCU, and other law enforcement entities such as HHS OIG, the U.S. Attorney, the Illinois Attorney General and the FBI to support its criminal investigations.

Law Enforcement

Enforcement Activities	# Cases
Referrals to Law Enforcement	39
Law Enforcement Data Requests	69

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 prepares the case for criminal prosecution by 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	871	$4,441,804
Founded	511	
Unfounded	360	
Convictions	18	
Type of Investigations		Percent
Absent Children		11%
Absent Grantee		2%
Assets		5%
Employment		15%
Expenses Exceed Income		1%
Family Comp / RR In Home		13%
Family Composition		11%
Impersonation		1%
FS Traffic / LINK Misuse		8%
Interstate Dup. Assistance		2%
Other Income		14%
Residence Verification		15%
TPL		2%

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

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

Enforcement Activities	# Cases	Total Dollars Established
Reviews Completed	1,773	Cost Avoidance: $2,639,420 SNAP Overpayments: $3,512,148
Pending Administrative Disqualification Hearing	312	
Disqualifications	1,032	
Unsubstantiated	72	

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's 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	14	$233,176
Founded	10	
Unfounded	4	
Convictions	0	

CLIENT MEDICAL CARD MISUSE

The OIG conducts investigations when clients or vendors are suspected of misuse or misrepresentations concerning the medical programs. Client fraud occurs when clients are suspected of misusing their medical cards or their cards are used improperly without their knowledge. Typical examples include loaning a medical card to ineligible persons, visiting multiple doctors during a

Client Medical Card Misuse

Enforcement Activities	# Cases	Total Dollars Established
Investigations Completed	30	$28,564
Founded	17	
Founded In-Part	4	
Unfounded	9	

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.

FRAUD PREVENTION INVESTIGATIONS

The Fraud Prevention Investigations (FPI) program targets error-prone public assistance applications, which contain suspicious information or meet special criteria for pre-eligibility investigations. During the past seventeen Fiscal Years, the FPI program has provided an estimated average savings of $12.24 for each $1.00 spent by the state. FPI has averaged a 62% denial, reduction or cancellation rate of benefits for the 52,732 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over $149 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 2012, the program generated 3128 investigations, of which, 1283 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated gross savings for calendar year 2012 at $8.6 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP).

Fraud Prevention Investigations

Enforcement Activities	# Cases	Total Cost Avoidance
Investigations Completed	3128	$8,620,284
Denied Eligibility	192	
Reduced Benefits	880	
Cases Canceled	211	
Approved	1845	

LONG TERM CARE-ASSET DISCOVERY INVESTIGATIONS (FISCAL IMPACT)

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, the Department of Human Services 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 eligibility requirements.

Long Term Care Asset-Discovery Investigations

Enforcement Activities		# Cases	Total Cost Avoidance
Investigations Completed		938	$16,042,828
Approved	Impose Sanction Period/Group Care Spenddown	125	
	Impose Sanction Period/Regular Group Care Credit	57	
	No Sanction Period/Group Care Spenddown	297	
	No Sanction Period/Regular Group Care Credit	169	
Denied	Client Requested Application be Withdrawn	161	
	Client Refused to Cooperate/Failed to Provide Verifications	129	

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). While in previous years the OIG was limited to only those recipients over-utilizing narcotic prescriptions, the SMART Act expanded the OIG's authority to restrict recipients to "ANY" type of over-utilization. During this investigative process, the matters are reviewed by staff and medical consultants; clients whose medical services indicate abuse are restricted to a primary care physician, pharmacy, or other provider type 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	714	$2,232,702
12 Month	New Restrictions	219	
	Released or Canceled Restrictions	79	
	Converted to 24 Month Restrictions	237	
24 Month	New Restrictions and Re-restrictions	276	
	Released or Canceled Restrictions	31	
Total clients restricted as of 12/31/2012		1,213	

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	201
Substantiated	46
Unsubstantiated	154
Administratively Closed	1
Types of Allegations Investigated	**Percent**
Non-Criminal (Work Rules)	61.6%
Discourteous and Inappropriate Behavior	6.2%
Failing to Follow Instructions	3.1%
Negligence in Performing Duties	24.4%
Conflict of Interest	4.6%
Falsification of Records	4.3%
Sexual Harassment	0.4%
Release of Confidential Agency Records	1.6%
Misuse of Computer	4.6%
Work Place Violence	0.4%
Time Abuse and Excessive Tardiness	2.7%
Conduct Unbecoming State Employee	9.3%
Criminal (Work Rules)	8.5%
Theft or Misuse of State Property	1.9%
Commission of or Conviction of a Crime	0.8%
Criminal Code ILCS 720	5.0%
Misappropriation of State Funds	0.8%
Security Issue, Contract Violation	28.7%
Special Project, Background Check, Assist other Agencies	1.2%

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. Misconduct Outcomes identified in 2012 are listed below.

Misconduct Outcomes	# Actions
Misconduct Identified in 2012	21
Employee	18
Vendor/Contractor	3
Misconduct Resolutions Reported in 2012	37
Discharge	3
Resignation	3
Suspension	12
Other, such as reprimands	9
Referred to Other Sources for Resolution	3
Administrative Action Pending at Year End	5
No Action Taken by Agency	2

NEW PROVIDER VERIFICATION

Previous 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 for a 180 day probationary period. This process has been expanded under the SMART Act to include comprehensive monitoring of all providers for a one year probationary period. During the on-site 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	108	$2,168,223
Enrolled	75	
Not Enrolled Withdrew Application	2	
Applications Returned	12	
Applications Denied	2	
On-Site Verifications Completed	99	

ONGOING OIG FRAUD INITIATIVES

PREDICTIVE MODELING AND ANALYTICS IN ILLINOIS : A CMS BEST PRACTICE

Background

The OIG uses technology and analytical tools to detect fraud, waste and abuse in the Illinois Medical Assistance Program. One of these tools, the Dynamic Network Analysis (DNA) Predictive Modeling System, is the most recent addition and is used to take a more proactive and scientific approach to identifying potential providers and recipients engaged in inappropriate activities. The DNA system's development was initiated in 2007, through a federal CMS Medicaid Transformation Grant (MTG) of $4.8m. The system was custom built by the OIG, through a collaborative effort with Northern Illinois University.

The DNA system is an online-analytical intelligence system that utilizes advanced statistical models, data mining techniques and domain-expert rules to generate comprehensive reports for provider and recipient pattern analysis, customized routines, and ad hoc inquiries. Since the system "went live" in September 2011, this tool has been incorporated into the business processes of OIG and used in making referrals and developing audits. The OIG's initial appraisal of the DNA Predictive Modeling System are significant in terms of precision, efficiency, and the amount of support to OIG daily business processes; the impact on Medicaid policy changes; and the return on investment. By recognizing the impact this system can have and the opportunities it presents, the OIG has developed a forward-looking analytical program. Systematic development and technological integration will expand the DNA system for broader use, so as to strengthen the benefits to the taxpayers of Illinois. This section provides an overview of the current DNA Predictive Modeling System and the OIG enhancement/integration plan.

System Description

There are several major components in the current DNA Predictive Modeling System: Predictive Modeling, Sampling Universe Creation, Profile Inquiry, Fraud/Quality of Care Routines, and Canned Reports. Each component can serve as an individual analytical module or complement each other to fit different users' needs for customized inquiries. With a user-friendly interface designed for analysts and administrators, the system is an information hub to manage predictive modeling selection, referral, complaint, and audit preparation processes.

The DNA system supports a rapid-response to the request of any user for real-time provider or recipient analysis. It also assists OIG in audit data preparation and sampling validation and stratification, and generates the final audit recoupment worksheets. Furthermore, it serves as an inquiry reporting center for customized routines, frequently used reports, and administrative information.

DNA is an OIG in-house system that has direct access to the HFS electronic data warehouse (EDW) and an internal Audit/Peer-Review tracking system. In its current form, the DNA system provides its users with the advantages of **data integrity** and **real-time analysis**.

System Impact

The DNA system has been extremely beneficial to the OIG and other departments - such as ISP-MFCU, U.S. Attorneys, FBI, Federal CMS and Illinois HFS - in responding to various requests and providing proactive recommendation through analysis. As the OIG continues to identify the impact of the DNA system on its business processes, it is noteworthy that the DNA system has already contributed to the audit process, policy changes, information management and fraud detection methodologies and has resulted in impressive cost avoidance since its deployment. The following section summarizes the highlights of the DNA system's impact in these OIG business areas:

Audit Process

- Increased efficiency on desk audits. During 2012, $13million in recoupable dollars that pertain to inpatient stay, duplicate billing, and loaded mileage transportation services from 2009-2011 were identified and processed, resulting in the issuance of nearly 1,100 desk audits to 384 providers.
- An additional potential $23 million dollars were flagged as recoupable for "no corresponding medical service payments" to these same providers.
- Increased efficiency and effectiveness on the audit data preparation for sampling validation and stratification to the final recoupment.
- 95% of audited NET providers who have fraudulent claims were identified by the DNA Predictive Modeling system.

Policy Change

- Group Psychotherapy services, 89 Ill. Adm. Code 140.413(a)(4)(C), changed based on an analysis produced by the DNA Predictive Modeling System resulting in a reduction of NET transportation costs and group psychotherapy costs.
- The Psychiatric Services Treatment Plan Form (PTSP) for Group Psychotherapy was developed as a result. These forms enhanced the HFS NET prior approval process resulting in the ability to validate group psychotherapy services.

Information Management

- The most significant contribution of the DNA system has been on information management. The system helps analysts save time on data collection and data processing, and invest more time on actual analysis. The manual input required on existing third party analytical system takes 90% of the total process time, while using the DNA system allows analysts to spend 90% of the project time actually performing analysis. The DNA system has helped the OIG increase staff productivity, even as headcount shrinks.
- The DNA system has helped OIG reduce errors and redundant processes by maintaining data integrity and avoiding the time consuming and error prone data load issue in current systems.

Fraud Detecting Methodology

- The system successfully identifies known and unknown providers engaging in fraudulent activities.

- Traditionally, Medicaid fraud detection was a "pay and chase" model, where claims were honored in a timely fashion and reviewed for potential fraud at a later date. Now it has been changed to a more proactive model, where the OIG can perform pre-payment analyses and reviews.

System Enhancement Plan

As the OIG recognizes the success of the DNA Predictive Modeling System, the OIG has had to figure out what direction to take the system in the future. OIG recognizes the DNA system's capacity of expansion and acknowledges the needs of the constant evolution of the system. The results and recommendations brought about through the analyses performed influence current and future policy making and add value to the overall management of the Medical Assistance Program. Although the OIG is gratified with the improvements made to detect and prevent fraud, waste and abuse, the OIG is also aware that some providers with the intent to defraud the system learn from the OIG's processes and alter their future conduct or behavior. Hence, the OIG will continue its ongoing efforts to maintain information; update and add additional data sets to enhance our current capabilities; adjust protocols resulting in changes to policies and procedures; and expand the study area in the system in order to capture and prevent new fraudulent patterns.

The OIG believes that system integration between the DNA system, the surveillance utilization review system, the OIG audit processes, the available network analysis technologies, and the current executive information system will leverage the OIG and strengthen our decision making processes for years to come. In order to take full advantage of the system integration, it is critical to integrate the current data repository with many other important data sources—Secretary of State vehicle and corporate information, Department of Corrections criminal data, Department of Public Health vital statistic, etc. Additionally, OIG plans to incorporate Lexus/Nexus information by applying batch processes to our current business flows. The integration of these data sources will allow the OIG to create a broad data inquiry center. This integration is a more efficient use of resources, including physical databases, hardware, operations, time, staffing and associated costs. In the future, a single sign-on system that is user friendly, easy to operate, contains synchronized and up-to-date information, and with sound statistical approaches built in, will empower users and maximize the effect of the OIG's fraud detection capabilities.

