

**Department of Healthcare and Family Services**

Office of Inspector General

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# Annual Report

Fiscal Year 2017

**BRUCE RAUNER, GOVERNOR**

Bradley K. Hart, Inspector General



## Mission

The mission of the Office of Inspector General is to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in programs within the Illinois Medical Assistance Program.

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**Office of Inspector General  
Illinois Department of Healthcare and Family Services  
Fiscal Year 2017  
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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). The 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). The DPA became the Department of Healthcare and Family Services (the Department) 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 the Department, 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 prevent fraud as an independent watchdog, has enabled the program integrity component to increase its impact on Department programs. The OIG investigates possible fraud and abuse in all of the programs administered by the Department and some DPA legacy programs currently administered by DHS. The OIG also has jurisdiction over the Community Care Program (CCP) within the Department on Aging (DOA). 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 Fiscal Year (FY) 2017, the OIG had a staff totaling 169 employees.

The 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 FY 2017, with Bradley K. Hart serving as the Inspector General. The OIG continues working to expand its integrity activities by researching and developing new programs and technologies.

## NOTABLE ACCOMPLISHMENTS

### **\$195 Million - OIG Total Cost Savings and Avoidance**

In FY 2017, the Office of Inspector General (OIG) for the Illinois Department of Healthcare and Family Services (the Department) continued with a comprehensive, program integrity work-plan, which included focused and expansive fraud, waste and abuse investigations, audits, and reviews. The OIG implemented several new initiatives, and enhanced several ongoing initiatives that led to a continuation of prevention and enforcement during FY 2017. This aggressive work plan resulted in a cost savings and avoidance of *\$195 million dollars*.

*...This aggressive work plan resulted in a cost savings and avoidance of \$195 million dollars.*

The OIG consistently recognizes vulnerabilities, creates broad solutions, and realizes tangible results. When the OIG identifies new patterns of improper billing or fraud schemes, the work plan is adjusted to allocate resources to maximize program activities and savings to the State of Illinois. For example, in FY 2017, the OIG Work Plan included notable initiatives (page 5) in the area of the Long Term Care-Asset Discovery Investigations (LTC-ADI). As a result of the initiative, the LTC-ADI unit realized gross savings of \$146 million.

*...the LTC-ADI unit realized gross savings of \$146 million.*

The OIG Work Plan included thousands of investigations, audits, and reviews in FY 2017 aimed at combating fraud, waste and abuse. These activities include:

- 2,793 Bureau of Medicaid Integrity Audits (BMI);
- 221 Provider Peer Reviews;
- 19,858 investigations of fraud allegations received through the Welfare Abuse Recovery Program (WARP);
- 866 investigations conducted by the Bureau of Investigations (BOI);
- 135 Administrative Sanctions hearings initiated by the Office of Counsel to the Inspector General (OCIG); and
- 1,903 restrictions of clients through the Recipient Restriction Program (RRP) due to overutilization of narcotics

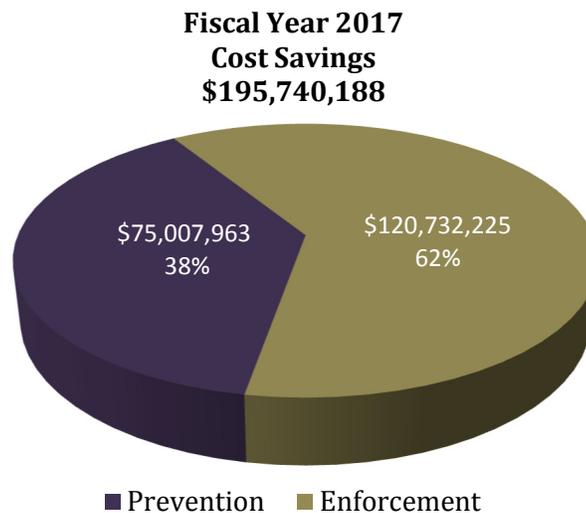
Details of the prevention and enforcement activities are outlined in the sections that follow.

# OIG PROGRAM INTEGRITY COST SAVINGS AND AVOIDANCE

During FY 2017, the OIG has moved forward on numerous fronts to expand the depth and breadth of our Program Integrity Mission. The OIG has continued to strive to fulfill its mandate of preventing and detecting fraud, waste and abuse in the Medicaid program, by relying on the hard work of the OIG staff, cooperation with various state and federal government agencies, and the deployment of new technology and scientific methods. This three-pronged strategy has resulted in better prevention methods and more efficient detection tools. The savings realized not only benefit the Department, but several other state agencies as well. Through these efforts, the OIG has succeeded in generating cost savings, as well as in raising awareness of the importance of Program Integrity among clients, providers, and the citizens of Illinois.

## OIG Fiscal Year Savings

In FY 2017, the OIG realized a savings of approximately \$195 million through collections and cost avoidance. The OIG utilized a range of enforcement and prevention strategies outlined in this report to realize those savings. The OIG’s actions for FY 2017 resulted in a Return On Investment (ROI) to the taxpayer of \$8.70 for every dollar expended.



### Prevention Activities

- [Provider Sanctions Cost Avoidance](#)
- [SNAP Cost Avoidance](#)
- [LTC-Asset Discovery Investigations](#)
- [Recipient Restrictions](#)

### Enforcement Activities

- [Provider Audit Collections](#)
- [Fraud Science Team Overpayments](#)
- [Global Settlements](#)
- [Restitution](#)
- [Provider Sanctions Cost Savings](#)
- [Long Term Care - Asset Discovery Investigations](#)
- [Client Overpayments](#)
- [Client Medical Card Overpayments](#)
- [Child Care Overpayments](#)
- [SNAP Overpayments](#)
- [Client Program Overpayments](#)

## OIG FISCAL YEAR 2017 HIGHLIGHTS

### Long Term Care-Asset Discovery Investigations

The Department is responsible for the Medicaid Long Term Care (LTC) program for approximately 55,000 eligible residents in over 700 nursing facilities. The mission of the program is to ensure LTC residents requesting coverage for LTC services are eligible and are in compliance with federal and state regulations. LTC-ADI is charged with ensuring that resource disclosure and transfer policies are appropriately enforced. Execution of this effort is a partnership between the OIG and Department of Human Service Family Community Resource Centers (DHS FCRC). LTC-ADI completes reviews and provides resource directives on LTC applications meeting specified criteria referred by DHS Human Service Caseworkers.

The goal of this unit is to prevent ineligible persons from receiving long-term care benefits and to deter improper sheltering of assets and resources. The reviews uncover undisclosed resources and unallowable resource transfers, by saving tax dollars and making funds available to qualified applicants who have no ability to pay for their own care.

Over the last several years, federal changes have placed significant new demands on states and applicants for LTC services. The federal Deficit Reduction Act (DRA) of 2005 made significant changes to the eligibility rules for Aid to the Aged, Blind and Disabled (AABD) Medicaid long term care coverage. Some of the changes included an increased look-back period for asset transfers to five years, stricter asset transfer penalties, restrictions on annuities and a homestead equity cap. In addition, the “SMART Act” was signed into law in June of 2012, which further restricted Medicaid eligibility. As a result of the increase in referrals due to the implementation of these changes, LTC-ADI experienced a significant increase in processing periods. The unit was expanded to ensure timely review and disposition of cases involving asset transfers.

Senate Bill 0026 was passed by the General Assembly and signed into law on July 22, 2013 as [Public Act 98-104](#) (Act). The Act amended the Public Aid Code to require an expedited long-term care eligibility determination and enrollment system be established to reduce long-term care eligibility determinations to 90 days (or fewer by July 1, 2014) and streamline the long-term care enrollment process.

The OIG is the principle entity to investigate long-term care eligibility, and to ensure that individuals have not improperly transferred or failed to disclose assets or resources in a manner that is not permitted by law. In doing so, OIG ensures appropriate use of scarce state tax dollars. Improved procedures were designed to maximize operational efficiency associated with the review of long-term care applications. As a result of these improvements, an increased amount of savings was realized. Additionally, LTC-ADI assumed responsibility for referrals during the appeal process ensuring appropriate representation of case outcomes.

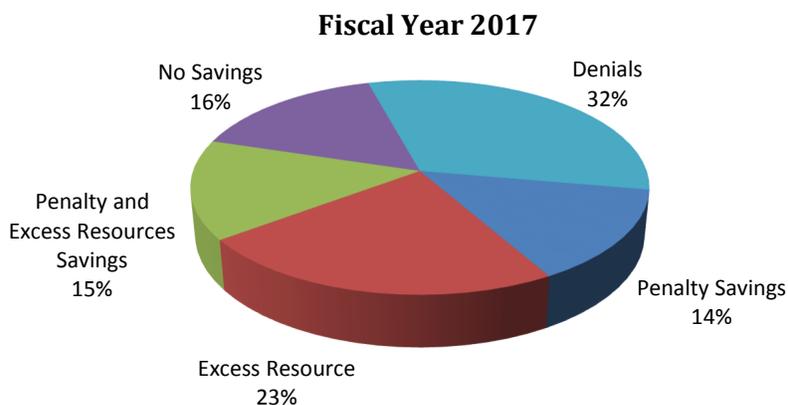
The LTC-ADI team consists of support staff, analysts, and an attorney. The analysts are responsible for comprehensive reviews of an LTC applicant’s financial documentation to discover unreported and transferred resources and assets. The LTC-ADI attorney is responsible for providing legal counsel on the eligibility impact of various legal vehicles (including trusts, wills, life insurance, and annuities); novel transfer issues (including personal care contracts); and spousal issues (including divorce, separation, spousal refusal, and spousal transfers). The attorney also handles the administrative appeals of LTC-ADI directives.

In addition to work on individual eligibility matters, OIG also takes a proactive approach to maximizing administrative efficiency and compliance within state and federal laws. The OIG engages in extensive outreach and education with those entities that specialize in elder and Medicaid eligibility law, LTC facilities, and sister agencies that perform various eligibility tasks.

**NOTABLE RESULTS**

The LTC-ADI unit completed 2702 cases in FY 2017. Of the completed cases, 1411 resulted in a savings to the taxpayer from penalties, excess resources or a combination of both. Costs were avoided (not authorized assistance) in 854 cases. A gross savings of \$146,029,786.26 was realized, with a return on investment of \$55.24 for every \$1.00 spent.