A brief description of the DNA System Enhancement/Integration Plan is listed below:

- **DNA Surveillance Utilization Review Integration:** One of the OIG's major goals is to enhance the system's in-depth review and analysis to apply to more provider types, by creating more customizable routines, logic, infrastructure and reporting functions into the DNA system. The OIG believes these changes will further enhance its ability to prevent and, detect fraud, waste and abuse.

- **Recipient MATRIX:** As Illinois marches toward some form of managed care, the OIG has plans to implement the use of a recipient MATRIX. Much like the provider MATRIX built into the original development of the DNA system, this MATRIX will allow the OIG to data mine from the perspective of the recipient (or customer). This

analysis can lead to the development of fraud, waste and abuse cases, even where fee for service data is not available.

- **Expand DNA Model:** Expand the DNA models and data aggregation capabilities to cover other OIG business processes.

- **Statistic Functions:** Add statistical indicators to the process of Sampling and Universe creation and validation. Also add tables and graphs (e.g. histogram, scatter plot, pie chart) to help analysts examine frequency, normality, outliers and homogeneity, in order to make more informed decisions.

- **Data Exploration Integration**: Two types of exploration functions will be added to the DNA system, in order to help analysts explore data and develop new study areas.

  –*Link Exploration Analysis:* A link analysis and data visualization tool developed via the framework for Social Network linkage analysis. The analysts can explore providers' social networks, interrelationships, and interconnected activities. This is a major enhancement for the OIG. Through dynamic data mining techniques and interactive visualization, the OIG personnel can explore any target or group of targets by simply using current profile reporting variables. This link analysis tool not only helps analysts visualize data but also provides simulation of the social network itself. It is a visual representation of the extensive Provider Profile and is expected to be more powerful for the users.

  Through dynamic data mining techniques and interactive visualization,… can explore any target or group of targets…

  –*Drill-down Capability*: This capability probes problematic claims for providers and recipients by exploring and "drilling-down" on any given demographic or service information.

- **Audit activities**
  –Enhance the existing sampling creation and validation process; make it a dynamically guided selection process.
  –Develop functionality that can create Audit Reports.
  –Develop an Audit Result Extrapolation Calculator.
  –Automate data preparation for all audit plans.
  –Develop an online audit result corresponding/monitoring system (portal) to shorten the audit investigative cycle and make the audit more interactive with providers.

- **CASE integration**: Because the DNA system can quickly respond to requests, it is expected that, in the future, the system integration will automate the process of receiving and reporting audit results and notifying the OIG's CASE management system. Such automation will help the OIG proactively and quickly handle the receivables and payment suspensions (when applicable).

- **Executive information System:** An interface that dynamically produces high level overviews and summaries for administration. Obtaining and examining this information from all dimensions will help executives monitor statewide benchmarks, measure outcomes, foresee trends and problem areas, and make decisions accordingly. The Executive Information System will include the following functions:

  –*Spike Reporting Tool:* Spike reporting is used to establish an early warning mechanism to alert the OIG to any inappropriate provider/recipient services or billing activities and summarize the data at statewide or individual provider/recipient levels on a periodic basis. The principle behind this enhancement is to control the "pay and chase" model and to discover fraud, waste and abuse at a much earlier point in time.
  –*Just-in-time Information Portal:* Able to retrieve most updated information and respond to changes efficiently and effectively.
  –*Trend Analysis Capability:* Compare and study the patterns across years by various categories (e.g. certain providers, claims, recipient behaviors, quality of care controls, etc.), and attempt to predict the future.
  –*Data Visualization*: Use of graphs like bar charts, plots, pie charts, etc. will help executives quickly observe changes and be more responsive when reporting findings.
  –*Summary Capacity*: Enable executives to summarize information by different categories (e.g. statewide provider with selection of sub groups).

The OIG is pursuing the realm of predictive analytics and predictive modeling with a drive to detect, prevent and recoup overpayments due to fraud, waste and abuse in the Medical Assistance Program. The use of these tools will help the OIG preserve the precious taxpayer funds used throughout the system and provide the taxpaying public with a sense that these funds have been managed efficiently, preserved from misuse, and therefore made available to serve others in need.

OIG FRAUD INITIATIVES, INVESTIGATIONS AND DECISIONS

STRENGTHENING PROGRAM INTEGRITY AND COMBATING FRAUD WASTE AND ABUSE

The Uncollectible Debt Committee Initiative

The OIG established the Uncollectible Debt Committee Initiative, including representatives from the OIG, HFS and the Illinois Attorney General's Office. The purpose of the Committee is to: (1) establish best practices for the collection of debt owed to HFS; (2) to increase collections and aggressively pursue debt owed to HFS; (3) establish a streamlined procedure to certify uncollectible debts in order to expedite federal matching fund reimbursements to the State; and (4) establish a systematic procedure for a quarterly review of unresolved debt issues. As a result of the efforts of this initiative, over $10 million in uncollectible debt has been certified and nearly $5 million will be received in Federal Matching Funds.

Additional goals of the committee are to review legislative initiatives and other policies to assist in debt collection. This goal was achieved, in part, through several new laws that have been enacted as part of the SMART ACT, which increased the ability of Department to collect debts owed to the State.

Long Term Care Asset Discovery Initiative

In May 2012, the OIG took responsibility for overseeing the Long Term Care Asset Discovery Initiative. The LTC-ADI project began in 1996 when the OIG began conducting investigations of long term care medical assistance (LTC) applications meeting certain error-prone criteria as identified by Family Community Resource Centers (FCRCs) in Cook (Medical Field Operations) and DuPage counties. The program was subsequently expanded statewide in 2005. Additional changes, taking effect on July 1, 2012, have further centralized the Asset Discovery Investigative process within OIG for those Long Term Care applications exhibiting a substantial risk for state benefits fraud.

Sanctions - Preventing further losses due to fraud and abuse on the State

The OIG's authority to impose sanctions on individuals and entities is contained in 305 ILCS 5/12-4.25 and Illinois Administrative Code Section 104.16. The effect of a sanction or voluntary withdrawal is that no program payment will be made for any items or services, including administrative and management services. Program payment will not be made to any entity in which a listed individual is serving as an employee, administrator, and operator or in any other capacity for any services, including administrative and management services furnished, ordered or prescribed on or after the effective date of the sanction or voluntary withdrawal. In addition, 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.

One key program integrity function of the OIG is the oversight and enforcement of Program provider sanctions. In 2012, in effort to strengthen Program Integrity, the OIG continued its new and aggressive initiative to expedite Department sanction actions against high risk providers. In addition to enforcing Illinois Program sanctions, the OIG reviews federal 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, the OIG takes action to exclude the provider from eligibility in the Illinois Program.

The OIG systematically updates 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. 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. OCIG serves as the liaison for employers seeking to verify whether a provider is currently sanctioned.

OIG - Integrity Agreement Initiative: Insuring Provider Compliance and strengthening the monitoring and enforcement of Department rules and policies

In order to strengthen the monitoring and enforcement of Department rules and policies; ensure the integrity of Program claims submitted by providers; and improve the quality of care rendered to Program recipients, in Calendar Year 2012, OIG increased its use of comprehensive integrity agreements. The Integrity Agreement Initiative was implemented 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, OCIG staff negotiates, and monitors compliance of comprehensive provider integrity agreements.

Providers who enter into integrity agreements are required to consent to specific obligations that ensure the correction of past deficiencies and the provider's future compliance with Department rules and policies. An integrity agreement is one aspect of a larger settlement agreement constructed for the purpose of requiring resolution of specific deficiencies. While many IAs have common requirements that strengthen the enforcement of existing Department policies and rules, each agreement involves corrective action obligations to ensure conduct at issue is resolved. Additionally, they extend the post-settlement period from one year to as many as five years, thereby allowing for enhanced monitoring and enforcement during the post-settlement period. Importantly, the integrity agreements reserves the right of the OIG to impose additional sanctions, up to and including immediate termination of the Provider's eligibility to participate in the Medicaid Assistance Program, in instances where the provider fails to comply with the terms of the agreement. The following represents a summary of some of the OIG Integrity agreements.

OIG Actions Involving Unauthorized Use of Medical Assistance Cases: Combating Recipient Fraud, Waste, and Abuse

The Illinois Medicaid Reform Law (P.A. 096-1501) was signed into law in January 2011. The program integrity section of the Medicaid Reform Law, located at 305 ILCS 5/8A-2.5, authorizes the OIG to seek to recover any and all State and federal monies for which it has improperly and erroneously paid benefits as a result of a fraudulent action, as well as authorized civil penalties.

In September 2011, the Department filed its proposed rules amending 89 Ill. Adm. Code Sections 104 and 140, in order to establish the procedural framework for Department hearings regarding the unauthorized use of medical assistance, enforcement of Final Administrative Decisions, and collection of repayment and penalty amounts. The Administrative Rules became effective on May 7, 2012.

OIG Enforcement Actions: Proven Results against high-risk providers

OIG administrative actions have proven successful in eliminating potential losses due to fraud perpetrated by high risk providers. The magnitude of the OIG's actions in fighting fraud and abuse are evident by the number of successful provider sanctions and recovery actions. Equally notable is the number of high-risk providers who have been terminated from the Program and are no longer able to receive payment for improper billings submitted to the State. In Calendar year 2012, the OIG successfully sanctioned over 151 providers and/or owners of these high-risk providers. These administrative actions prevent expenditure of State dollars caused by fraudulent or otherwise improper billings.

Provider Audits

Recoupment of Overpayments

During 2012, the OIG established $34,850,180 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 contract vendors were only utilized to conduct audits of long-term care facilities and inpatient hospitals.

In 2012, the OIG completed 1,281 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.

Electronic Health Records – Provider Incentive Payments

The Department began making Medicaid incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) for adopting, implementing or upgrading certified electronic health record (EHR) technology during calendar year 2012. EHs or EPs that received a Medicaid incentive payment are subject to a post-payment review to confirm that the provider's attestation giving rise to receipt of payment was correct. The post-payment review procedures will be designed to assist the OIG in identifying recoupment indicators

and other potential payments made in error. Providers receiving Provider Incentive Payments (PIP) will be given a risk score based upon certain predetermined factors and within each category of risk, providers will be randomly selected for post-payment review. Providers selected for a routine post-payment compliance audit who have received PIP payments will also be subject to a post-payment PIP review.

The OIG began identifying providers for post-payment PIP reviews in late 2012, and anticipates audit commencement in early 2013.

Transportation Desk Audits

In June 2012, BMI, working in conjunction with BFST, completed 1,052 desk audits of transportation providers based on a data analysis of paid claims in three discrete categories: duplicate billing, loaded mileage, and transportation during an inpatient stay. The OIG identified approximately $8.7 million in overpayments and, by the end of 2012, had already recouped over $1 million.

In light of the success of this project, and the high ROI, the OIG anticipates expanding these types of data driven audit projects during 2013.

Peer Review

Asthma Project

In 2012, the Department utilized its predictive modeling system to target Medicaid providers who have consistently delivered substandard care to asthmatic patients, thus placing these recipients at significant risk of harm. The goal of this project was to identify providers demonstrating the highest risk scores applicable to substandard asthmatic treatment care protocols based upon criteria gathered from the National Asthma Education and Prevention Program Expert Panel Report 3: Guidelines for Diagnosis and Management of Asthma (2007).

In the study, ten providers were selected for review. Fifteen charts from each of the ten physician providers were analyzed by the OIG Peer Review staff and reviewed within one of three cohort analysis groups: 0-4 years of age; 5-11 years of age; and 12 years of age and older. In addition, a facility review questionnaire was completed for each provider reviewed which assessed the availability of suitable equipment, current medications, asthma action plans, emergency care protocols, and patient education advance directives.

Of the twenty providers studied, OIG Peer Review staff noted that eight of the ten providers had quality of care concerns in greater than fifty percent of the categories. In addition, OIG Peer Review staff noted that all ten of the providers reviewed were practicing medicine beneath the standard of care for patients with chronic asthma. Two of these providers have been recommended for termination, two providers have received letters with concerns and will be re-reviewed at a later date, and the remaining six providers will appear before the Medical Quality Review Committee in 2013.

PREVENTION ACTIVITIES

Fraud Prevention Investigations (FPI)

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

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

During the past seventeen Fiscal Years, the FPI program has provided an estimated average savings of $12.24 for each $1.00 spent by the state. FPI has averaged a 62% denial, reduction or cancellation rate of benefits for the 52,732 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total gross savings has reached over $149 million.

During Calendar Year 2012, the program generated 3128 total investigations, of which, 1845 were approved, 1283 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 2012 of $8.6 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP). The estimated cost savings for calendar year 2011 was $7.48 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 OIG completed 938 investigations during Calendar Year 2012. Of the investigations completed, unallowable asset transfers were identified and penalty periods imposed in 182 of these investigations. The gross savings realized in 2012, based on the identified penalty periods of the 182 cases was $16,042,828. For every $1 spent on administrative costs relevant to the LTC-ADI program, $7.26 of savings was realized.

This saving and return on investment does not include the other adverse actions that resulted from the LTC-ADI investigations. 297 of the 938 cases investigated resulted in the client paying for some of their long term care expenses through monthly spenddown. In addition, 290 of the applications sent to LTC-ADI were denied because the client either withdrew their application or failed to cooperate with the investigation.

LTC-ADI worked closely with the Division of Medical Programs, the Office of General Counsel and our sister agency, DHS, to strengthen Program Integrity for long term care assistance:

- New Medicaid rules for Long Term Care proposed by the federal government in the Deficit Reduction Act of 2005 were implemented in Illinois beginning in 2012.
- Prior to implementation of the new Medicaid rules, Save Medicaid Access and Resources Together Act (SMART ACT) was passed.
- New Medicaid rules (DRA) including the SMART ACT tightened loop-holes to bring an end to schemes.
- Schemes had been allowed to develop as a result of a practice of misinterpreting Illinois Medicaid Policies going unchallenged.
- Many such practices were discovered during LTC-ADI investigations

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 LTC-ADI program played a significant role in the implementation of the new Medicaid rules.

In 2012, the LTC-ADI program was selected to act as a central unit for the State of Illinois to receive and review long term care Medicaid applications under certain triggering events. Designation as the central unit resulted in an increase in the number of referrals to LTC-ADI since implementation in mid 2012. Other factors proposed in the new Medicaid policy also effectuated the increase in referrals:

- Long Term Care as defined by the federal government extends referrals to include Supported Living facilities and Department on Aging Home and Community Based Services
- Option to refer changed from voluntary to mandatory
- Referrals include applications reporting a spouse living in the community

The new Medicaid policy further advanced the role of LTC-ADI by expanding the referral criteria used by DHS staff. LTC-ADI expertise was instrumental in assisting development of

the new criteria based on LTC-ADI experience identifying areas where interpretation of the new rules could be compromised:

- Applications reporting the purchase of an annuity
- Applications reporting a trust
- Applications reporting loans, promissory notes, reverse mortgages, home equity line of credit
- Applications reporting contract for deed transactions
- Applications reporting caregiver contracts

OCIG provides legal counsel to LTC-ADI on a myriad of issues. In addition to assisting LTC-ADI, OCIG reviews and provides guidance for all trusts, including trusts sent from DHS not related to long term care.

The new Medicaid policy also provided a process for handling hardship waivers that had previously been inconsistent and virtually undefined. LTC-ADI assumed the responsibility of receiving the hardship waiver requests. OCIG reviews and responds to hardship waiver requests, ensuring consistent application of policy requirements.

The Division of Medical Programs recognized a need for consistency throughout the state regarding valuation of farmland. LTC-ADI, having used a method developed by the University of Illinois in conjunction with the Department of Revenue, has been able to fill that need. Inquiries from DHS are sent to LTC-ADI for farmland fair market valuation relative to all programs where determination of the value is pertinent.

Federally Mandated Medicaid Eligibility Quality Control (MEQC) Program
FFY 11 – Moms and Babies Pilot

For the FFY11 MEQC pilot, the OIG targeted Moms and Babies cases to fulfill the requirements for MEQC. 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 identified eligibility concerns and overall program discrepancies that could impact Medicaid (Title XIX) funds.

The results of the reviews were provided to CMS in July 2012 and were as follows:

- BMI selected 945 active cases for the review period of October 2010 through
- September 2011. A total of 896 cases representing $26,972 claims paid were completed and/or reviewed and 49 cases were dropped. The cases were dropped due to the inability to verify eligibility requirements due to the recipient not being cooperative or responsive or not being able to locate the recipient.

Of the 896 cases reviewed for Moms and Babies eligibility, 627 (70%) were eligible and 269 (30%) were ineligible.

For the 269 cases determined not eligible for the Moms and Babies program, 93% were due to the woman no longer being pregnant/postpartum, 4% were no longer residents of

Illinois and 3% were over the income standards for the program. Most (88%) of the cases no longer eligible for the Moms and Babies program were due to the agency not taking action to remove the woman from the program.

Regarding the 269 cases not eligible for Moms and Babies, 207 (83%) were eligible for another Medicaid program and 62 (7%) were not. For the 62 cases not eligible for any Medicaid program, 52 had payment errors totaling $5,096 of the total paid claims $419,655 for cases reviewed, resulting in a 1.21% payment error rate.
Of the 62 errors not eligible for any Medicaid program, 36 (58%) were agency errors and 26 (42%) were client errors. The majority (76%) of the errors were due to the client no longer being pregnant/post-partum. Sixteen percent of the errors were due to residency and the remaining 8% of errors were due to income in excess of the standard.

Regarding the 62 errors not eligible for any Medicaid program, 3% were attributed to women coded with income up to 133% of the FPL, 3% to women coded with income over 133% but not over 200% and the remaining 1% was attributed to women who were either a non-citizen, inmate, or in a state operated facility with income less than 200% of the FPL. Of the total paid claims for cases reviewed, these cases represented only 1.21% for a payment error rate.

FFY 12 – Post Newborn Pilot
Throughout FFY 2012, the OIG conducted reviews of Post Newborns to satisfy the MEQC requirement. The pilot targeted the eligibility of individuals 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 re-determined when the newborn reaches age one year." Previous reviews have revealed individuals still receiving coverage under the Moms and Babies newborn program following one year of age. The purpose of this review was to determine the child's eligibility for Medicaid, for purposes of Title XIX funding.

The OIG conducted 502 of these reviews in 2012. Case reviews will continue in 2013 and a Summary of Findings will be submitted to CMS.

FFY 13 – Web Applications Pilot
The OIG received approval in August 2012 to target individuals approved for Medicaid assistance as a result of a web (Internet) application. The process to apply for medical assistance via the web began on January 23, 2009. Applicants with an Illinois address may file a web application from wherever they have access to the Internet. The web application is available 24 hours a day, 7 days a week.

The purpose of this review is to determine if applications processed electronically are more susceptible to errors and to collect information that may be helpful for improving the electronic process of applying for assistance. The reviews will identify those individuals not eligible for the Medicaid program they were approved for and correct individual case and overall program discrepancies that could impact Medicaid (Title XIX) funds.

The OIG began the reviews in December 2012 and will continue throughout FFY13. A Summary of Findings will be submitted to CMS no later than July 2014.

Negative Case Action Reviews (NCAR)

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 11 - In July 2012, the OIG submitted the results of the FFY11 negative case action reviews to CMS. The results were as follows:

BMI sampled 228 negative case actions and completed reviews on 225. Of the three 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 and one should have been excluded from the sample.

Nine error cases were discovered, resulting in a 4.00% case error rate. Eight cases were denied erroneously and one case was cancelled erroneously. Of the eight cases inappropriately denied, four were due to the client not appearing for an interview (interviews are not required), two were for income exceeding the Qualified Medicare Beneficiary standard (income did not exceed standard) , one for the client not providing required financial verifications needed to determine eligibility and one for disability requirements not being met. One case was cancelled inappropriately due to the client's death. Individual case corrective action was completed on all error and drop cases when appropriate.

FFY 12 – The reviews for this sample period was substituted with the federally mandated PERM Medicaid negative reviews as allowed by CMS. The reviews began in November 2012 and will continue into 2013. (See PERM section below.)

FFY13 – The reviews for this sample period began in December 2012 and will continue throughout 2013. The results of the reviews will be submitted to CMS as part of the Summary of Findings due to CMS on or before July 31, 2014.

COOPERATIVE EFFORTS

Federal Program Participation

Payment Error Rate Measurement (PERM) Initiative

CMS developed the PERM program to comply with the Improper Payments Information Act (IPIA) of 2002 which requires measurement of programs at risk for significant improper payments. To measure the at risk programs, states are mandated to complete eligibility and payment reviews of Medicaid and SCHIP cases, both active and inactive. The reviews are conducted every three years. The OIG began the FFY12 PERM measurement for eligibility in October 2011.

As of December 31, 2012, the OIG has conducted 895 of the required 1020 reviews. These reviews will continue into 2013. Results of the case (eligibility) and associated payment reviews are electronically submitted each month to CMS. CMS calculates the error rates and will produce a final State case and payment error rate as of July 1, 2013.

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.

Local Education Agency - 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 Local Education Agency (LEA) 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.

The pilot study was completed in 2011, and in 2012, the OIG expanded its review to include the approximately 900 LEAs that were not included in the pilot study. The Department has contacted the vast majority of LEAs, and is in the process of compiling records and conducting record reviews. 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.

Recovery Audit Contractors

Section 6411 of the Federal Patient Protection and Affordable Care Act requires states to establish programs to contract with Recovery Audit Contractors (RAC) to audit payments to Medicaid providers. In 2012, the Department finalized and published its Request for Proposals (RFP) for RAC auditors. In December 2012, the contract was awarded to Health Management Systems (HMS). The Department has expedited the implementation of this program and hopes to begin audits in mid 2013.

Audits conducted pursuant to the RAC contract will include all provider types and all audit types, with the exception of inpatient DRG and CPA-LTC audits, which are already being performed under contracts awarded in previous years. Payment for the audits conducted will be based upon a contingency fee at a fixed percentage of the amount actually collected by the Department. The Department anticipates that overpayments identified in calendar year 2013 will be relatively low in comparison with later years, as the audits will likely not commence until at least June 2013. However, once the audit process is finalized and the audits are underway, the Department expects that the RAC contract will prove to be a successful, complementary extension of the audits already being conducted by in-house audit staff.

ENFORCEMENT ACTIVITIES

OCIG Notable Final Administrative Decisions and Recoveries

OCIG is responsible for ensuring the Program Integrity 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 OCIG 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 2012, monetary recoveries achieved through OCIG administrative actions amounted to over $5.1 million. The following are some of the notable Final Administrative Decisions and settlement recoveries.

- Hospital – Final Administrative Decision for Recovery of $3,052,399.74 - OCIG filed a recovery action against a hospital for failure to pay its annual assessments. The Department determined that the provider's liability, including penalties, totaled $3,052,399.74. After an administrative hearing, the ALJ issued a Recommended Decision for recovery in the amount of $3,052,399.74. The Director issued a Final Administrative Decision adopting the ALJ's decision.