Long-Term Care-Asset-Discovery Investigations		
Enforcement Activities	# Cases	Total Savings
Cost Savings Cases <sup>1</sup>	1,411	\$74,972,639
Cost Avoidance Cases <sup>2</sup>	854	\$71,057,147
No Savings	437	\$0
Total Investigations Completed	2,702	\$146,029,786



<sup>1</sup> Cost Savings is a projected savings determination and defines final disposition data as the determination used after the regulated arbitration date and may contain instances of re-application or appeal after the arbitration timeframe.

<sup>2</sup> Cost Avoidance methodology was provided by HFS Bureau of Long Term Care and was based on the average daily payment by the Department for a long term care facility times the average days a resident remained in the facility prior to death within the previous five years.

## OIG Audit Initiatives

The OIG identifies potential vulnerabilities to the integrity of the Illinois Medicaid Program. These issues cannot be addressed on a reactionary basis, one audit at a time. Accordingly, the OIG has developed a multi-faceted strategy to eliminate current fraud, waste and abuse trends, as well as to prevent new trends from developing.

- The OIG analyzes the relevant regulatory framework, including federal and Illinois law, federal guidance, approaches used in other states, and Department policy. If change is needed, the OIG pushes for change through the legislative, rulemaking, and policy development processes;
- The OIG utilizes its diverse staff of attorneys, auditors, investigators, health care professional and information technology experts, in order to tailor specialized audit and investigatory initiatives;
- The OIG engages in extensive public outreach, in order to facilitate provider education and future compliance;
- The OIG aggressively pursues administrative actions, in order to recover overpayments and appropriately sanction problem providers;
- Special Ongoing Projects, DME, Enhanced Data and Review Audits and;
- The OIG takes advantage of its close working relationship with law enforcement, ensuring the efficient and organized referral of cases for criminal and civil prosecution.

The OIG has developed audit algorithms to identify and monitor potential billing inconsistencies. The OIG adjusts its audit plans to maximize the effectiveness of its program integrity activities; including the use of data mining, fraud science routines, and internal and external audits.

When the OIG identifies improper billing patterns or fraud schemes, it adjusts its audit plan to allocate resources between internal and external auditors to maximize its impact on program vulnerabilities. The OIG developed specialized internal task force teams to conduct audit reviews in areas of identified program vulnerabilities and high risk. This includes but is not limited to, dental, home health, deceased recipient payments, hospice, durable medical equipment, and non-emergency transportation providers among others.

Additionally, the OIG utilized their partnership with other state and federal resources to insure a greater and immediate impact on high-risk provider specialty areas. Through, FY 2017, the OIG continued to utilize external vendors to assist the OIG in performing audits of high-risk providers and high-risk areas. In FY 2017, the OIG continued to utilize the services of external Certified Public Accountant vendor(s) to perform financial audits of the Long Term Care Facilities that have over 60 Medicaid beds. These vendors perform specialized financial and asset audits on all Medicaid residents within these facilities to determine potential credit balances and overpayments made to facilities based upon resident income and asset reviews.

The federal Centers for Medicare and Medicaid Services (CMS) continue to provide external auditors to the State of Illinois to perform Universal Program Integrity Contractor (UPIC) audits. The FY 2017 UPIC vendor is AdvanceMed, and OIG is working closely with the UPIC to perform audits on behavioral health, hospice, laboratory, and a selection of home-health agency providers.

The Recovery Audit Contractor (RAC) audits are federally mandated audits to be performed by an external vendor. The current RAC vendor is Health Management Services (HMS) and these auditors perform audits of provider payments and associated financial records specific to all Department fee for service payments made to a contractually agreed scope of Medicaid provider(s).

In FY 2018, the OIG intends to expand the use of these specialized internal audit teams, CPA, UPIC and RAC auditors to aggressively address Medicaid program vulnerabilities. Finally, the OIG intends to continue work with all Compliance teams and Special Investigation Units of the Managed Care Organizations (MCO) to further enhance and ensure program integrity oversight.

#### ***PROPOSED AUDIT INITIATIVES***

##### **Durable Medical Equipment Non-Covered Services Initiative**

In FY 2018, the OIG Audit staff will implement a self-audit project to identify services provided and reimbursed by the Department, to Durable Medical Equipment (DME) providers, which are identified as Non-Covered Services based upon Department policy (Topic M-204 “Non-Covered Services” of the Handbook for Medical Equipment and Supplies effective on and after September of 2015).

The initial scope of the audit will consist of services provided and paid on a fee for service basis for recipients who are in a Department of Corrections (DOC) setting, in a State Mental or Developmentally Disabled facility and/or recipients enrolled within a Managed Care setting at the time the service was provided by the DME provider. The initial scope of the audit will also consist of DME services provided to recipients who are age 21 and over who are in a hospice setting, as the hospice provider is required to provide the DME services as part of the hospice stay.

The planned initial audit period is for dates of service of January 1, 2012 through December 31, 2014 and a follow-up audit will occur for dates of service January 1, 2015 to current. There are approximately 876 active DME agencies in the Medicaid program. It is anticipated that this self-audit will affect approximately 80% - 90% of the active DME agencies. It is also anticipated that this self-audit will be implemented during FY 2018 and will take approximately 6-8 months to complete.

The initial Durable Medical Equipment provider self-audit potential overpayments for the audit period of January 1, 2012 – December 31, 2014 are anticipated to be approximately \$5 million. The OIG will conduct a follow-up audit for dates of service January 1, 2015 – currently, after the initial audit project is completed and will encourage the DME agencies to take advantage of the OIG self-disclosure process.

### Hospital Non-Covered Services Initiative

The OIG Audit staff has identified a new hospital initiative for FY 2018 entitled Hospital Non-Covered Services. The OIG staff has worked in conjunction with the Healthcare and Family Service hospital policy staff to identify hospital services reimbursed by the Department that were determined to be non-covered services. The non-covered services identified are specific procedure codes in relation to Emergency Room visits, Office visits provided within an Outpatient Place of Service and certain Pulmonary Rehabilitation Services.

The OIG is planning to implement this self-audit beginning in January or February of 2018 as a follow-up to the Hospital Global Billing audits. It is anticipated that approximately 275 hospitals will be identified as a result of this audit initiative and the potential recoupment will be approximately \$5 – 8 million.

### Physician Professional Component Billing Initiative

A new proposed initiative for FY 2018 will mirror the Hospital Global Billing initiative by identifying physicians who bill for the professional component of a laboratory and/or x-ray reading that was also billed by the Hospital. According to Medicaid policy, if the radiologist and/or pathologist are salaried by the hospital, the hospital can bill for the global rate (both the professional and the technical component). The radiologist and/or pathologist cannot bill for these services with a modifier of 26(professional component) or TC (technical component).

The OIG will request a data run from the Bureau of Fraud Science and Technology to identify these services. The audit findings will be sent out as self-audits to the providers for review of potential improper billings. The provider(s) will have the opportunity to agree or disagree with the findings. It is anticipated that this audit initiative will go out to providers around January – February of 2018 and will go to approximately 100 providers. It is estimated that the potential recoupment will be approximately \$500,000.00.

### Standardized Formal Provider Audit Packages

The OIG audit management staff will continue working on development of professional audit package(s) by provider type that will be a template for all audit staff to utilize when conducting an audit and presenting audit results to provider(s). In FY 2017, audit management staff developed an internal audit compliance library to house all audit templates, process and procedure manuals along with all management approved templates and letters. The BMI audit management staff has completed a standardized template for all Physician, Long-Term Care, and Home Health agency audits. The revised audit packages will continue to be a work-in-progress until a formalized and standardized audit package is developed for all Department Medicaid Provider(s) subject to an audit by the OIG. It is anticipated that by the end of FY 2018, audit packages will be developed and formalized on approximately 80% of the Medicaid provider types.

## ***ONGOING AUDIT INITIATIVES***

### **Ambulance and Transportation Services Fraud and Prevention and Recovery**

The OIG identified Program vulnerabilities involving providers of non-emergency ambulance and transportation services. The identified vulnerabilities included improper duplicate billing, billing for loaded mileage, billing for services paid during an inpatient stay, upcoding, billing for services not rendered and other improper billing practices.

In response, OIG developed comprehensive transportation audit strategies that ensure regular monitoring of ambulance and other transportation services. Specialized BFST data routines are performed routinely to identify improper payments. Desk audits are performed to recover these improper payments and the OIG conducts both scheduled and unscheduled onsite field audits to evaluate medical necessity, to verify services billed were rendered, and to ensure general compliance with Department regulations and policies.

The OIG also evaluated whether there was proper completion and submission of a Medical Certification for Non-Emergency Ambulance (MCA) form for patients discharged who require medically supervised ground ambulance services. As part of these audits, the OIG includes extensive education to ensure ongoing compliance with transportation services. This OIG initiative includes both medical necessity audits, encompassing a full review of a recipient's relevant medical records; and, documentation compliance audits, which focus on a provider's compliance with Department documentation requirements and the proper completion of a MCA service form. In FY 2018, the OIG will continue with this audit initiative to ensure that transportation services are appropriate for the recipient's medical condition at the time of transport.

### **Dental Service Integrity Compliance**

In FY 2017, the OIG completed an audit initiative a result of a data review that showed a marked increase in dental payments for orthodontic services. The OIG performed audits on identified providers of orthodontic services. At the time of these audits, the Department's policy was to have DentaQuest perform a comprehensive evaluation based upon two Department approved tools. Tool #1 was the Orthodontic Criteria Index (Scoring) and Tool #2 was the Malocclusion Severity Assessment (Salzmann). The two tools were used in conjunction to determine the medical necessity for all Orthodontic services as part of the prior approval process.

As a result of the OIG audits, a proposed Department policy change was implemented that changed the current medical necessity prior approval tools of the Salzmann and the Orthodontic Criteria Index to the Handicapping Labio-Lingual Deviation (HLD) index tool. The HLD is a more comprehensive, robust and widely accepted tool in determining medical necessity for orthodontic services. The OIG will continue into FY 2018, the evaluation and monitoring of all dental services provided and billed to the Department. Audits will continue to assess adequate medical necessity measures being taken by our

Dental provider(s). The OIG intends on expanding internal audits of general dental services to determine whether such payments are in accordance with Illinois Medicaid requirements.

#### Home Health Services Fraud Prevention and Recovery

Home Health Agencies (HHAs) continue to be reviewed as providers that may be performing questionable billing practices. Due to identified fraud, waste and abuse in the area of Home Health Services, CMS imposed a statewide moratorium on newly enrolling agencies.

The OIG will continue to work in collaboration with CMS Center for Program Integrity and the UPIC vendor when appropriate to conduct joint audits. The OIG has planned approximately 5-10 home-health agency audits during FY 2018.

#### Hospital Global Billing Payment Prevention and Recovery

The Hospital Global Billing initiative incorporated the verification of potential improper billings by hospitals for lab and x-ray services. Whereby the hospital received the global rate (technical and professional component) and the non-salaried pathologist and/or radiologist also billed separately for the professional component of the rate for the same patients on the same day while the patient was receiving services in an outpatient setting.

This initiative was implemented in FY 2016 incorporated an audit period that included dates of service January 1, 2010 – December 31, 2014. The result of this initiative was that self-audits were sent out to 272 hospitals with an identified potential overpayment amount of \$4.6 million. During FY 2017, \$4.4 million was recouped from the hospitals as non-disputed overpayments. Approximately 25 hospitals self-disclosed global billing improper payments for dates of service January 1, 2015 – current. A second result of this initiative was the implementation of billing changes by a large majority of the hospitals to ensure that correct procedure modifiers are included on the hospital billings to the Department. The OIG staff had many discussions with hospital executive management staff who ensured that changes were going to be made to their internal computer systems to ensure that accurate billing of procedure modifiers occur in future billings.

The OIG will be continuing this audit for dates of service January 1, 2015 – current excluding the services that were identified and recouped via the self-disclosure process. It is anticipated that this follow-up audit will commence mid FY 2018 and will result in an estimated recoupment of \$2 million.

#### Long Term Care Fraud Prevention and Recovery

The OIG identified program vulnerabilities associated with Long Term Care payments. The use of both internal and external certified public accountants that specialize as auditors ensure greater impact on this identified area of risk for the Department. The OIG has implemented audit initiatives aimed at broadening the scope of oversight over long-term care payments. The OIG has a separate internal audit team that conducts financial audits of long-term care providers and oversees audits performed by the external contractors. Long Term Care Audits include financial audits of the facility's non-medical

records and cost reports. In FY 2018, the OIG intends to expand the scope of the Long Term Care audits. This includes audits aimed at comprehensive evaluation of their potential for fraud, waste and abuse.

#### Post Mortem Payment Prevention and Recovery

The OIG implemented a successful initiative identifying and recovering payments made by the Department for deceased Medicaid recipients. This audit initiative required the OIG staff to conduct aggressive outreach to Medicaid providers and provided education on healthcare fraud laws and Department regulations pertaining to the improper billing for deceased recipients.

The OIG intends to continue to monitor for improper payments made for deceased recipients and to perform audits on providers who were paid improper payments. The OIG has implemented monthly monitoring of these payments using the OIG Dynamic Network Analysis (DNA) system. Further, when appropriate, and when the audit provides evidence of improper conduct by a provider, the OIG has invoked its authority to Sanction providers through payment suspensions and terminations from participation in the Medicaid Program.

#### External Contract Vendor Auditor Initiative

In general, the OIG contracts with external vendors who perform various audits under the oversight and direction of the OIG audit team. The OIG work plan includes the use of both internal and external auditors to allow for a wide range of fraud, waste and abuse detection activities and to ensure broad oversight within Program operations. The ability to utilize both internal and external auditors with diverse subject matter expertise allows the OIG expansive oversight capability. The following is a summary of the external audit activities.

- Certified Public Accountant – Long Term Care (CPA-LTC) – Financial audits of Long Term Care facilities performed by three individual CPA firms – These audits include reviews of financial statements, the facility’s non-medical records, and cost reports. The purpose of these audits is to recoup overpayments paid to the facility based upon each Medicaid recipient’s financial status and review of the resident’s exempt asset status.
- Recovery Audit Contractor(s) (RAC) – Federal law requires states to establish programs to contract with a RAC to audit payments made to Medicaid providers. The OIG utilizes a RAC Vendor to supplement its efforts for all provider types and all audit types with the exception of Pharmacy and CPA-LTC audits. Payment to the RAC vendor is a statutorily mandated contingency fee based on the overpayments collected. During FY 2018, RAC audits will be expanded to focus on other areas of the Medicaid program, such as Physician, Durable Medical Equipment, Home Health, Hospice, and Transportation (including Ambulance) service providers among other areas.
- Universal Program Integrity Contractor (UPIC) – The OIG in partnership with the federal Centers for Medicare and Medicaid Services’ Center for Public Integrity (CPI) performs audits

on specialized and targeted Medicaid provider types. The CPI offers states the use of UPIC auditors, in order to perform these targeted audits at no cost to the State. The UPIC is the expansion of the Medicare focused Zone Program Integrity Contractor (ZPIC) program that allows the UPIC to perform program integrity functions over both Medicare and Medicaid. The UPIC contractor's will initially be focusing on Behavioral Health, Home Health, Hospice and Laboratory provider audits based upon agreement by both the UPIC vendor and the Office of the Inspector General.

### Enhanced Self-Audit and Self-Disclosure Reviews

Self-Audit Reviews involve identifying a potential audit scenario and identifying via data analytics potential overpayments made to Medicaid Providers. Self-Audit reviews will involve working with Medicaid Provider(s) via data reports, letters, and e-mail communication to require the Medicaid Provider to review all identified overpayments and reconcile all provider disputed discrepancies. The result of the self-audit review will allow the OIG to recover overpayments made to the provider and allow the provider to reconcile payment issues via the self-audit or through self-disclosure process.

Self-Disclosure Reviews involve the identification of irregularity in the billing practices of a provider. In appropriate circumstances, the OIG requires a provider to conduct its own investigation and overpayment self-disclosure. The OIG will verify the overpayment amounts through data analytics and professional review. As a result of the Self-Disclosure Protocol and initiatives, the Department has received over 150 self-disclosure cases.

In 2013, as a result of the SMART Act, the Department established a protocol to enable health care providers and vendors to disclose an actual or potential violation of Medical Assistance (Medicaid) program requirements. The OIG established a voluntary disclosure process that providers may utilize upon detection and receipt of an overpayment from the Department. This process is called the "[Provider Self-Disclosure Protocol](#)". This protocol will assist providers to comply with overpayment detection and repayment obligations under the federal Patient Protection and Affordable Care Act.

The intent behind the self-disclosure protocol is to establish a fair, reasonable, and consistent process that is mutually beneficial to the providers and the Department. The OIG realizes situations may vary as to whether a referral to the protocol is even necessary, therefore the protocol is written in general terms to allow providers and the OIG flexibility to address the unique aspects of each case. Every disclosure is reviewed, assessed, and verified by the Department on an individual basis.

In exchange for the provider's good faith self-disclosure and continued cooperation, the Department may offer a waiver or reduction of interest payable on the overpayment, extended repayment terms, and a waiver of some of all of the applicable sanctions or penalties.

All Self-Disclosures are analyzed and memorialized by the Audit Development Committee to determine potential overall impact to the Department. Self-Disclosure that can be implemented as effective and efficient audits across all provider(s) and provider types will be submitted to the Executive Audit Compliance Committee who then will determine which audit scenario/proposals will be implemented with the Internal BMI Audit plan.

## OIG COMPOSITION AND ACCOMPLISHMENTS FOR FY 2017

The OIG staff includes attorneys, nurses, data analysts, investigators, accountants, quality control reviewers, fraud researchers, information technology specialists, and support staff. The following is an overview of OIG composition, including functions and goals of the staff:

### Administration

**Fiscal Management** includes the oversight of all fiscal matters, including collections/bad debt, procurement, and budget responsibilities. Collections/Bad Debt tracks overpayments and court-ordered restitution from providers; a process that involves establishing accounts in the accounts receivable 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 referred to the Office of the Attorney General for collection, establishment of liens or write off.

The OIG budget is projected annually. Staff monitors the expenditures and requests additional funds as needed for special projects and initiatives. Staff is also responsible for the payment of invoices and vouchers to vendors for various contractual services.

**Personnel and Labor Relations** handle necessary paperwork for all personnel transactions, labor relation issues, deferred compensation, direct deposits, and the sick leave bank.

### Management Research and Analysis

The **Management Research and Analysis Section** (MRA) processes the reviews of New Provider Verification (NPV) applications and provider revalidations. These include High, Moderate and limited risk providers. The unit also processes Fingerprint-based background checks as part of enhanced enrollment screening provisions contained in Section 6401 of the Affordable Care Act and Illinois [305 ILCS 5/12-4.25](#). Criminal Background checks begin with all High Risk providers and can include other providers as determined during the review process. All documentation and licenses must be current to provide services for Illinois Medicaid clients.

MRA is the liaison with the Managed Care Organizations (MCO) and tracks the investigations conducted by the MCOs as they relate to Fraud, Waste and Abuse. This also includes overseeing quarterly and Task Force meetings with the MCOs, ISP – Medicaid Fraud Control Unit (MFCU), and the Department’s Bureau of Managed Care (BMC). The meetings bring together the unity of the types of fraud seen amongst the State and Managed Care entities. Highlights can include particular investigations that have a large recovery or that may have commonality across different payers or books of business.

MRA works with the Fraud and Abuse Executive (FAE) in presenting all case types to ISP-MFCU to ensure that additional information is provided in a timely and accurate manner.

MRA is also responsible for gathering materials and data monthly for the OIG executive team and rolling that information into the OIG Fiscal Year Annual report. In the future, MRA will also assist in the publication of special reports for OIG.

**New Provider Verification** was the monitoring of non-emergency transportation providers, which began in June 2001. This was done by performing pre-enrollment on-site visits to verify their business legitimacy and by performing an analysis of their billing patterns to detect aberrant behaviors during a 180-day probationary period. This process has been expanded under the SMART Act to include monitoring of high, moderate and at times limited risk providers. This expansion includes Fingerprint – based background checks, verification of licenses, insurances, corporate standings, and on-site visits.

High and Moderate risk providers are monitored through their billings for one-year. Limited risk providers are monitored for a nine-month probationary period. During on-site visits, the business' location and existence is confirmed; information provided on the enrollment application, including ownership information, is verified; and the business' ability to service Medicaid clients is assessed. Depending on the provider type, the Bureau of Investigations or the Bureau of Medicaid Integrity would conduct the onsite readiness review.