  ...Recovery of $3,052,399.74 – OCIG filled a recovery action against a hospital ...

- Physician – Final Administrative Decision for Suspension and Recovery of $372,771.80 - OCIG filed a termination and recovery action against a physician after a post-payment compliance audit revealed that the provider had received over-payments totaling $372,771.80. After an administrative hearing, the ALJ issued a Recommended Decision for suspension of the provider for 12 months and for recovery in the amount of $372,771.80. The Director issued a Final Administrative Decision adopting the ALJ's decision.

- Transportation Provider – Final Administrative Decision for Termination and Recovery of $392,079.75 - OCIG filed a recovery action against a physician after a post-payment compliance audit that revealed that the provider had received over-payments totaling $392,079.75. After an administrative hearing, the ALJ recommended a recoupment for the full amount of the audit findings totaling $392,079.75, termination of the provider from the Medicaid program, and debarment of the owner. The Director adopted the ALJ's recommendation.

- Physician – Settlement Recovery of $250,000.00 - OCIG filed a termination and recovery action against a psychiatrist provider after a post-payment compliance audit revealed that the provider had received overpayments totaling $271,903.82. Prior to administrative hearing, the provider agreed to settle the case by repaying the Department $250,000.00.

- Non-emergency Transportation Provider – Final Administrative Decision for Termination and Recovery of $110,953.45 - OCIG filed a termination and recovery action against a non-emergency transportation provider after a post-payment compliance audit determined that the provider had received overpayments totaling $110,953.45. After an administrative hearing, the ALJ issued a Recommended Decision for termination of the provider, barmen of the company's owner, and recovery of the full amount of $$110,953.45. The Director issued a Final Administrative Decision adopting the ALJ's decision.

- Physician (Group Psychology) – Recovery of $99,277.90 - OCIG filed a termination and recovery action against a physician after a post-payment compliance audit that revealed that the provider had received over-payments totaling $99,277.90. Prior to the conclusion of the administrative hearing, the provider agreed to settle the case by entering into an Integrity Agreement wherein the provided agreed not to participate in group psychology; to reform his practice with OIG monitoring; and to the total recoupment amount of $99,277.90.

- Physician – Recovery of $77,580.69 - OCIG filed a termination and recoupment action against a physician provider after a post-payment compliance audit determined that the provider had received overpayments totaling $77,580.69. Should the provider reapply to participate in the Program after the 12 month period, the provider must also to appear before a Medical Quality Review Committee.

- Optometrist – Final Administrative Decision for Recovery of $65,918.09 - OCIG filed a termination and recovery action against an optometrist provider after a post-payment compliance audit revealed that the provider had received overpayments totaling $65,908.19. After an administrative hearing, the ALJ issued a Recommended Decision for recovery in the amount of $65,908.19. The Director issued a Final Administrative Decision adopting the ALJ's decision.

OIG Peer Review Cases – Ensuring Quality of Care to Program Recipients

Another OIG key function is to ensure that the medical providers rendering care to recipients in the Medical Assistance Program are providing quality care. Therefore, it is paramount that individual healthcare professionals providing care to Medicaid recipients meet certain professional standards. After evaluation by the Bureau of Medicaid Integrity-Peer Review nurses, OCIG brings peer termination actions against providers who furnished goods or services to a recipient which, when based upon competent medical judgment and evaluation, are determined to be (1) in excess of the recipient's needs, (2) harmful to a recipient or (3) of grossly inferior quality. Peer termination cases, which are brought for the sole purpose of denying, suspending, or terminating a provider's participation in the Medical Assistance Program; involve complex medical and legal issues, which require evaluation by both staff attorneys and consultant health care professionals.

- Physician – Peer Review Termination - OCIG filed a peer termination action against a physician, alleging that the physician improperly and excessively prescribed pain medications without medical necessity placing recipients at risk of harm. Prior to administrative hearing, the provider agreed withdraw from the Program for 12 months and to appear before a medical quality review committee to establish his discrepancies corrected prior to reapplication. Additionally, the provider agreed to forfeit all billings from the date of the termination action until the date of settlement.

- Physician – Peer Review Termination - OCIG filed a peer termination action against a physician, alleging that the physician: (1) inadequately evaluated and managed asthma; (2) inadequately evaluated and managed diabetes; (3) inadequately evaluated and managed urinary tract infections; (4) failed to document general wellness and preventive health screening; (5) failed to document transition and coordination of care between inpatient and outpatient care; (6) inadequately documented complete comprehensive and updated histories; (7) inadequately documented complete comprehensive physical examinations; (8) inadequately documented vital signs; and (9) failed to document screening, maintenance laboratory and ECG procedures. Prior to administrative hearing, the provider agreed to settle the case by signing an Integrity Agreement, which incorporated all allegations of wrongdoing and required the provider to submit medical records to establish his compliance. The Integrity Agreement further provided for automatic termination if the provider violated any conditions of the Agreement.

OIG Provider Termination, Suspension and Denial Cases

It is paramount that OIG seeks to suspend, terminate or deny Program eligibility to healthcare professionals who fail to meet licensing requirements. Therefore, OIG moves to effectuate the immediate denial, suspension or termination of a provider from the Medical Assistance Program when such vendor is not properly licensed or when such vendor's professional license or certification has been revoked, suspended, not renewed or otherwise terminated by the appropriate licensing agency. Equally important to the integrity of the Medical Assistance Program is the denial, suspension or termination of any person, firm or corporation (or an officer or person owning either directly or indirectly 5% or more shares of stock in the corporation) convicted of an offense involving: (1) fraud or willful misrepresentation related to Medicaid, Medicare, the provision of health care services, or a violation of the Illinois Public Aid Code; and (2) a conviction for an offense related to murder, a Class X felony, sexual misconduct or a criminal offense that may subject recipients to an undue risk of harm, a crime of fraud or dishonesty, a crime involving a controlled substance, or a misdemeanor relating to financial misconduct.

- Physician – Denial of Reinstatement to the Program - OCIG filed an action seeking to deny a previously terminated provider's application for reinstatement into the Program. During his time in the Program, the provider had provided care to Program recipients, which was: (1) of grossly inferior quality; (2) presented a risk of harm to recipients; and (3) was in excess of recipient needs. Additionally, the

provider: (1) provided prescription medications to Program recipients while he was a terminated from the Program; and (2) made false statements on his Provider Enrollment Application. After an administrative hearing, the ALJ recommended that the applicant's reinstatement application be denied. The Director adopted the ALJ's recommendation and denied the application.

- Physician – Denial of Reinstatement to the Program - OCIG 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 suspended by the Illinois Department of Financial and Professional Regulation for allegedly fondling several female patients. After administrative hearing, the ALJ recommended that the applicant's reinstatement application be denied. The Director adopted the ALJ's recommendation and denied the application.

- Physician – Denial of Reinstatement to the Program - OCIG filed an action seeking to deny a provider's application for reinstatement into the Program. The provider had withdrawn from the Program pursuant to a settlement agreement. The Department sought to deny the reinstatement because the provider allegedly: (1) wrote prescriptions to Program recipients while she was withdrawn from the Program; and (2) provided false statements on her Provider Enrollment Application. After administrative hearing, the ALJ recommended that the applicant's reinstatement be denied. The Director adopted the ALJ's recommendation and denied the application.

- Barred Individual – Denial of Reinstatement to the Program - OCIG filed an action seeking to deny the application of a previously barred individual. The Applicant had previously been barred when a provider, which he owned, was terminated by the Department, pursuant to a Final Administrative Decision. The barred individual reapplied to the Program as the owner of a new entity. The Department sought to deny the reinstatement because: (1) the barred individual had significant outstanding debts owed to the Department; (2) the barred individual failed to provide information to establish that he could reasonably be expected to meet the written requirements of the Department or to establish that he was fit to participate in the Program. After administrative hearing, the ALJ recommended that the application be denied. The Director adopted the ALJ's recommendation and denied the application.

- Physician – Integrity Agreement Denial of Reinstatement to Program - OCIG filed an action seeking to deny a suspended provider's application for reinstatement into the Program. OCIG further alleged that the physician: (1) inadequately evaluated and managed diabetes; (2) failed to conduct a neurological examination in a patient complaining of a headache; (3) failed to document a neurological examination in a patient complaining of dizziness and a headache; and (4) failed to perform adult preventative maintenance. Additionally, the provider wrote prescriptions for Program recipients while he was suspended from the Program. Prior to

administrative hearing, the provider agreed to settle the case by signing an Integrity Agreement, which incorporated all allegations of wrongdoing and required the provider to submit medical records to establish his compliance. The Integrity Agreement further provided for automatic termination if the provider violated any conditions of the Agreement.

- Physician – Integrity Agreement - Denial of Reinstatement to Program - OCIG filed an action seeking to deny a previously terminated provider's application for reinstatement to the Program. The applicant had previously been indefinitely suspended by IDFPR and terminated as a provider in the Program for allegedly fondling numerous female patients. OCIG alleged that these allegations were so egregious that the application for reinstatement should be denied. After administrative hearing, the ALJ recommended that the application be denied. The Director issued a final administrative decision, adopting the decision of the administrative law judge and denied the application. Subsequently, the applicant filed an appeal for administrative review in the circuit court. The circuit court vacated the Department's decision and remanded the case back to the Department for rehearing. The provider agreed to settle the case by signing an Integrity Agreement, which allowed the provider to treat only male Program recipients for the first 2 years of his reinstatement. The Agreement provided for automatic termination if the provider violated any conditions of the Agreement.

- Dental Provider – Integrity Agreement Denial of Reinstatement - A dental provider applied for reinstatement to the Program following termination. The provider was originally terminated for leaving the country without notice, which resulted in continuity of care problems for her patients. The Department entered into a three year Integrity Agreement which required: (1) the provider to limit her relationship to the Program as an employee of specified providers; and (2) her patients have access to other dental providers. In addition, the applicant was required to file yearly reports detailing all employee agreements and earnings. Failure to comply with the Agreement will result in termination of the provider.

- Durable Medical Equipment Provider (DME) – Integrity Agreement, Denial of Reinstatement and Recovery of $158,818.47 - The owners of a DME had previously owned a transportation corporation. The transportation corporation had ceased operation and had voluntarily withdrawn from participation in the Program. The Department conducted two audits of the transportation provider and identified overpayments of $158,818.47. The DME provider, the prior transportation provider, and the DME owners entered into a settlement agreement to repay the Department in full. The entities and individuals also entered into a three year Integrity Agreement, whereby they established a Code of Conduct and developed written policies and procedures regarding the operations of the DME. The DME also establish a yearly training program to implement its policies and procedures to ensure accurate record keeping and accurate billing for services rendered. The DME

is required to file yearly certifications that it is in compliance with the terms of the CIA. Failure to comply with the agreement will result in termination of the provider.

Enforcement and Provider Sanctions

The following is a summary of pending administrative actions to recover state and federal monies expended as a result of the unauthorized medical assistance.

- Unauthorized Use Action: $43,796.41 - Alleged False Reporting of Household Status - OCIG issued a Notice seeking to recover $43,796.41 in unauthorized use of medical assistance for the period of September 1, 2009 through April 10, 2012. A BOI investigation found that a recipient falsely reported that a child living outside of the recipient's home was a member of the recipient's household, in order to receive medical assistance. Using school records and other evidence, BOI determined that the child lived in Wisconsin during the period of medical assistance.

- Unauthorized Use Action: $37,463.26 - Alleged False Reporting of Household Status - OCIG issued a Notice seeking to recover $37,463.26 in unauthorized medical assistance for the period of August 1, 2009 through February 28, 2011. A BOI investigation found that a recipient falsely reported that a child living outside of the recipient's home was a member of the recipient's household, in order to receive medical assistance. Using school records and other evidence, BOI determined that the child lived in Texas during the period of medical assistance.