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high-risk category. A 5 percent or greater owner includes any individual that has any ownership interest (either direct or indirect) in a high-risk provider or supplier. Note that the high level of risk category applies to providers and suppliers who are Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers; Home Health Agencies (HHA); and Non-Emergency Transportation Providers (NEMT). It also applies to providers and suppliers who have been elevated to the high-risk category based upon prior OIG sanctions or for owing a debt to the Department pursuant to provisions of federal regulations [42 CFR §455.100 Subpart B—Disclosure of Information by Providers and Fiscal Agents and §455.400 Subpart E—Provider Screening and Enrollment](#).

Enrollment may be denied for various reasons: an incomplete enrollment package; a non-operational business; the inability to contact the applicant; a requested withdrawal by the applicant; applying for the wrong type of services; and the applicant's non-compliance with fingerprinting or documentation requirements. Once the applicant has addressed the issue(s) and re-submitted the application, the process is re-started. Applicants can also be denied enrollment for other reasons such as the failure to establish ownership of vehicles; fraud detected from another site affiliated with the applicant; an applicant's participation in the Medicaid Program using another provider's number; and providing false information to the Department.

After the provider is approved and past the probationary period, the State Medicaid agency must revalidate the enrollment of all providers regardless of provider type at least every 5 years.

Revalidations are conducted as full screenings appropriate to the risk level very similar to the NPV process.

New Provider Verification	
Enforcement Activities	# Cases
Enrolled	200
Withdrew Application	1
Applications Returned	36
Applications Referred for Denial	1
On-Site Verification with Concerns	6
On-Site Verification with No Concerns	56
Provider Monitoring	80
Reviews	384

Provider Revalidations	
Enforcement Activities	# Cases
Approved Revalidation	226
Referred to OCIG	2
Provider Withdrew from the Medicaid Program	7
On-Site Verification with Concerns	11
On-Site Verification with No Concerns	62

### The Fraud and Abuse Executive

The **Fraud and Abuse Executive (FAE)** coordinates federal and state law enforcement activities related to the Illinois Medicaid program. FAE is the liaison with the Illinois State Police Medicaid Fraud Control Unit (MFCU). The FAE evaluates and transmits fraud and abuse referrals to MFCU. The FAE monitors these referrals and upon completion of MFCU’s investigations, the FAE coordinates any necessary administrative actions. Administrative actions could include Audit reviews, Peer Reviews and payment suspensions, as well as possible termination from the Illinois Medicaid program.

In the event of Program related issues, the FAE works in conjunction with OCIG on the implementation of payment suspensions pursuant to [42 C.F.R. 455.23](#) as well as the enhanced payment suspension capabilities authorized by the [SMART Act \(PA 97-0689\)](#).

In addition to supporting MFCU criminal investigations on Medicaid providers, the FAE also coordinates data collection and data analysis support to other law enforcement entities such as the Department of Health and Human Services (HHS-OIG), the various U.S. Attorneys, the Illinois Attorney General, National Association of Medicaid Fraud Control Units (NAMFCU), and the FBI.

The FAE identifies key Department 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, HHS-OIG and the U.S. Department of Justice.

FAE is also responsible for tracking referrals sent from OIG to other agencies. Referrals are made to other Illinois state agencies such as the Illinois Department of Financial and Professional Regulation, the Illinois Department of Public Health, DHS, as well as Federal CMS and HHS-OIG. These referrals can result from committee reviews, audits, etc., in which provider education, licensing concerns or billing concerns have been identified and need to be addressed.

Law Enforcement	
Enforcement Activities	# Cases
Referrals to Law Enforcement	85
Law Enforcement Data Requests	69

### The Welfare Abuse Recovery Program

The **Welfare Abuse Recovery Program (WARP)**, processes fraud and abuse referrals from citizens, local DHS offices, state and federal agencies and law enforcement entities concerning recipients and providers. WARP conducts research on referrals by accessing information from DHS, Secretary of State, Illinois State Police (ISP), DPH vital records, employment and unemployment history as well as various other sites. Through phone calls, internet, mail, and e-mail inquiries, WARP established \$1,029,703.40 in Food Stamp and Cash Grant overpayments on a total of 527 cases during FY 2017.

Fraud Allegations	
Source	Received
Calls	10,942
Referrals(includes web, emails, USPS and other government employees)	8,266
Requests from DHS Local Offices	650

WARP receives fraud referrals from internal and external entities and gathers the supporting documentation. WARP reviews the information, assigns a case number, and determines how/where to route the case. WARP can send the information to the BOI for additional investigation, close the case for lack of merit, forward the case onto a DHS Local Office (LO) for additional follow up, or send all findings to the DHS Bureau of Collections (BOC) to have a dollar amount and timeframe established. If the information is sent to BOC, they will then respond with the appropriate overpayment amount.

Client Program Overpayments	
Client Program	Total Overpayments Established
BOC LO Food Stamps	\$1,205,255
BOC LO Grant	\$94,415
Total	\$1,299,670

## 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 the Department programs and operations, and provides all legal support for OIG internal operations. OCIG represents the OIG in administrative fraud and abuse cases involving the Department programs. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements, and renders program guidance to 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 Illinois 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 eligibility; state income tax delinquency cases; civil remedies to recover unauthorized use of medical assistance; and legal determinations affecting recipient eligibility for LTC-ADI Investigations. OCIG brings joint hearings with the Department of Public Health (DPH) in instances when they seek to decertify a long-term care facility. Finally, OCIG assists with responses to Freedom of Information Act (FOIA) and subpoena requests.

In FY 2017, OIG terminated, denied, suspended, or excluded over 254 providers, individuals, and entities from participation in the Illinois Medical Assistance Program. Searchable exclusion lists are available on [OIG's Web site](#). Providers who are terminated or debarred from the program are restricted from participation in the Program and may not be employed by any entity receiving payment by a federal or State health care program.

Sanctions	
Hearings Initiated	# Cases
Termination	32
Termination/Recoupment	28
Recoupment	72
Suspension	0
Denied Application	1
Decertification	1

Final Actions	# Cases
Termination	88
Termination/Recoupment	41
Suspension	2
Voluntary Withdrawal	6
Recoupment	115
Decertification Resolution	0
Civil Remedy	0
Barrment*	8

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

Reinstatement Actions	# Cases
Termination	32
Termination/Recoupment	28
Recoupment	72
Suspension	0
Denied Application	1
Decertification	1

Total Medical Provider	
Sanctions Dollars	# Cases
Cost Savings	\$1,080,968
Cost Avoidance	\$1,003,854

The following are descriptions of the some of the type of cases that involve OCIG attorneys and support staff in the research and preparation.

- Provider Assistant Termination and Recoupment Cases - The Illinois Department of Human Services (DHS) Home Services Program (“HSP”) is a state and federally funded Medicaid waiver general assistance program ([42 CFR 440.180](#)), designed to prevent the unnecessary institutionalization of individuals, who may instead be satisfactorily maintained at their home, and at a lesser cost to the State of Illinois. [89 Ill. Admin., Code 676.10 \(a\)](#). While DHS is responsible for ensuring that funds are available for the Home Services Program, HSP program oversight is also administered by the Department “as the State’s approved Medicaid agency.” [89 Ill. Admin. Code 676.10 \(b\) and \(c\)](#). A wide variety of home care services are provided to these Illinois Medicaid recipients by persons commonly referred to as individual providers or Provider Assistants (“PAs”). Many PA cases involve fraud, waste, or abuse concerns, including especially improper and misspent funds resulting from a PA’s submission of fraudulent time sheets; actions based on serious criminal conduct; or allegations involving risk of harm and abuse to recipients. When such issues are identified, PA’s are referred by DHS to OIG for further investigation and appropriate administrative action.

FY 2017 brought a sharp increase in the number of PA Termination and PA Termination/ Money Recoupment cases being investigated, filed, and heard. During the past year, the Department filed 54 such cases with the Department's Bureau of Administrative Hearings. The OIG's attention to these cases fosters Illinois public policy to safeguard public monies expended for the benefit of this state's most vulnerable citizens. The OIG's renewed focus on PA cases is part of a broader effort carried out in conjunction the Governor Rauner's Health Care Fraud Elimination Task Force, including the participation of other sister state agencies, namely the Illinois State Police Medicaid Fraud Control Bureau, and the Illinois Attorney General's office.

- **Transportation Desk Audit Termination and Recoupment Cases** - During FY 2017, the Department filed approximately 135 transportation desk audit cases. These cases sought Termination and Recoupment or Recoupment only for the audit findings consisting of billing for loaded mileage, duplicate billing, and billing for transportation while a recipient was a hospital inpatient. The Department was able to obtain service of process on these transportation Vendors approximately 60% of the time. This rate of service takes into consideration the unpredictability of the medical transportation business and circumstances where Vendors purposefully evade or do not otherwise accept service of the Notices filed.

In the cases where service was effectuated, approximately 20% of these Vendors requested formal administrative hearings, and the remaining 80% either paid back the Department the full recoupment amount or were found to be in default, resulting in a Recommended Decision and a Final Administrative Decision for the Department or a Recommended Decision awaiting a Final Administrative Decision.

In instances where the Department was unable to obtain service, these recoupment cases were withdrawn pursuant to a request by the Department's Bureau of Vendor Hearings. These un-served cases remain under investigation and in the case rotation for further attempts at re-service following additional research into the Vendor's valid last known address.

- **Post Mortem Recoupment Cases** - During the latter part of the FY 2017, the Department investigated and processed approximately 265 new Post Mortem money recoupment cases. These Post Mortem cases will be filed during the beginning of FY 2018, with approximately 20 to 30 cases being filed every month. In order to reduce the number of these still pending Post Mortem cases, the Department took steps to re-schedule the BAH's Transportation Desk Audit Preliminary Call with Post Mortem cases being heard first. Thereafter, the Department's Post Mortem and Transportation cases will be rotated on a monthly basis to ensure that both types of Vendor administrative cases are heard.

The ability to file, schedule, and hear additional Medical Vendor Hearing cases is limited by the reduction in personnel, including specifically attorneys, investigators, and staff members within the Office of the Inspector General, as well as with a reduction and changes in Administrative

Law Judge personnel and ancillary staff members assigned to hear and handle medical vendor hearing cases. The ability to timely process the back log of cases and schedule them for an administrative hearing is also constrained, in part, by the existence of a Bureau of Administrative Hearings Standing Order. Generally, this limits the filing of all new Department cases to a maximum of 50 new cases per month, with a maximum number of 25 cases to be filed on the Preliminary Calls scheduled for the first and third week of each month. The Department is cooperatively working with the BAH to file and hear more cases for FY 2018.

## **Bureau of Fraud Science and Technology**

The **Bureau of Fraud Science and Technology** (BFST) is responsible for the introduction, development, maintenance, and training of staff on new technologies, and maintaining [OIG's Website](#). BFST utilizes sophisticated computer technology to analyze, detect, and prevent fraud, waste and abuse by providers and recipients. BFST oversees the maintenance and enhancement of the Dynamic Network Analysis (DNA) Predictive Modeling System, a Center for Medicare & Medicaid Services (CMS) "Best Practice" put into production in September 2011; and Case Administrative System Enquiry (CASE), a highly sophisticated case tracking, and document management system developed specifically for OIG. BFST responds to referrals from within and outside the Department. The areas within BFST include the Provider and Recipient Analysis Section (PRAS), Recipient Restriction Program (RRP), Fraud Science Team (FST) and the Technology Management Unit (TMU).

**Provider Analysis Unit** (PAU) is an intricate part of BFST and uses the DNA system in its analysis. DNA-SURS compares a provider's billing patterns against its peers to identify outliers. Together with the Predictive Modeling analytics and other statistical indicators, these unique systems have streamlined the analysis process, increased reporting accuracy, and ultimately allowed OIG to quickly and accurately prevent, detect, and eliminate fraud, waste, abuse, misconduct, and mismanagement from providers of Medicaid services and by recipients enrolled in Department programs. For example, utilizing the information provided from the DNA Predictive Analytic model and profile-reporting system, the Provider Analysis Unit looks at the who, what, when, where and why of a specific provider's billing trends, payment amounts, business inter-relationships and pharmaceutical prescribing patterns. The analyst then compares that provider's practices to like providers, with same specialty, in the same area of the state to identify potential quality of care infractions, risk of harm to Medicaid recipients or for fraudulent activity or "outliers". Once fraud, waste, or abuse of the Medicaid system is identified or suspected, the case is referred for a more focused audit, Peer review, or referred to law enforcement for suspected criminal violations. These investigations could possibly result in recoupment of money from the provider back to the State of Illinois. If recipients health and well-being are jeopardized the provider may also face disciplinary sanctions to include suspension and/or termination of Medicaid provider privileges.

Additionally, using the same complex and unique systems mentioned above, and based on Department-defined categories and risk levels, BFST expanded their analysis processes to encompass other provider types such as Durable Medical Equipment providers, Personal Assistants and Home Health providers.

In the provider transportation arena, New Provider Verification (NPV) is another integral component of BFST where transportation providers wanting to enroll as a new provider are evaluated for potential fraud, waste, or abuse. New provider applications are routed to OIG NPV for confirmation and verification of required enrollment documentation. The proposed transportation provider is analyzed at predetermined intervals prior to approving enrollment. If concerns for fraud, waste, or abuse are discovered, enrollment can be denied or postponed.

The **Recipient Restriction Program** (RRP) is another key component to PRAS. RRP receives referrals or tips regarding potential recipient fraud, waste, abuse, or misconduct from multiple resources including [OIG's Website](#), Medicaid Fraud Hotline and Recipient Restriction Hotline calls. Like the Provider Analysis Unit, the RRP uses the DNA Predictive Analytic model and profile-reporting system to proactively, identify overutilization of Medicaid services by enrolled recipients. Additionally, by studying restriction cases and utilizing domain expert knowledge, BFST has built an intelligent recipient selection system in which recipients' service and billing patterns are examined. This unique system has enabled BFST to identify the recipients who may be abusing Medicaid services much earlier than with previous systems. During their review process, the analyst determines if the diagnoses listed on medical claims support the use of medical or pharmacy services received. When fraud, waste, or abuse of medical services is identified, the analysis is forwarded to the Physician Consultant for recommendations. To optimize services and quality of care for Medicaid recipients, the Physician Consultant often recommends the recipient be restricted to a single Primary Care Physician and/or a single Primary Care Pharmacy. These primary care providers must coordinate and approve most outpatient services and all prescriptions. To date, there are approximately 1900 active recipient restrictions.

The Cost Avoidance from FY 2016 of \$1,660,786 reflects the continued downward trend into FY 2017. This downward trend is due to loss of budget funding causing payment lags resulting in lower number of case reviews by professional medical contractors, e.g. physicians, pharmacists, medical doctors, etc. In FY 2017, RAU staff reviewed an average of 200 clients (Medicaid recipients) per month, down from FY 2016 due to limited staff resources. These include Medicaid recipients in traditional Fee for Service (FFS) plans as well as those who have transitioned into MCOs. Even though OIG RRP makes recipient restriction recommendations to all MCOs, many MCOs do not have recipient restriction, or "lock in programs" implemented. This severely limits the Departments ability to restrict those clients identified as "over users" of medical benefits. As more MCOs implement these programs, cost avoidance dollars will increase.

Additionally, the budget impasse has played an important role in OIG hiring and retaining consultants in every department. The three RAU staff continues to analyze cases for Physician Consultant review. Currently, however, RAU has one contracted physician to complete all reviews. This has resulted in a significant (9 month) backlog of cases awaiting review. These are cases being recommended for restriction, but that restriction cannot be implemented until the final step of Consultant Evaluation is completed, which also impacts cost avoidance dollars.

Client Medical Abuse		
Client Restrictions	# Clients	Total Cost Avoidance
Client Reviews Completed	2,313	
12 Month Restrictions as of 6/30/2016	893	
New Restrictions	403	
Released or Canceled Restrictions	33	
Converted to 24 Month Restrictions	111	
Clients Restricted as of 6/30/2017	1,014	\$421,800
24 Month Restrictions s of 6/30/2016	944	
New Restrictions and Re-restrictions	126	
Released or Canceled Restrictions	21	
Clients Restricted as of 6/30/17	889	
Total Restricted as pf 6/30/2017	1,903	

The **Fraud Science Team** (FST) develops fraud detection routines to prevent and detect health care fraud, abuse, overpayments, and billing errors. FST works with the Department to identify vulnerabilities and solutions in the Department’s payment system. FST routines are analytical computer programs written in Statistical Analysis System (SAS), Teradata SQL, and DataFlux, utilizing the Department 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. BFST also takes systematic approaches to plan and implement the integration of sampling selection and audit reporting, DNA-CASE integration, statistic validation, executive information summaries, and other analysis that will improve OIG’s operational and decision-making processes.

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

### Bureau of Investigations

The **Bureau of Investigations** (BOI) provides professional investigative services and support to the Department and to DHS in an effort to prevent, identify, investigate, and eliminate fraud, waste and abuse by providers and recipients in all programs under OIG’s jurisdiction. The Bureau attempts to

promptly, investigate any suspect person or entity and vigorously pursues 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 Bureau is responsible for processing criminal background fingerprint results for all high-risk transportation providers enrolling with the agency.

In addition, during FY 2017, BOI identified \$6.3 million in potential Medicaid recoveries due to total ineligibility. Currently, there is no process to collect these monies.

Client Eligibility		
Enforcement Activities	# Cases	Total Overpayments Established
Founded	522	
Unfounded	166	
Investigations Completed	688	\$11,930,494
Convictions	16	
Administratively Closed	42	
Type of Investigations	# of Allegations	Percent (%)
Absent Children	892	12
Absent Grantee	126	2
Assets	230	3
Employment	1819	24
Family Comp / RR In Home	1226	16
Family Composition	718	9
FS Traffic / Link Misuse	564	7
Interstate Duplicate Assistance	71	1
Other Income:	776	10
Prosecution	152	2
Residence Verification	900	12
Third Party Liability	119	2
Total	7593	100%

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 provided 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 the DHS Bureau of Collections for possible civil litigation.

Child Care		
Enforcement Activities	# Cases	Total Dollars Established
Founded	2	
Unfounded	0	\$81,710
Investigations Completed	2	
Convictions	1	

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 when their cards are used improperly without their knowledge. Typical examples include loaning a medical card to ineligible persons; visiting multiple doctors during a short time period for the same condition; obtaining fraudulent prescriptions; selling prescription drugs or supplies; or using emergency room services inappropriately.

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

Client Medical Card Misuse		
Enforcement Activities	# Cases	Total Dollars Established
Founded	1	
Founded In-Part	0	\$137
Unfounded	1	
Investigations Completed	2	

The goal of the Bureau is to ensure the integrity of the Temporary Assistance to Needy Families (TANF) program, **Supplemental Nutrition Assistance Program** (SNAP), Medicaid, and other assistance programs. The functions of BOI include client eligibility, provider fraud, prosecution, SNAP/ Electronic Benefit Transfer (EBT) disqualifications/investigations and child care investigations.

Clients who intentionally violate the 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 10 years for receiving duplicate assistance and/or trafficking. Cost avoidance in SNAP cases is calculated as the average amount of food stamp issuances made during the overpayment period times the length of the disqualification period.

Supplemental Nutrition Assistance Program			
Enforcement Activities	# Cases	Total Dollars Established	
Referred to BAH	2189		
Reviews Completed	3127		
Pending ADH decision	83		
FADS	446	Cost Avoidance:	\$2,525,162
Waivers	570	SNAP Overpayments:	\$3,309,259
Lost	12		
Court Decisions	27		

During FY 2017, BOI completed various types of investigations throughout the state. A number of investigations that had been completed during this fiscal year have elements of particular interest that are noted below:

- Absent Children - In April 2016, an allegation was received that a DHS client's children were not living in the assistance unit. It was determined that the client's four children were living in three other households for the period of February 2011 through April 2017. During this time, the client collected assistance for all of the children and an estimated SNAP overpayment was calculated for \$33,330. The investigation was completed in April 2017 and has been submitted to DHS for further processing.
- Absent Grantee - A joint investigation with the Department along with Homeland Security and U.S. Citizenship and Immigration Services, was conducted after receiving an allegation stating a client was receiving SNAP benefits while residing in India. The investigation revealed the client was residing in India and that their gainfully employed daughter used the client's SNAP benefits thinking they were entitled to them as they claimed the client on her taxes as a dependent. The client's daughter provided a signed and notarized Affidavit to the Department of Homeland Security, U.S. Citizenship and Immigration Services stating that they would pay back DHS. The investigation completed in June found for the period of April 2012 through November 2014 an estimated SNAP overpayment of \$2,394. The cancelled case was sent to BOC for further processing.
- Client Eligibility and Child Care / RR in Home / Unreported Employment Income - A BOI investigation found that a client was married and that the spouse was employed since May 2013. As a result, of the living arrangement for the period of June 2013 through August 2016, the client received an overpayment of \$21,148 in SNAP benefits. The investigation was completed in December 2016 and submitted to the DHS, Bureau of Collections.
- Another investigation conducted by BOI, determined that the above client had also received child care assistance from May 2013 to August 2016, again without reporting that the employed spouse lived in the assistance unit. The child care investigation, also completed in December

2016, was submitted to the Bureau of Child Care and Development, which calculated that as a result of this living arrangement, for the period of June 2013 through August 2016, the client received an overpayment of \$71,738.27 in child care assistance.