- Unauthorized Use Action: $16,315.59 - Alleged False Reporting of Household Status - OCIG issued its notice to recover $16,315.59 in unauthorized medical assistance for the period of August 1, 2008 through April 1, 2011. A BOI investigation found that a recipient falsely reported that a child living outside of the recipient's home was a member of the recipient's household, in order to receive medical assistance. While the mother had reported that the dependent resided with her, the investigation revealed a court order dated August 18, 2008, awarding temporary custody to the father.

- Unauthorized Use Action: $16,496.28 - Alleged False Reporting of Household Status - OCIG issued a Notice seeking to recover $16,496.28 in unauthorized medical assistance for the period of August 18, 2005 through October 31, 2011. A BOI investigation found that a recipient falsely reported that a child living outside of the recipient's home was a member of the recipient's household, in order to receive medical assistance. While the mother had reported that the child resided with her, the investigation revealed a school records and a court awarding custody to the father in 2005.

- Unauthorized Use Action: $5,736.00 - Alleged False Reporting of Residence - OCIG issued a Notice to recover $5,736.00 in unauthorized medical assistance for the period of December 1, 2005 through January 27, 2011. A BOI investigation revealed

employment, government, and school records proving that the respondent and her children had moved to Missouri and no longer lived in Illinois.

- Unauthorized Use Action: $2,058.62 - Alleged False Reporting of Household Status - OCIG issued a Notice seeking to recover unauthorized use of medical assistance for the period of August 1, 2008 through April 29, 2011. A BOI investigation found that a recipient falsely reported that a child living outside of the recipient's home was a member of the recipient's household, in order to receive medical assistance. The investigator obtained statements from the father that his son had been living with him and obtained school attendance records, which confirmed that the child did not live with the recipient.

Client Investigations
Client Prosecution Cases
During 2012, the Bureau of Investigations (BOI) referred 17 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 that are highlighted below.

Prosecution Investigation

- Unreported Income - A client residing in Sangamon County received public assistance from DHS from April 2006 through March 2009. BOI determined that the client deliberately failed to report her employment to the Sangamon County Family & Community Resource Center (FCRC) in order to prevent the reduction and/or cancellation of her public assistance.

  The concealment of her employment allowed the client to receive $12,101 in excess Supplemental Nutrition Assistance Program (SNAP) benefits from April 2006 through March 2009. The case was submitted to the Sangamon County State's Attorney's office in September 2012, and is still pending review by that office.

- Identity Theft and Falsified TANF work experience hours - BOI assisted the Rockford Police Department on an investigation involving a DHS client that had allegedly committed identity theft. The investigation determined the client had falsified work experience hours, which were required for her TANF eligibility, and had stolen the identity of a cousin to receive the child care subsidy money that was disbursed to provide child care services for her children. A TANF overpayment for the period of March 2012 through June 2012 was identified in the amount of $1,422.00 and a child care overpayment for the period of July 2011 through June 2012 was identified in the amount of $9,126.38. This case was presented by the Rockford Police Department to the Winnebago County State's Attorney Office in July 2012 and is pending prosecution.

- Unreported Income - A BOI investigation found that for the period of September 2005 through August 2011 a client failed to report all her household's income to DHS. This unreported income included child support, unemployment insurance

benefits and income from employment. The resulting SNAP overpayment totaled $30,632.

This case was presented to the Rock Island County State's Attorney's Office on August 28, 2012. On January 11, 2013, the client pled guilty to Food Stamp Fraud and was sentenced to 24 months probation. A condition of this client's probation is to pay DHS restitution in the amount of $30,632.

- Family Composition - A client residing in St. Clair County received public assistance from DHS from May 2007 through May 2010. BOI determined the client deliberately failed to report she resided with her husband in order to prevent the reduction and/or cancellation of her public assistance.

  The client's failure to report she resided with her husband resulted in her fraudulently receiving $16,511 in excess SNAP benefits from August 2008 through May 2010. The case was submitted to the St. Clair County State's Attorney's office. In December 2012, the defendant pled guilty to a reduced misdemeanor charge of theft in relation to a felony charge of State Benefits Fraud. The defendant was sentenced to 24 months probation and 50 hours of community service to be completed during her first year of probation.

- Unreported Self-Employment Income - A client residing in Jefferson County received public assistance from DHS from February 2006 through October 2011. BOI determined the client deliberately failed to report her husband's income as a self-employed contractor in order to prevent the reduction and/or cancellation of her public assistance.

  The client's failure to report her husband's self-employment income resulted in her fraudulently receiving $34,879 in excess SNAP benefits from February 2006 through October 2011. The case was presented to the Jefferson County State's Attorney's office in December 2012. The case is currently pending prosecution.

- Child Care / Provider – Conflicting Outside Employment - A client residing in St. Clair County operated a medical transportation business, where she performed duties as a driver, during the same hours she operated her home daycare. BOI conducted an investigation jointly with the Bureau of Child Care Development (BCCD) and BMI to determine the client did operate a medical transportation business during the same hours she operated her home daycare.

  The defendant's conflicting outside employment resulted in her fraudulently receiving $70,786.62 in child care payments from January 2011 through April 2012. The defendant's license as a Medical Transportation Provider was revoked. The case is currently pending litigation.

- Unreported Income – Alias Name and Social Security Number - An investigation found that a client failed to report income she earned while using an alias name and social security number for the retirement benefits she received under her alias. She also received income, under her alias identity, from the U.S. Department of Housing and Urban Development (HUD) for payments as a landlord. The OIG investigation took place in conjunction with the Social Security Administration (SSA) and HUD. Ultimately, the case was referred to the US Attorney's Office – Northern District of Illinois on March 18, 2010. BOI identified an overpayment of $11487.32, $6,231.00 in SNAP benefits and $5,256.32 in financial assistance. On December 19, 2011, the client pled guilty to Embezzlement and Theft (Public money, property or records). On May 1, 2012, the client was sentenced to 3 years probation and ordered to pay $74,900.00 in restitution ($41,092.00 to SSA, $22,071.00 to HUD, $11,487.00 to DHS and $250.00 to US Treasury).

- False Identity / Multiple Assistance - An investigation found that a client failed to report his receipt of public assistance and Social Security benefits in his name and an alias name. The OIG investigation took place in conjunction with an SSA investigation for federal criminal prosecution. The case was referred to the US Attorney's Office – Northern District of Illinois on November 5, 2009. BOI identified an overpayment of $28,126.00; $1,151.00 in financial assistance and $26,975.00 in SNAP benefits. On November 26, 2012, the client pled guilty to one count of Theft of Public Money related to the SSA fraud; the public assistance count was dismissed. However, his sentence included restitution for the public assistance fraud. The client's sentence included 3 years probation, 3 months home detention and $134,905.00 in restitution ($107,995.00 to SSA and $26,910.00 to DHS.)

- Employment / Falsified Pay Information - An investigation found that a client falsified her household income to remain eligible for public assistance. The client was a Social Security Administration employee. The investigation was completed in August 2010 and BOI notified the OIG – Social Security Administration (SSA) of the employee misconduct and public assistance fraud. OIG – SSA completed their investigation in December 2010. The case was referred to the US Attorney's Office – Northern District of Illinois in March 2011. BOI identified a SNAP overpayment of $27,913.00. In March 2012, the client was charged with one count of Mail Fraud and one count of Theft of Government Benefits. During the prosecutor's review and discussion of the investigation, a medical overpayment of $29,279.00 was included. On December 10, 2012, the client pled guilty to both counts. A sentencing hearing is scheduled for March 13, 2013.

- Impersonation - An investigation, initially completed in January 2012 as a client eligibility investigation, was referred to the Kane County State's Attorney's Office for criminal prosecution in March 2012. The investigation found that an undocumented immigrant used the identity of a citizen to apply for and receive public assistance. The investigation was worked with the Aurora Police Department. BOI identified an

overpayment of $8,117.64, $3,469.00 in SNAP benefits and $4,648.64 in medical benefits. The case is in "Warrant Status" and pending litigation.

- Residency - An investigation, initially completed in June 2012 as a client eligibility investigation, was referred to the US Attorney's Office – Northern District of Illinois for criminal prosecution in July 2012. The investigation found that a client failed to report that she and her children were no longer residents of Illinois; the family resided in Indiana. The investigation was worked with the OIG – Social Security Administration. BOI identified an overpayment of $39,277.24, $29,966.00 in SNAP benefits and $9,311.24 in medical benefits. The client was scheduled to plead guilty on January 25, 2013; however, a trial date was scheduled for June 17, 2013.

Client Eligibility Investigation

- Family Composition - This case was referred by Macoupin County Family & Community Resource Center (FCRC), to BOI. A BOI Client Eligibility investigation found a client falsified that the father of her child was residing in the home. The client claimed the father of her child lived out of state when he actually resided with the client. Upon questioning the client, she said he had just moved into her home.

  The investigation was completed in May 2012 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $31,086 from September 2007 through March 2012. The Department of Human Services (DHS), Bureau of Collections has initiated collection activity.

- Absent Grantee and Interstate Duplicate Assistance - A BOI investigation found in August 2012 that an Illinois SNAP client had resided in Texas and not Illinois from December 2010 to February 2011 and from April 2011 to August 2011. The investigation further found that from January 2011 through February 2012 this client simultaneously received SNAP benefits from Illinois and Texas. The results of the investigation were submitted to the local DHS office, which calculated that the client had received an overpayment of $6,469 in SNAP benefits.

- Family Composition - A BOI investigation found in July 2012 that a SNAP client failed to report to DHS that the father of her three children was living in the assistance unit from January 2008 through September 2011, during which time the father had employment income. The results of the investigation were submitted to the local DHS office, which calculated the client had received an overpayment of $20,134 in SNAP benefits.

- Falsification of All Kids Applications - A referral reported problems with a number of All Kids applications received by the Bureau of All Kids (BAK). BAK noted a large number of applications completed by an agent who was disenrolled many years ago based on a previous BOI investigation. BAK questioned if application information was falsified to make clients eligible for medical assistance. Initially, BOI received

information that 14 applications were questionable. As time progressed, BAK reported receiving over 100 applications with an estimated 50% of the cases involving self employment. BOI requested 7 of the 14 questionable applications to review for eligibility issues and was able to contact 2 applicants but because of language barriers, only one interview was successful. The investigation determined that information submitted on the client's application was correct. Additionally, BOI found that the company solicited prospective clients through advertisements in local ethnic newspapers. An advertisement was obtained and translated and while the company did not advertise a fee for their services, clients were assessed a $185.00 fee to assist with the completion of the All Kids application. The cases were completed in July 2012. As the owner of the company was no longer an All Kids agent, BOI had no recommendation regarding the company assisting clients with applications. However, BOI recommended that BAK review the legality of the company's use of the All Kids logo in their advertisement.

- Self – Employment / Assets - An investigation found that a client failed to report his correct income from the businesses he owned in the states of Illinois and Washington. The investigation found that the client under-reported his income from his Illinois business to the Illinois Department of Employment Security which made him eligible for public assistance. Additionally, the client was found to have used monies from the businesses for gambling purposes. It was also determined that the client falsified information and reported different income information to the US Department of Homeland Security in order to become a sponsor and modified his reported income for tax purposes in furtherance of the sponsorship. The case was worked with the US Department of Homeland Security. The investigation was completed in October 2012 and referred to the local DHS office with an estimated overpayment of $10,957.97, $6,330.00 in SNAP benefits and $4,627.97 in medical benefits.

- Income / Household Composition - This case was a hotline referral sent to BOI. This investigation revealed the client's husband, and father of her children, was employed and residing with her at her residence. The husband's employment began in February 2010. The client neglected to report her husband's income to the Department of Human Services (DHS) during the period of February 2010 through September 2012. Various pieces of official documentation confirmed the husband in the household.

  The investigation was completed in September 2012 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $24,777 for the period February 2010 through September 2012.

- Residency/Interstate Duplicate Assistance/Employment/Unemployment Compensation - An investigation found that a client was residing in Indiana and received assistance for her family in both Illinois and Indiana. Additionally, she was found to be working in Indiana and had received Unemployment Compensation.

The investigation was completed in March 2012 and referred to the local DHS office with an estimated overpayment of $19,804.27; $17,087.00 in SNAP benefits, $2,260.00 in financial assistance and $457.27 in medical benefits.

The investigation also found that the client's two sisters used the same Illinois address while receiving assistance in both Illinois and Indiana. Two additional investigations were opened, completed, and referred to the local DHS office in November 2012. One investigation found an estimated overpayment of $15,266.60; $9,919.00 in SNAP benefits, $4,221.00 in financial assistance and $1,126.60 in medical benefits. The other investigation found an estimated overpayment of $22,675.76; $16,025.00 in SNAP benefits, $3,640.00 in financial assistance and $3,010.76 in medical benefits.

- Employment / Unreported Income - This case was referred to BOI by the U.S. Department of Housing and Urban Development (HUD), OIG. BOI initiated a Client Eligibility investigation and found a client committed welfare benefits fraud by failing to report employment and gross wage earnings to the Department of Human Services (DHS). In addition, the client failed to report the receipt of Unemployment Insurance Benefits (UIB) to DHS. The investigation found the client was issued two separate Social Security Numbers (SSNs) by the Social Security Administration (SSA), and she used one SSN for employment purposes, while using the other SSN to receive welfare benefits. Because she did not report both SSNs to DHS, the client was able to hide the employment and gross wage earnings from DHS when she applied and reapplied for welfare benefits.

  The investigation was completed in August 2012 and referred to the Champaign County FCRC for the calculation of an overpayment. The BOI investigation estimated an overpayment of SNAP benefits totaling $20,367 for the period November 2007 through June 2012

- Employment / Assets - Joint Investigation with Illinois State Police and Commerce Commission Police - This St. Clair County employment status case was referred to BOI. A BOI Client Eligibility investigation, in conjunction with Illinois State Police and Commerce Commission Police, found the client received self-employed income and had assets.

  The investigation was completed in October 2012 and found the client benefited from medical services in the amount of $151,225.16 made to medical vendors from May 2010 through March 2011. The overpayment was referred to the Bureau of Administrative Litigation.

- Family Composition - This case was referred by the Pike County Human Service office, to BOI. A BOI Client Eligibility investigation found the client failed to report the client's husband resided with the assistance unit.

The investigation was completed in December 2012 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $47,609 from August 2006 through November 2012.

- Falsification of Employment Verifications and Child Care Arrangements - An investigation found that a child care provider falsified employment verification for eight clients in order to receive child care payments for their children. Alleged employers confirmed that the clients did not work for them and that the verifications were falsified. Seven of the eight clients were interviewed and they confirmed that they did not work at the alleged employers and did not provide the employment verifications to the department. Some clients advised that their forms had been altered and falsified. The case was completed in August 2012 and referred to DHS – Bureau of Child Care and Development with an estimated child care overpayment of $56,161.00.

General Investigations

During 2012, BOI referred two (2) 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. Some of the cases referred included public assistance investigations completed by BOI that may have involved employee misconduct. The results were sent to the OEIG for further review/action.

Client Eligibility

- Absent Grantee / Impersonation - A referral was received from the OIG – Social Security Administration reporting that a client receiving Social Security and public assistance benefits had never resided in Illinois. In September 2012, this case was sent to the OEIG because the client's representative payee, who maintained that his mother resided with him, is a state employee. The case is currently under joint investigation by BOI and OIG – SSA. The OEIG will be advised of the results of the investigation.

- Employment / TPL / Other Income - An anonymous referral was received reporting that a client who worked for a state contractor falsified her income to receive public assistance benefits. In September 2012, this case was sent to the OEIG because it was noted that income cross-matches were cleared without budgeting corrections or overpayments filed. The case is currently under investigation by both agencies.

- Responsible Relative in the Home - A referral was received from the OEIG reporting that a client failed to report her marriage to the father of her child. Both the client and the father of her child were state employees. In May 2012, this case was referred to the OEIG. The investigation was completed in December 2012 and was unfounded.

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.

According to the U.S. Department of Agriculture, Food and Nutrition Service Midwest Regional Office, Illinois continues to be one of the most active states in the Midwest Region in pursing clients suspected of EBT fraud and is highly regarded by the Department of Agriculture. Illinois has been instrumental in helping out other states in the Midwest Region by sharing EBT procedural information with out of state staff, with little to no experience, with disqualified retailer cases.

In 2012, the SNAP Fraud Unit received a total of 955 SIPV referrals. The Unit has received approximately 28 new EBT retailer referrals since July. The Unit completed 1,773 reviews, participated in 1,674 Administrative Disqualification Hearings and processed 23 prosecution disqualifications. There were 715 administrative hearing decisions rendered of which 643 were positive, resulting in disqualification of the client.

The SNAP Fraud Unit processed 541 signed waivers (client admission of guilt). In addition, the Unit obtained signed waivers on over 37 second offense cases, which resulted in two year disqualifications; two cases with ten year disqualifications; and, two cases with permanent disqualifications.

The Unit's efforts in 2012, led to the following notable accomplishments:

- SNAP Fraud Unit received a signed waiver for two overpayments of $38,781 and $9,915, totaling $48,696. The client was disqualified for one year because she did not report employment or assets.
- SNAP Fraud Unit received additional positive hearing decisions on cases that had significant high dollar overpayments: $30,166; $27,732; $23,775; $22,825; $20,259; $19,741; $16,655, and $16,527.
- SNAP Fraud Unit attained additional signed Waivers on cases that had significant high dollar overpayments: $25,832; $23,632; $24,853; $16,681, and $16,609.

HFS Employee Investigations

The OIG Bureau of Internal Affairs (BIA) completed 201 employee and contractor investigations during 2012.

Hiring Allegations

- Based upon a referral from HFS management, an investigation was completed on the hiring of a senior public service administrator (SPSA) and the qualifications of the individual. The hiring bureau had concerns about the validity of information included on the Central management Services (CMS) 100 application, statements made during the Bureau of Selection and Recruitment interview, and the individual's ability to fulfill position responsibilities as an SPSA. The hiring bureau stated that the probationary employee would not be certified in the SPSA position. The employee lacked the seasoned SPSA experience for the complex policy development, supervisory experience, and ability to complete priority assignments.

  BIA reviewed the candidate's employment applications and the employee's probationary evaluation. The program administrator was consulted at the state agency where the employee allegedly gained the work experience cited on the employment applications and during the position interview. The Administrator stated the employee did not act in the capacity of an assistant to the program administrator nor did she supervise six professional level staff. A copy of the last performance evaluation was also obtained which did not indicate any supervision nor assistant administrator level responsibilities.

  It was determined the employee falsified two employment applications by indicating experience in supervision and evaluation of six professional level staff. The employee claimed to have the duties and responsibilities of an assistant division manager when, in fact, the employee was an administrative assistant and completed duties consistent with that title. The employee was granted an interview for the SPSA position based upon the false and misleading information provided on her employment applications. The probationary employee voluntarily resigned her position with HFS during the BIA interview.

- Two employees filed an anonymous complaint with OEIG regarding the selection of a public service administrator (PSA) position. The complainants alleged that the selected candidate did not meet the "specialized skill" requirements on the job posting.

  The Division of Personnel and Administrative Services advised that 46 bids for the position were received. An additional 10 candidates made a transfer request for the position. The bargaining unit position applicants were sorted by eligibility and eleven applicants had contractual rights to the position. The remaining applications would only be eligible for the position if none of the applicants with bargaining unit rights to the position possessed the specialized skills.

  Personnel contacted the eleven applicants with contractual rights to the position and determined that none possessed the specialized skills, which meant the position would be filled by "other means." However, because the position was Rutan Exempt, the hiring bureau was eligible to select the candidate from applicants that

bid on the position without an interview. The candidate selected possessed an A grade for the PSA title, therefore, there was no evidence that the hiring bureau failed to follow Departmental policy in the filling of the PSA Rutan Exempt position.

Inappropriate Behavior/Sexual Harassment

- Two HFS employees reported that a co-worker attempted to enlist their assistance in servicing her boyfriend's child support case. Via departmental email, the employee explained to the co-workers that she and her boyfriend lived together and that she had loaned him bond money to get released from jail.

  The investigation developed sufficient credible evidence to support the allegation that the employee used the Agency's email system to send personal emails to co-workers concerning her boyfriend. The employee also admitted that she accessed all of her boyfriend's child support cases through the Key Information Delivery System. The employee said she was searching for court information that might help her get her bond money returned. The employee was disciplined for violating Departmental policies.

- An HFS employee was suspected of drinking alcohol during the workday on state of Illinois leased property. Surveillance was conducted and the employee was observed consuming alcohol during working hours on state of Illinois premises. The employee also admitted that for two months he had consumed alcohol during his workday while on state leased property. The employee was discharged.

- An HFS manager reported that she suspected an employee had removed her own personnel file and other work related documents after being given a new assignment. The employee admitted to taking her own personnel file and the fundraising documentation for the State Employees Combined Appeal bureau file. The employee returned these two files.

  Several other work files were also missing. Although the employee denied destroying or removing these files, the paper files under her control were missing. The employee was also instructed not to delete any electronic files. The employee forwarded the electronic files to the management designated replacement and then deleted the electronic documents. The employee failed to follow supervisory instruction but the electronic documents were not compromised. The employee was disciplined for her behavior.

- A child support client reported that an Agency employee engaged in sexual harassment by kissing her several times and making sexual comments to her about her appearance while she attended an eligibility appointment.

  The allegation that the employee engaged in inappropriate and discourteous behavior towards a client could not be substantiated. The employee denied making any inappropriate remarks to the client and denied engaging in any inappropriate

behavior, to include kissing the client. While the client appeared credible in her account of what took place, the absence of a third party witness or any admissions by the employee made this case difficult to sustain. BIA recommended the employee remain in a work area visible to his supervisor and others. Additionally, we recommended the employee be enrolled in HFS Bureau of Training course Preventing Sexual Harassment.

- A custodial parent (CP) filed a complaint that she was given false and misleading information by an HFS contractual employee who had a personal relationship with the non-custodial parent (NCP). The contractual employee had separated from HFS contractual employment before the referral was received by BIA.

  The investigation determined that the contractual employee contacted the CP on behalf of the NCP and convinced the CP it was in her best interest to accept a $7,500.00 payment in exchange for reducing the balance owed to her by the NCP. The CP stipulated that the NCP would pay all of his June 2012 child support payments and remain current in future child support payments. In return, the CP was willing to forgive a portion of the past due child support payments. The contractual employee advised the CP she had to travel to Chicago from Belleville, Illinois to handle the matter. The NCP's balance in July 2012 was $27,795.67, which included $7,405.02 in interest.

  When the CP asked the contractual employee about the June 2012 payments, she was told the NCP had made the payments when in fact he had only paid approximately half of the amount he was court ordered to pay. The contractual employee advised the CP to insert the dollar amount of $22,055.83 instead of the actual amount of $7,500.00 on the Affidavit of Direct Pay form. This entry by the CP was a statement that the dollar amount entered had been paid directly to her and the amount would be deducted from the balance owed by the NCP.