- Client Eligibility / Absent Children - A BOI investigation completed in December 2016, found that a client was receiving SNAP benefits for three children that did not live in the assistance unit. Specifically, the investigation found that one of the client's children had lived with great-grandparents since the time of birth (November 2013) and two other children had lived with one of the children's father since the client began receiving SNAP benefits in September 2014. The completed investigation was submitted to the DHS Local Office, which calculated an overpayment that was a result of the three children having lived outside the assistance unit. The client received an overpayment of \$10,996 in SNAP benefits for the period of September 2014 through December 2016.
- Client Eligibility / Absent Children - A BOI investigation revealed that the client's children had not been living with the assistance unit dating back to at least December 23, 2015. At that time, two of the children were taken into protective custody by the Department of Children and Family Services (DCFS) and placed in foster care, where they remain. DCFS confirmed that no other children or adults were living with the client when two of the children were taken into protective custody. The investigation found that the client reported to the DHS, in January 2016, that a child had been born in December 2015, and was living in the assistance unit. In May 2016, the client reported that three children, including the one born in December 2015, were all living with the client but DCFS was able to confirm that no children were living with the client subsequent to December 2015. The failure of the client to accurately, truthfully report information to DHS resulted in the client receiving an estimated overpayment of food stamp benefits totaling \$3,823.00 for the period from January 2016 through October 2016.
- Client Eligibility / Absent Grantee / Residence Verification - A BOI investigation revealed that a client committed welfare benefits fraud by failing to report to the DHS that they were living in Indianapolis, IN, while continuing to receive food stamp benefits from Illinois. The investigation found that the majority of the LINK transactions occurred in the Indianapolis, IN area. The client then moved to Michigan on July 1, 2016, and continued to make transactions with her LINK card in Michigan until August 16, 2016. DHS was not notified of her move to Michigan until after speaking with BOI investigator on August 16, 2016. The client claimed that they did not use her LINK card in Indiana or Michigan. The failure of the client truthfully report information to DHS resulted in the client receiving an estimated overpayment of food stamp benefits totaling \$13,916.00 for the period from February 2014 through August 2016.
- Client Eligibility / Employment - A BOI investigation found that an undocumented alien receiving SNAP benefits was working using a false identity and not reporting that income to

DHS. The investigation completed in March 2017 and found that as a result of this unreported income, the client received an estimated overpayment of \$15,881.00 in SNAP benefits for the period of December 2013 through August 2016.

- Client Eligibility / Employment / Other Income - A BOI investigation completed in August 2016, found that a client failed to report to the DHS Local Office, income from employment and child support. The completed investigation was submitted to DHS for calculation of the overpayment period from August 2011 through August 2016, as a result of the client's failure to accurately, report the correct income. It was determined that the client would receive an overpayment of \$30,675 in SNAP benefits.
- Client Eligibility / Family Composition - A BOI investigation completed in December 2016 found that a client failed to report that the employed spouse was living in the assistance unit. The investigation was submitted to the DHS local office, which calculated that for the period of January 2010 through December 2016 the client received an overpayment of \$43,742 in SNAP benefits.
- Client Eligibility / Family Composition - A BOI investigation found that in February 2017 a DHS client failed to report that both the client and spouse had unreported income from employment, unemployment benefits and worker's compensation. The results of the investigation were submitted to the DHS local office, which calculated that as a result of the household's unreported income, for the period of December 2014 through April 2017, the client had received an overpayment of \$18,645 in SNAP benefits.
- Client Eligibility / Family Composition - A BOI investigation found that a SNAP client failed to report the responsible relative had resided in the assistance unit and that during which time had income from employment. The investigation was completed in September 2016 and submitted to the DHS Local Office, which for the period of January 2013 through July 2016 the client received an overpayment of \$26,455 in SNAP benefits.
- Client Eligibility / Family Composition – A BOI investigation was opened in January 2016 alleging that a SNAP client had falsely reported to DHS in July 2013 that they had separated from their employed spouse. The investigation found that the clients' employed spouse never left the assistance unit in July 2013 and continued to live in the assistance unit through the date of the investigation. The investigation was completed in November 2016 and submitted to the DHS local office. DHS calculated that the client received a SNAP overpayment totaling \$23,974.
- Client Eligibility / Family Composition / Absent Child - A BOI investigation completed in August 2016, found that a client was married and that their spouse was employed from June 2013 through August 2016. The investigation further found that the client's child, who had been

included as a member of the assistance unit, had lived outside the assistance unit from June 2013 through August 2016. The completed investigation was submitted to the DHS local office for a calculation of an overpayment of SNAP benefits totaling \$15,929.

- Client Eligibility / Family Composition / Employment - A BOI investigation completed in December 2016, found that a client's employed spouse lived with the client from March 2012 through October 2016. The completed investigation was submitted to the DHS local office, which calculated that as a result of this living arrangement, the client received an overpayment of \$28,841.00 in SNAP benefits.
- Client Eligibility / Family Composition / Responsible Relative in the Home / Employment - The client, a resident of Clark County, deliberately failed to report living with the responsible relative and their employment income to the Department of Human Services in order to prevent the reduction and/or cancellation of public assistance. The client received an excess of \$12,172.00 in SNAP assistance from DHS during November 2014 through September 2016. The investigation completed in April 2017 was referred to the local DHS office for collection.
- Client Eligibility / FS Traffic / LINK Misuse - The investigation found that the client was booked into the custody of the Champaign County Sheriff's Office (CCSO) on July 29, 2015, where the client remained until October 6, 2016 when the client was transferred to the custody of DOC to begin serving a 60-year prison sentence. The investigation found that during the period from July 30, 2015 through August 1, 2016, while the client was in the custody of CCSO, their LINK account was accessed numerous times. The client was the only member of the assistance unit in this case, and unable to access his LINK account while incarcerated, thus indicating that they allowed unauthorized access to their LINK account. The failure of the client to accurately and truthfully report, information to DHS resulted in the client receiving an estimated overpayment of food stamp benefits totaling \$1,740.00 for the period from August 2015 through May 2016.
- Client Eligibility / FS Traffic / LINK Misuse - The investigation found that the client committed welfare benefits fraud by failing to notify DHS that a member of their assistance unit was not in the home due to being incarcerated. The investigation found that the member of the assistance unit was initially booked into the custody of the CCSO on March 30, 2016, where they remained until the client posted bond on August 12, 2016. The individual was booked back into CCSO custody two weeks later, on August 26, 2016, and remained in CCSO custody until December 1, 2016, when they were transferred to the custody of DOC to begin serving a 16-year prison sentence. A check of DHS records found that the client had called the DHS local office to inquire about their SNAP amount. At that time, the client stated that the client was in the home. When questioned further, the caller said that the individual went to DOC at the beginning of January 2017, while never acknowledging that the client had been incarcerated in Champaign

County. The failure of the client to truthfully, report information to DHS resulted in the client receiving an estimated overpayment of food stamp benefits totaling \$1,335.00 for the period from April 2016 through December 2016.

- Client Eligibility / Ineligible Household Member / Family Composition - The investigation found that the client did not report to DHS that a member of their assistance unit was no longer living in the home. The investigation found that the individual had been booked into the custody of CCSO on February 5, 2016, and that they remained in CCSO custody until September 15, 2016, when they were transferred to the custody of DOC to begin serving a three-year prison sentence. The investigation found that the client had at least three contacts with DHS after the individual began their period of incarceration, and that the client did not notify DHS that the household member was no longer living in the home. The failure of the client to truthfully, report information to DHS resulted in the client receiving an estimated overpayment of SNAP benefits totaling \$1,073.00 for the period from April 2016 through November 2016.
- Employment / Interstate Duplicate Assistance / Family Composition - A BOI investigation completed in November 2016 found that two of the client's children lived outside the assistance unit from January 2013 through November 2016, and another child outside the assistance unit from May 2013 through November 2016. The investigation further found the client was married in July 2013 and living with their employed spouse since the date of the marriage. The investigation further revealed the client received interstate duplicate assistance from Illinois and Arizona for the period of December 2012 through January 2013 and April 2013 through October 2013 and received interstate duplicate assistance from Illinois and Mississippi for the period of August 2013 through July 2014. The completed investigation was submitted to the DHS local office, which calculated that as a result of these issues, the client received three SNAP overpayments totaling \$17,080.
- Family Composition / Employment - A referral was received alleging the DHS client's responsible relative was living in the assistance unit and had income from employment. The investigation revealed the client's responsible relative was living in the assistance unit and was receiving unreported income from employment. Even though the responsible relative is an illegal immigrant and ineligible to receive SNAP assistance, his income should have been budgeted as part of the assistance unit income. The period under investigation covered March 2013 through September 2016. The investigation completed in September 2016, was referred to the DHS Local Office for calculation of a SNAP assistance overpayment of \$19,826.
- Family Composition / Responsible Relative in the Home / Employment - An allegation was received stating the client resided with the responsible relative and that they were both employed for approximately four years while not reporting their income. The investigation found the client and the responsible relative had two children together and had resided together for several years prior to them having said children, which was proven with documentation from several sources.

The client attempted to provide falsified documentation at the time of the interview with the BOI Investigator who challenged the client on said documentation and the client acknowledged DHS would think the responsible relative was in her household. The investigation was completed in January 2017 and referred to the DHS Local Office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of \$16,183.00. The case is being referred for possible prosecution.