  The investigation found there was collusion between the NCP, the NCP's wife, and the former contractual employee, which placed the CP in jeopardy of receiving the child support payments she was lawfully entitled to by court order and potentially placed her in a financial hardship. The CP was given credit for the $7,500.00 direct payment leaving a total balance of $20,199.10.

Time Abuse and Falsification of Records

- An HFS employee was suspected of misusing his state issued computer. A forensics review of the employee's state issued computer showed he had two business websites that he had accessed from his state computer, a computer consulting business, and a reptile business. At the time of the computer seizure, the employee was accessing Amazon.com on his state issued computer. The employee acknowledged that he had accessed his two business websites and numerous other non-work related websites during HFS business hours when confronted by investigators.

The employee admitted that he utilized PayPal from his work computer to pay an unauthorized outside computer consultant for work product related to projects he was assigned at HFS. BIA investigative resources further revealed the employee had been conducting secondary employment during state time with two separate businesses since his hire date two years prior. The employee voluntarily resigned his position with HFS, waived all reinstatement rights to the state of Illinois, and agreed not to seek or accept employment with HFS or the state of Illinois in the future.

- BIA received an anonymous complaint alleging an HFS manager arrived to work after her scheduled start time, took extended lunches and breaks, and left prior to the end of her scheduled work day. Through a combination of surveillance, a review of computer audit logs, security control records, payroll records, hotel receipts and the employee's inability to recall her specific whereabouts on the dates in question, we determined the employee received compensation for approximately 12 hours of work time that she was not eligible to receive. The employee told investigators that she did not record her actual arrival time at the office and failed to adequately record her field activities.

  Our monitoring also demonstrated the employee used the agency computer system and state of Illinois network for personal reasons. During the period of review, the employee sent or received 201 personal and non-essential emails that were not agency or business related and thus prohibited by HFS policy. The employee received discipline for her behavior.

- An HFS supervisor reported to BIA that an employee was suspected of abusing time by taking excessive breaks and leaving early from the worksite. BIA observed the employee arriving late and departing early from her worksite on five out of seven days. The employee was also observed six out of seven days extending her lunch break. Over the period of surveillance, the employee had five hours and 19 minutes of unaccounted time. The employee admitted to investigators her time abuse behaviors. The employee also failed to accurately record her actual arrival and end of day departure times on the employee timekeeping sheet. The employee received discipline for the time abuse and falsification of official documents.

- Three separate investigations were completed on an HFS employee based upon multiple conduct complaints. The first complaint came from an unknown female who told an HFS manager that she believed the employee was going out in the field for personal reasons. The second complaint alleged the employee was accessing the child support, work history and unemployment computer systems for personal reasons. The third referral came from an HFS manager who received a call from a police officer requesting employment history and HFS eligibility information for individuals that had been arrested. The officer stated that the employee was his only contact and the she had provided him with this information on five or six occasions in the past twelve months.

The investigation revealed the employee had been questioned by a supervisor regarding her excessive time in the field. Two witnesses also verified that the employee accessed the HFS computer system to view child support and employment data to see if her male acquaintances were paying their child support. It was also determined the employee used her state of Illinois computer to access real estate property in Cook County and surrounding counties for personal reasons. The three allegations and subsequent investigations were put on hold when the employee went on a non-service related disability leave. Upon the employee's return to work, she was issued cumulative discipline for the three investigations.

Data Security Breaches

- A manager reported that employees were able to access an HFS client database by entering their user identification number without a password. Division staff admitted to being aware of how to bypass entering a password for about a year. Staff worked through the night to resolve the security problem and make the system available to users the next day with the appropriate security measures in place.
  The investigation determined that an HFS supervisor failed to perform his duties. The supervisor knew or should have known that bypassing the use of a password to access a departmental database was a serious matter that must be reported through appropriate channels within his division.

  In addition, two employees were cited when, by their own admissions, they were aware of the security issue in accessing the database without a password. One employee was aware of the security breach for approximately one year and even shared the information with co-workers. The second employee was aware of the security breach for approximately two months after receiving an email, which specifically explained how to circumvent entering a password.

  The employee failed to take appropriate action by reporting the issue to her immediate supervisor. All three employees received discipline for their conduct.

- A temporary services manager received a telephone call from an unknown female alleging that a male temporary services employee was writing down client social security numbers (SSN), names, and addresses and selling the information. The caller alleged the temporary services employee was receiving unemployment benefits from another state and receiving and selling Illinois Link benefits to his HFS coworkers for cash. The caller claimed to be an HFS employee who witnessed these activities. The subject denied having an Illinois Link card and denied selling Illinois Link benefits to coworkers. He also denied that he copied or recorded HFS client information. The temporary services employee acknowledged receiving unemployment benefits from Wisconsin approximately nine months ago. The subject said the caller was likely his fiancée who was upset with him because he owed her $88.00.

The investigation determined the temporary services employee received benefits via the Illinois Link card and had accessed the benefits multiple times in the past thirty days including on the day of his BIA interview. Based upon surveillance video, we were able to identify the temporary services employee as the source of the Illinois Link transactions. The subject failed to report his temporary services earnings to DHS as required by policy.

None of the staff in the subject's work area observed him recording client information or making a paper record of client information. In addition, none of the staff reported that the subject tried to sell his Illinois Link card. A computer forensic examination of the temporary services employee's computer did not show any evidence of client SSN's or client information being collected.

When the subject's fiancé was contacted by BIA, information was developed that she may also be employed and receiving Illinois Link benefits. Both the former temporary services employee and his fiancé were referred to BOI for potential fraud. The temporary services employee was banned from HFS and the temporary employment agency was advised that he should not be assigned to any state agency in the future.

- The Division of Medical Programs received a complaint from an individual who had received a letter from a Dixon Correctional Facility inmate. The complainant believed that the inmate had obtained her personal information from her eye glasses prescription after being advised during an eye appointment that the inmates at Dixon Correctional Industries fabricated eye glasses for Medicaid recipients. The letter from the inmate stated that he had been in prison for thirteen and one half years and that he was getting out next year.

  This investigation determined that the Dixon Correctional Facility inmate received a Joliet area newspaper and read the complainant had received a traffic ticket. The newspaper article listed the complainants name and address, which the inmate used to write her a letter. The inmate also being from the Joliet area said he took a chance and wrote a letter to the female hoping she would respond back to him. The inmate was warned by correctional officials to cease all attempts at contacting the complainant.

  This investigation also determined that the Medicaid recipient information is not available to the inmates fabricating the eye glasses and, in fact, the complainant's eye glasses were not made at the inmate's facility.

U.S. Department of Health & Human Services - OIG

- A U.S. Department of Health & Human Services (HHS), OIG Special Agent contacted HFS for assistance in identifying and securing applications and timesheets associated with a Personal Assistant (PA) case. The client was a disabled child and approved for the PA program. The parents allegedly convinced at least one PA to

falsify the time records by adding additional time that they had not worked. The parents then took a kickback from the PA after she received and cashed her check. The PA was a student at Bradley University and also works for another family as a PA. Apparently, the PA explained the situation to the second family and was told the situation sounded fraudulent and that the PA should report it, which she then did.

At BIA's request, the Bureau of Medicaid Integrity provided a listing of all payments made to PA's on behalf of the client and investigators obtained the original client file from the contractor. The HHS Special Agent determined the loss amount for this case was approximately $500. The U.S. Attorney declined prosecution, as it did not meet their prosecution guidelines. As a result of contacts made during this investigation, three additional fraud referrals were made to Medicaid Fraud Control Unit.

APPENDIX A - RECENT PROGRAM INTEGRITY STATE AND FEDERAL LEGISLATION

Affordable Care Act (ACA) Program Integrity
The Affordable Care Act includes numerous provisions designed to increase program integrity in Medicaid, including terminating providers from Medicaid that have been terminated in other programs, suspending Medicaid payments based on pending investigations of credible allegations of fraud, and preventing inappropriate payment of claims under Medicaid.

Provider Participation and Screening requirement

- Section 6501
- Final Rule 42 CFR Part 1007 "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" - 2/2/11
- CMCS Informational Bulletin - 5/31/11

Pending Investigations of Credible Allegations of Fraud: Ensuring that federal funding is not provided to individuals or entities when there is a pending investigation of a credible allegation of fraud, unless the state determines that good cause exists not to suspend such payments.

- Section 6402 under Title VI Transparency and Program Integrity
- Final Rule 42 CFR Part 1007 "Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" - 2/2/11

National Correct Coding Initiative (NCCI): Incorporating "NCCI methodologies" in state Medicaid claims processing systems to promote correct coding, control improper coding and eliminate inappropriate payment of claims.

- Section 6507 under Title VI Transparency and Program Integrity
- State Medicaid Director Letter SMD#10-017 - 9/1/10
- CMCS Informational Bulletin - 9/10/10
- HHS Report to Congress - 3/1/11

Affordable Care Act (ACA) Program Integrity Recent Regulations
Recovery Audit Contractors (RACs): Establishing Recovery Audit Contractors (RACs) to audit payments to Medicaid providers. Medicaid RACs will identify and recover provider overpayments and will also identify underpayments.

- Section 6411 under Title VI Transparency and Program Integrity
- Proposed Rule 42 CFR Part 455 "Medicaid Program; Recovery Audit Contractors" - 11/5/10
- CMCS Informational Bulletin - 11/9/10
- State Medicaid Director Letter SMDL#10-021 - 10/1/10

- CMCS Informational Bulletin - 10/1/10

Home Health

Documenting that a health care provider has had a face-to-face encounter with a patient prior to ordering the provision of home health services.

- Section 6407 under Title VI Transparency and Program Integrity
- Proposed Rule 42 CFR Parts 409, 418, 424, et al. "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices" - 7/23/10
- CMCS Informational Bulletin - 9/8/10

Self Disclosure Requirements

- Section 6409 of the Patient Protection and Affordable Care Act (ACA)
- Section 1320a-7k(d)(2) requires a provider to self-disclose an overpayment within 60 days of the overpayment being identified or the date that any corresponding cost report is due, if applicable.

APPENDIX B - REFILL TOO SOON

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 represent the value of all rejected prescriptions, but the true savings are probably less.