- Family Composition / Responsible Relative in the Home / SSN Misuse / Employment / Other Income - This joint investigation with the Social Security Administration (SSA) of a client with two identities revealed that the client was collecting Supplemental Security Income (SSI) and SNAP and Medicaid assistance benefits with one social security number and was gainfully employed with a second social security number. The client also had a gainfully employed spouse, who had full medical coverage for the entire family. The client knowingly failed to report the true household composition and income resulting in a SNAP overpayment of \$74,141.00 for the period of October 2006 through December 2016 and a Medicaid overpayment of \$98,562.65 for the period of June 2004 through February 2017. The investigation was completed in June 2017, and was accepted for prosecution by the Cook County State's Attorney Office.
- Other Income / Family Composition / Employment - A joint investigation was conducted with BOI along with the SSA after receiving an allegation that the client was self-employed as a delicatessen owner and collecting Supplemental Security Income (SSI) and public assistance benefits while owning and actively managing the delicatessen. The investigation revealed the client owned and operated the delicatessen daily with a cash accounting system, but had legally registered the business to an elderly relative and all vendors billed the client's son. The delicatessen was lost prior to the investigation due to a fire; unfortunately, for the client, it was featured on local televised programming and it clearly showed the client actively working in the business. The client initially attempted to deny the ability to function normally to the SSA Special Agents, but after extensive interviewing, admitted to ownership and the use of family members to hide it. BOI followed the SSA period for the overpayment calculation and determined the SNAP overpayment totaled \$5,644. The investigation was completed in May 2017, and was accepted for prosecution by the Department of Justice.
- Prosecution Case / Family Composition - The client, a resident of Montgomery County, deliberately failed to report to DHS that a child resided in Texas in order to prevent the reduction and/or cancellation of public assistance. The client received an excess of \$8,490.00 in SNAP assistance from March of 2013 through January 2015. The investigation, completed in April of 2017, was referred to the Montgomery County State's Attorney for criminal prosecution.

- Prosecution / Child Care - A BOI investigation found that a child care client failed to report that the child care provider was incarcerated for the period of June 2011 through May 2012, which resulted in a child care overpayment of \$11,465.73. In December 2014, the case was referred to Kankakee County State's Attorney's Office, with the client subsequently being indicted on one count of State Benefits Fraud in March 2015. On October 4, 2016, the child care client plead guilty to the charge of State Benefits Fraud (Class 3 Felony) and was sentenced to thirty months of probation and ordered to pay restitution in the amount of \$11,466.
- Prosecution / Unreported Earnings - A BOI investigation found that a SNAP client deliberately failed to report income received from employment during the period of April 2014 through February 2016. During this time period, the client held two jobs, but only reported one of the jobs to DHS. The investigation, completed in March 2017, found that for the period of April 2014 through February 2016, the client received an overpayment of \$7,494 in SNAP benefits. The case was referred to the Henry County State's Attorney's Office on April 3, 2017 and the client has subsequently been indicted on one count of State Benefits Fraud (Class 3 Felony), with the case remaining pending at this time.
- Responsible Relative - In October 2016, a BOI investigation was opened at the request of the local DHS office. DHS believed the spouse to be employed and living in the assistance unit with the DHS client. The BOI investigation completed in April 2017, determined the spouse lived in the assistance unit with the client and children for the period of January 2010 through March 2017. The estimated SNAP overpayment is \$60,011 and has been submitted to the DHS, Bureau of Collections, for further processing.
- Responsible Relative / Employment - In October 2014, a BOI investigation was opened at the request of the local DHS office. They believed the client deliberately failed to report residing with the father of their children and employment income in order to prevent the reduction and/or cancellation of the client's public assistance case. The BOI investigation was completed in August 2016 and determined the father of the children was in the assistance unit and was employed for the period of August 2009 through July 2016. The estimated SNAP overpayment for this case is \$31,352.
- Family Composition - A BOI investigation found that a client's employed spouse was living in the assistance unit. The investigation completed in January 2017 found as a result of the living arrangement, the client had received an overpayment of \$28,158 in SNAP benefits for the period of May 2012 through December 2016. The completed investigation was submitted to the DHS Local Office for further processing.
- Client Eligibility / Residence Verification – The investigation found sufficient evidence that the client committed welfare benefits fraud in that they failed to notify DHS that client and two

children moved to Florida in January 2017. In failing to report that the client and their children moved to Florida, the client and her children continued to receive food stamp benefits in Illinois. The investigation verified that the client's children had last attended school in Illinois on December 16, 2016, and that they were enrolled in school in Florida on January 9, 2017. DHS case notes indicate that the client contacted the DHS Call Center on April 5, 2017 and self-reported their move to Florida. However, EPPIC records show that the client used their LINK card continuously in Florida from January 8, 2017 through April 30, 2017, with the exception of three days in mid-March 2017. EPPIC records show that the client continued to use their LINK card in Florida after they reported that they had moved to Florida. By failing to report in a timely manner that the client had moved to Florida, and by continuing to use the LINK card after moving to Florida, the client received a food stamp overpayment. The failure of the client to truthfully, report information to DHS resulted in the client receiving an estimated overpayment of SNAP benefits totaling \$1,836.00 for the period from January 2017 through April 2017.

### **Bureau of Medicaid Integrity**

The **Bureau of Medicaid Integrity** (BMI) performs compliance audits of providers and quality of care reviews and conducts Medicaid eligibility quality control reviews and special project reviews. The sections within the Bureau include audit, peer review, LTC-ADI, and central analysis section/quality control.

The **Audit Section** performs audits on Medicaid providers to ensure compliance with the Department policies. This section audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, durable medical equipment suppliers, and other types of providers. This Section reviews various records and documentation, including patient records, billing documentation and financial records. Deficiencies noted because of these audits may result in the 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 the Department's administrative hearing process. The Audit Section is also responsible for the oversight of the RAC program required by the Affordable Care Act (ACA).

The OIG initiates provider audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. The audit generally covers a 24-month period and is 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 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.

Collections by Audit Type	
Audit Type	Dollars
Desk Audit	(\$62,277)
Field Audit	\$14,240,450
Self Audit	\$2,835,895
FST Projects*	\$3,336,424
Self Disclosure	\$1,571,427
RAC	\$819,245
Other	\$12,043
Total	\$22,753,207
Restitution	\$167,599
Global Settlements	\$5,136,542
Total	\$28,057,348

\* Audits established through system routines

Audits Initiated	
	# Cases
Initiated	2,793
Completed	670
Pending (Backlog)	2,772

The **Peer Review Section** conducts provider quality of care reviews by sampling patient records. If this 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. Concerns that are more serious 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, sanctions, or referral to the Audit Section if potential compliance issues are suspected. In addition, a referral may be sent to the Departments of Public Health and Financial and Professional Regulation for related regulatory actions.

This 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. Peer review also reviews providers seeking to be reinstated into the Medicaid program.

The OIG staff nurses schedule onsite reviews with providers or request that the provider mail medical records to review. Applicants seeking reinstatement submit medical records for review. A written report documenting findings and recommendations is subsequently completed. Possible recommendations may include case closure with no concerns; case closure with minor deficiencies identified; or a referral to a department physician consultant for further review of potentially serious deficiencies. Additionally, a recommendation may be made to evaluate the reinstatement applicant's medical records. 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; and/or an appearance before the MQRC. In addition to the above recommendations, the provider may be referred to OCIG for suspension or termination from the Medical Assistance Program.

Peer Reviews	
	# Cases
EQ Health Reviews	58
Full Peer Reviews	31
Hotline Reviews	0
Modified Peer Reviews	1
Medical Quality Reviews	11
Peer Review Outcomes	
	# Cases
Letter to Provider with Concerns	13
Letter to Provider without Concerns	3
Referral for Sanction	5
Referral for Audit	3
Voluntary Withdrawal	5
Withdrew Reinstatement Request	1
Recommend Reinstatement	5

**Long Term Care – Asset Discovery Investigations** (LTC-ADI) section conducts reviews of long-term care applications that meet specified criteria related to the transfer and disclosure of assets. These reviews are designed to prevent taxpayer expenditures for individuals that have private funding available for their Long Term Care costs. Reported and discovered assets are reviewed, applying the Deficit Reduction Act (DRA) policies, and verifying transfers are for Fair Market Value (FMV). Undisclosed assets or those transferred for less than fair market value result in penalty periods where the recipient will be ineligible to receive Medicaid payments. During these penalty periods, the recipient is liable for the Long Term Care expenditures at a private pay rate. The LTC-ADI section, including members of

the Office of Counsel to the Inspector General, also review trust documents to determine if they meet current policy requirements. This section also manages all decision appeals through the administrative hearing process. Final determinations regarding LTC eligibility are returned to the local Department of Human Services Family Community Resource Center (FCRC) for implementation. This unit applied 796 penalty periods out of 2,702 investigations during FY 2017; these cases resulted in \$74.9 million in savings and \$71 million in cost avoidance, resulting in a Return on Investment (ROI) of \$55.24 for every dollar spent.

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

Long-Term Care-Asset-Discovery Investigations		
Enforcement Activities	# Cases	Total Cost Avoidance
Cost Savings Cases <sup>3</sup>	1,411	\$74,972,639
Cost Avoidance Cases <sup>4</sup>	854	\$71,057,147
Total Investigations Completed	2,702	\$146,029,786

The following LTC-ADI results were incorporated into final eligibility determinations during FY 2017:

- An application was referred to the OIG by the Macon County Hub for a property transfer. Upon review of the application, the applicant deeded ½ of her interest of 50 acres of farm ground to her son. A penalty was imposed for a cost savings of \$100,321.00.
- An application was referred to the OIG by Medical Field Operations for presence of an annuity. Upon review of the application, the analyst discovered that the applicant had an investment account with Raymond James with a balance of \$75,006.53 and also a savings account with a balance of \$36,414.54. The applicant is able to use these funds to pay for her own nursing home care, therefore saving the taxpayers \$111,421.07.
- An application was referred to the OIG by Medical Field Operations for consulting an attorney, transfers over \$5000, and a trust. Upon review of the application, the applicant had a checking and a savings account that were held in a trust. The family believed that the trust was

<sup>3</sup> Cost Savings is a projected savings determination and defines final disposition data as the determination used after the regulated arbitration date and may contain instances of re-application or appeal after the arbitration timeframe.

<sup>4</sup> Cost Avoidance methodology was provided by HFS Bureau of Long Term Care and was based on the average daily payment by the Department for a long term care facility times the average days a resident remained in the facility prior to death within the previous five years.

“protected”; however, during review of the trust language the trust was deemed as revocable. The funds held in the two accounts are available for the applicant to use for her own nursing home charges, therefore saving the taxpayers \$70,647.28.