Refill Too Soon

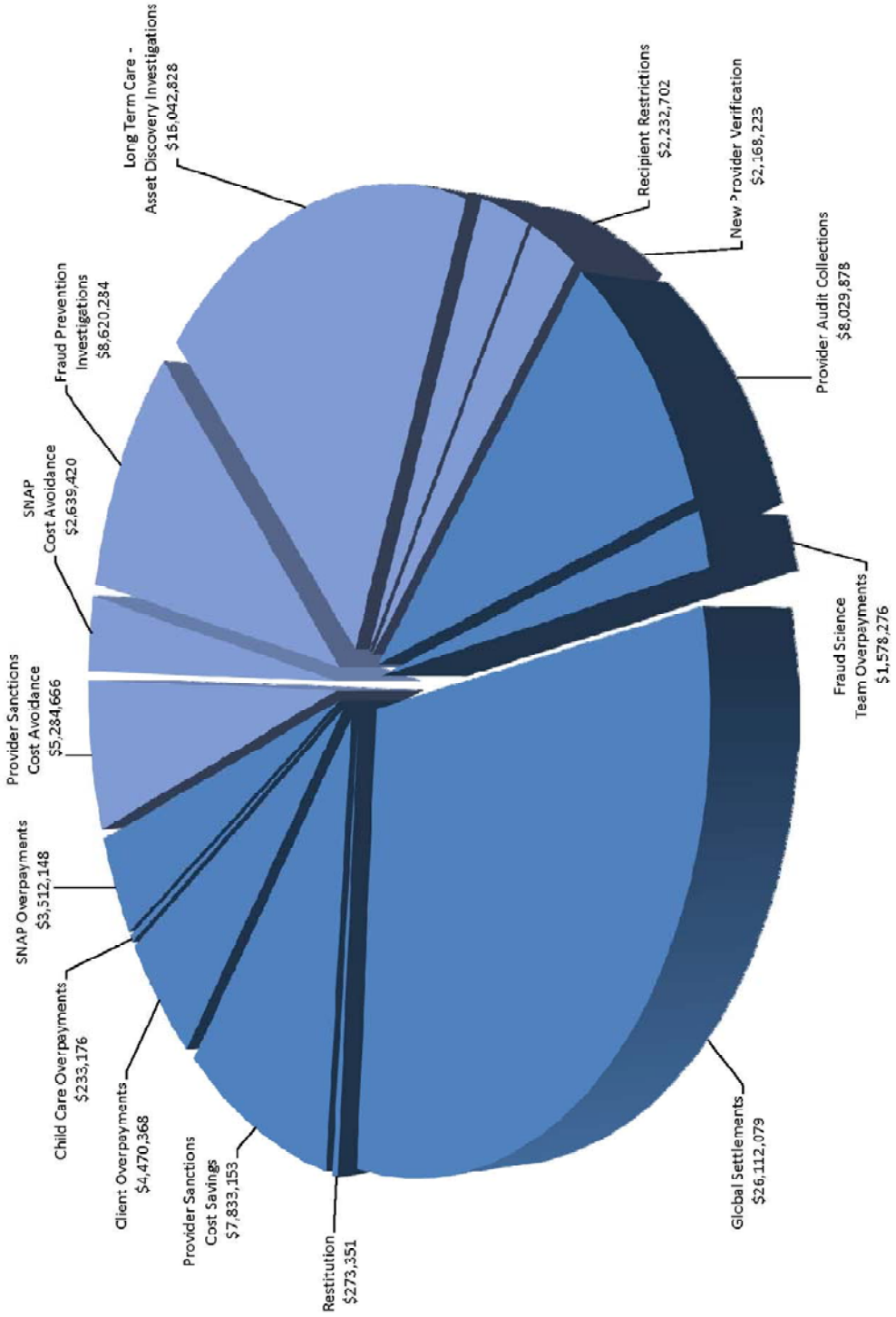
Total Number of Scripts	24,711,401
Amount Payable	$1,348,811,382
Scripts Not Subject to RTS	43,839
Amount Payable	$5,495,338
Scripts Subject to RTS	24,667,562
Amount Payable	$1,343,316,044
Rejected Number of Scripts	1,515,538
Estimated Savings	$91,308,784

APPENDIX C – AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

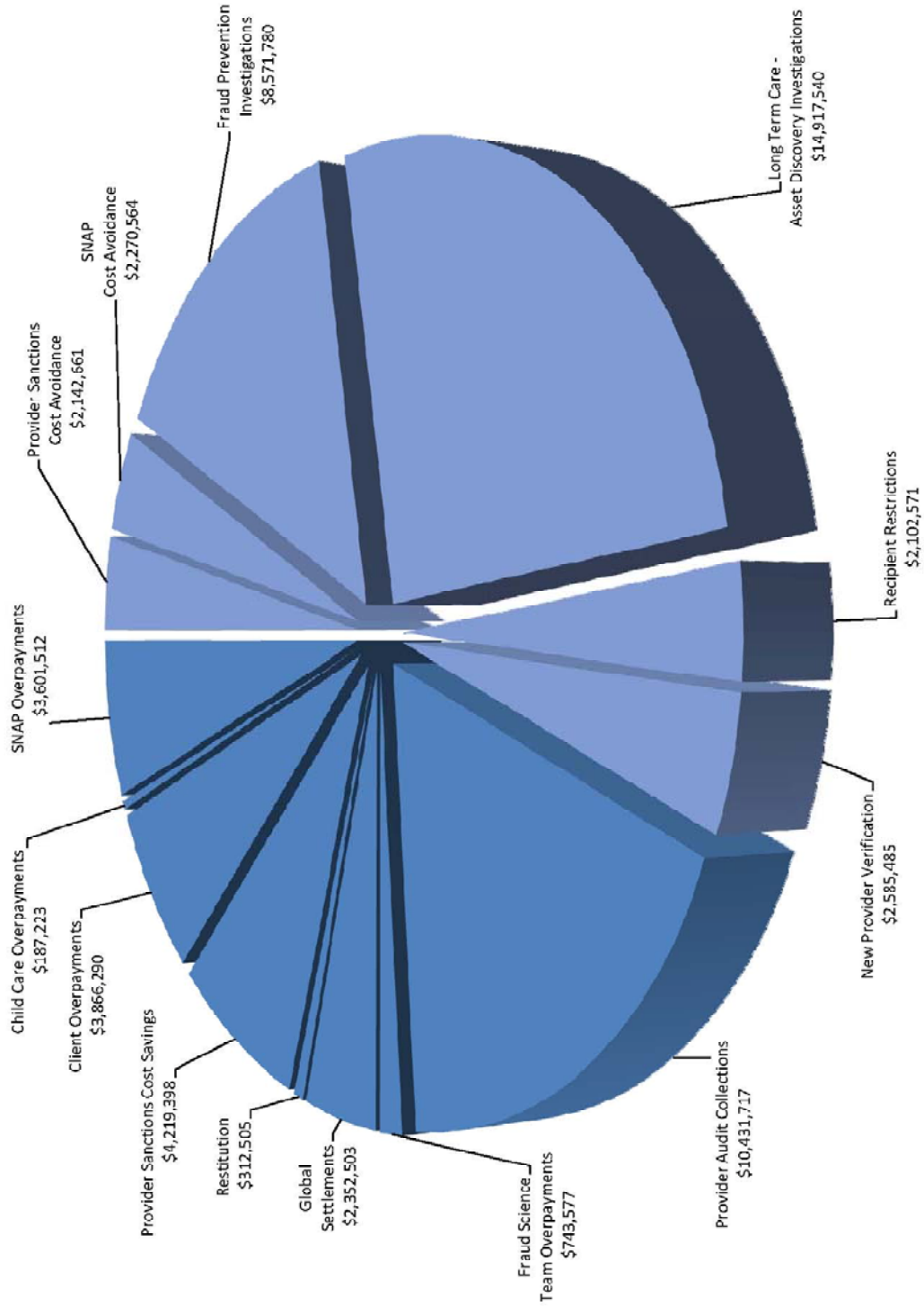
Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of Calendar Year 2012 Annual Report/Date on the OIG website; http://www.state.il.us/agency/oig/. The information, required by Public Act 88-54, is by provider type because the rates of payment vary considerably by type.

APPENDIX D – CHARTS

Calendar Year 2012 Breakout



Fiscal Year 2012 Breakout



APPENDIX E – ACRONYMS

ACA	Affordable Care Act
ALJ	Administrative Law Judge
ASU	Administrative Service Unit
BAK	Bureau of All Kids
BCCD	Bureau of Child Care Development
BFST	Bureau of Fraud Science and Technology
BIA	Bureau of Internal Affairs
BMI	Bureau of Medicaid Integrity
BOI	Bureau of Investigations
CAS	Central Analysis Services
CASE	Case Administration and System Enquiry
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
CP	Custodial Parent
CPA	Certified Public Accountant
CPA-LTC	Certified Public Accountant-Long Term Care
CVU	Central Verification Unit
DHS	Department of Human Services
DME	Durable Medical Equipment
DNA	Dynamic Network Analysis
DPA	Department of Public Aid
DPH	Department of Public Health
DPI	Department of Program Integrity
DRA	Deficit Reduction Act
DRG	Drug Related Grouper
EBT	Electronic Benefit Transaction
EHR	electronic health record
FAE	Fraud Abuse Executive
FBI	Federal Bureau of Investigations
FCRC	Sangamon County Family & Community Resource Center
FFY	Federal Fiscal Year
FPI	Fraud Prevention Investigations
FRS	Fraud Research Section
HFS	Department of Healthcare and Family Services
HHS	Department of Health & Human Services
HMS	Health Management Systems
HUD	Housing and Urban Development
IHAP	Inpatient Hospital Audit Program
ILCS	Illinois Compiled Statutes
IPIA	Improper Payments Information Act

Acronyms (Continued)

IPV	Intentional Program Violation
ISP	Illinois State Police
LAN	Local Area Network
LEA	Local Education Agency
LTC-ADI	Long Term Care-Asset Discovery Investigations
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid fraud control unit
MMIS	Medicaid Management Information System
NCAR	Negative Case Action Reviews
NCCI	National Correct Coding Initiative
NCP	non-custodial parent
NPV	New Provider Verification
OCIG	Office of Counsel to the Inspector General
OEIG	Office of Executive Inspector General
OIG	Office of Inspector General
PA	Personnel Assistant
PERM	Payment Error Rate Measurement
PIP	Provider Incentive Payments
PRAS	Provider and Recipient Analysis Section
PSA	public service administrator
QC	Quality Control
RAC	Recovery Audit Contractors
ROI	Return of Investment
RRP	Recipient Restriction Program
RTS	Refill too soon
SAS	Social Security Administration
SB	Senate Bill
SCHIP	State Children's Health Insurance Program
SIPV	Suspected Intentional Program Violation
SMART Act	Save Medicaid Access and Resources Together Act
SMD	State Medicaid Director
SMDL	State Medicaid Director Letter
SNAP	Supplemental Nutrition Assistance Program
SPSA	senior public service administrator
SQL	Structured Query Language
SSA	Social Security Administration
SSN	Social Security Number
SURS	Surveillance Utilization Review System
TANF	Temporary Assistance to Needy Families
TMS	Technology Management Section
TPL	Third Party Liability
UIB	Unemployment Insurance Benefits
US	United States

APPENDIX F – LISTING OF OIG PUBLISHED REPORTS

Title	Date
Passive Redetermination Analysis	September 2010
Office of Energy Assistance Low Income Home Energy Assistance Program Report	December 2009
All Kids Family Care Special Study Report	December 2008
New Provider Verification Report - April 2001 to September 2003	October 2005
School Based Health Services Technical Assistance Report	August 2004
Fraud Prevention Investigations: FY02 Cost Benefit Analysis	September 2002
Fraud Prevention Investigations: FY01 Cost Benefit Analysis	September 2001
Child Support Emergency Checks	June 2001
Fraud Prevention Investigations: FY00 Cost/Benefit Analysis	November 2000
Fraud Prevention Investigations: FY99 Cost/Benefit Analysis	March 2000
Death Notification Project: Identifying the Cause of Delay in Notification	February 2000
Non-Emergency Medical Transportation Reviews: Focusing on Compliance	December 1999
Project Care: Exploring Methods to Proactively Identify Fraud	December 1999
Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments	December 1999
Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century	September 1999
Recipient Services Verification Project: RSVP II-Home Health Care	August 1999
Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues	June 1999
Fraud Prevention Investigations: FY98 Cost/Benefit Analysis	December 1998
Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices	October 1998
Fraud Prevention Investigations: FY97 Cost/Benefit Analysis	February 1998
Medical Transportation: A Study of Payment and Monitoring Practices	December 1997
Funeral and Burial: A Review of Claims Processing Issues	October 1997
Maintaining A Safe Workplace: Best Practices in Violence Prevention	June 1997
Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings	May 1997
Fraud Science Team Development Initiative Proposal	April 1997

LISTING OF OIG REPORTS - CONTINUED

Title	Date
Medicaid Client Satisfaction Survey: April 1996-September 1996	April 1997
Prior Approval Study	May 1996
Clozaril Report	February 1996
Hospital Inpatient Project Summary Report	April 1994

Published reports are located on the OIG website: http://www.state.il.us/agency/oig/. If no link is available, please contact our office at (217)–524-6119 for a printed copy.

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