- An application was referred to the OIG by Medical Field Operations for a trust and transfers over \$10,000.00. Upon review of the application, \$171,000.00 was transferred from the applicant’s checking account to the children of the applicant. The attorney purchased a Medicaid qualifying annuity so the applicant could pay the private rate during the established penalty months. A penalty of \$171,000.00 was imposed.
- An application was referred to the OIG by the Macon County office for transfers over \$10,000.00. Upon review of the application, the analyst discovered that the applicant’s home, valued at \$74,009.00 had been deeded to her daughter a year before she entered the nursing home. A penalty was imposed for the transfer of the property for a cost savings of \$74,009.00.
- An application was referred to the OIG by Medical Field Operations for transfers over \$10,000.00. Upon review of the application, the analyst discovered that the applicant’s spouse had recently passed away. The analyst found that the spouse had \$88,000.00 of stock, and a property with a value of \$151,000.00. The applicant is able to use this money to pay for their own nursing home care therefore, saving the taxpayers \$239,000.00.
- An application was referred to the OIG by Medical Field Operations for an annuity and transfers over 10,000.00. Upon review of the application, the analyst discovered an Edward Jones account and a savings account with the bank. The applicant is able to use the funds from these accounts to pay for his own nursing home services, which totaled \$36,223.68 in cost savings to the taxpayers.
- An application was referred to the OIG by the Macon County Hub for presence of a trust and transfers over \$5000.00. Upon review of the application, the analyst discovered that the applicant owned 33 acres of farm ground. The value of the farm ground was \$245,762.22. The applicant has the means to pay for their own nursing home care.
- An application was referred to the OIG by the Macon County Hub for presence of a trust. Upon review of the application, the trust was immediately sent to the OCIG attorney. The attorney deemed the trust as a revocable trust, and all the assets held in the trust were available to the applicant. The applicant had an annuity and a home in the trust for a total of \$190,167.44. The applicants are able to pay for their own nursing home care and therefore saving the taxpayers’ money.
- An application was referred to the OIG by Medical Field Operations for consulting with an attorney, an annuity and a trust. Upon review of the application, the applicant transferred a home

with a value of \$218,942.78 to their disabled child. However, the analyst found that the attorney did not have the proper documentation to deem the child disabled as per the SSA standards and therefore a penalty was imposed for the amount of \$218,942.78. The case was appealed and the Bureau of Administrative Hearings affirmed the penalties of the Department.

- An application was referred to the OIG by the Macon County Hub for property ownership and a trust. Upon review of the application, the analyst discovered that the home valued at \$134,900.00 was sold at the same time the applicant was admitted to the nursing home. The applicant had four children and they split the proceeds of the property between them. The children of the applicant also cashed in 4 CD's and distributed the proceeds to the children. A penalty was imposed for a total cost savings of \$153,358.56 to the taxpayers.
- An application was referred to the OIG by the Macon County Hub for property ownership and an annuity. Upon review of the application, the analyst discovered that the applicant had a lump sum annuity with a value of \$62,664.19 and the applicant was put in spenddown. Shortly after the notice of decision was completed by DHS, the POA annuitized the annuity so that the applicant would receive equal installments for 10 years. The POA then appealed the spenddown decision. Upon appeal, they were instructed that this was not allowable; to change a resource after the decision by DHS was completed. The POA contacted the annuity company as was able to cash out the annuity in full and pay the nursing home the value of the annuity.
- An application was referred to the OIG by the Macon County Hub for transfers over \$10,000.00. Upon review of the application, the analyst discovered that the applicant had 106 acres of farm ground that was not disclosed by the POA. The farm ground has a value of \$728,120.00 as per an appraisal that the POA had completed on the farm ground. The applicant is over the asset limit and has access to funds to pay for his own nursing home care, therefore saving the taxpayer's money
- An application was referred to the OIG by the Macon County Hub for transfers over \$10,000.00, Loan/Promissory Note and Property Transfer. Upon review of the application, the applicant entered into a promissory note with his son for the proceeds from the sale of the applicant's property. The house sold and the proceeds were deposited to the applicant's checking account. Since the language in the promissory note was not suitable to allow the transfer and the money was still in the applicant's account, the balance should be used for the benefit of the applicant, therefore, saving the taxpayer's \$79,500.00.

**Central Analysis Section (CAS)** in conjunction with the **Quality Control (QC) Review Section** operates both the federally mandated Medicaid Eligibility Quality Control (MEQC) program and the

Payment Error Rate Measurement (PERM) initiative (both the eligibility and the claim component).<sup>5</sup> The MEQC is conducted annually and PERM is conducted every three years.

For MEQC, 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 paid claims 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, coordinates global corrective action to address program deficiencies, and ensures compliance with federal and state auditing standards.

For the PERM eligibility component, the sample (size is dependent upon previous year's results) is selected from the paid claims universe used in the PERM claims review. CMS contractors conduct the reviews and CAS/QC responds to the findings, collects documents, analyzes discrepancies, and ensures corrective action is implemented.

CAS also manages the PERM Claim Reviews (data processing - DP and medical record - MR) for the Department.<sup>6</sup>

CAS is responsible for the coordination of: the completion of questionnaires, identification of universe, on-site reviews, and systems access for federally contracted auditors. CAS also acts as the liaison between the department's staff responsible for the payment of claims and providers, ensuring the secure submission of documents received from the department and providers to the CMS auditors. In addition, CAS coordinates the development of and monitors a corrective action plan designed to eliminate or reduce errors utilizing various methods such as training, system programming, policy changes, etc.

### **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, and visitors in the Department buildings. The Bureau also obtains criminal history information from the Illinois State Police on new hires and on Department staff who require access to Secretary of State data. BIA conducts assessments for the Department involving threats from employees, non-custodial parents, clients and civilians and conducts annual fire and storm drills. Lastly, the Bureau is responsible for monitoring employee Internet traffic

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<sup>5</sup> The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.

<sup>6</sup> The DP review consists of ensuring the claim has been paid correctly according to the rates set at the time of the service. The medical record review consists of ensuring the provider has all the supporting medical documentation required for that claim type.

and the use of state resources. BIA conducts computer forensic examinations of Department PCs using surveillance and forensic software.

The OIG investigates allegations of employee and contractor 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
Substantiated	29
Unsubstantiated	330
Administratively Closed	1
Investigations Completed	360

Types of Allegations Investigated	Percent (%)
Non-Criminal (Work Rules)	99.7
Discourteous and Inappropriate Behavior	8.8
Failing to Follow Instructions	0.4
Negligence in Performing Duties	0.4
Conflict of Interest	2.9
Falsification of Records	68.2
Sexual Harassment	0.2
Release of Confidential Agency Records	0.2
Misuse of Computer	0.6
Work Place Violence	0.4
Time Abuse and Excessive Tardiness	4.0
Conduct Unbecoming State Employee	13.6
Criminal (Work Rules)	99.6
Theft or Misuse of State Property	0.3
Commission of or Conviction of a Crime	92.4
<a href="#">Criminal Code 720 ILCS 5</a>	0.3
Misappropriation of State Funds	0.9
Security Issue, Contract Violation	4.8
Special Project, 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 during FY 2017 are listed below:

Internal Investigations	
Misconduct Outcomes	# Actions
Misconduct Identified in 2017	29
Employee	28
Vendor/Contractor	1
Misconduct Resolutions Reported 2017	34
Discharge	3
Resignation	4
Suspension	8
Other, such as reprimands	6
Referred to Other Sources for Resolution	4
Administrative Action Pending at Year End	2
No Action Taken by Agency	15

Department Employee Investigations - BIA completed 360 employee and contractor investigations during FY 2017. Included in this total 270 background investigations were completed in FY 2017. A number of investigations that had been completed during FY 2017 have elements of particular interest are noted below:

- It was alleged that a Public Aid Lead Caseworker, took extended lunches, breaks, abused FMLA, and lived with someone who received a LINK card. The employee voluntarily resigned their position during an administrative interview effective close of business June 7, 2016.
- BIA completed a criminal history check on an Office Specialist. On the employee's State of Illinois Self-Disclosure of Criminal History form (CMS284B), they responded "yes" to the conviction question. The employee documented an arrest in 2010 for Domestic Violence and an arrest in 2010 for Driving under the Influence (DUI).

During the interview, the employee stated that they were arrested in 2010 while in Macon County (Illinois) for Domestic Violence involving the employee and the employee's stepchild. This employee was instructed by the court to attend a Domestic Violence Counseling program, which they successfully completed, and the charges were dropped. In addition, this employee stated that they were arrested in August 1998 while in the State of Florida (Orange County) for Possession of Cannabis (less than 29 grams). During the Internal Affairs interview the employee cited "forgetfulness" for not recording the conviction on the CMS 284B. The Office Specialist received a one day suspension.

- BIA completed a criminal record check on an Office Specialist. Criminal record inquiries into files and systems available to criminal justice agencies (based upon name search only) developed conviction information in the State of Illinois.

The investigation determined that the employee failed to disclose on the CMS 284B a conviction in Tazwell County for driving on a suspended/revoked license, thus by falsifying the CMS 284B form. The employee was fined, served 10 days in jail and was placed on 12 months Special Conditional Discharge.

The employee said it was not their intention to withhold information or mislead the employer. The employee also stated that from now forward they would list the conviction on all State of Illinois applications. The Office Specialist received a one day suspension on October 27, 2016.

- The Office of Executive Inspector General received an individual/applicant discrimination complaint dated October 29, 2015, alleging that a Department of Human Services Caseworker had tampered with a case for personal reasons. The complaint alleged that as a result of this tampering, DHS benefits for the complainant and the complainant's two children were changed so that they became ineligible for assistance. The Office of Executive Inspector General forwarded the matter to BIA for investigation.

The investigation determined that the Human Services Caseworker falsified a DHS benefits application by signing the complainant's name to the form. The employee used the state phone to call the complainant to obtain their personal information. The employee also used the state computer database to access the complainant's personal information. The employee shared the complainant's personal information with another Human Services Caseworker. The employee solicited another employee to process the fraudulent application and the second employee ultimately became an accessory to this wrong doing by agreeing to process the application. Although the complainant now has medical coverage through their employer, the employee's fraudulent actions could have caused harm to the complainant and the complainant's children because they were without medical benefits for a period of time. Both DHS employees were discharged on October 25, 2016.

- On October 21, 2015, BIA received a referral, which alleged that two Health Facilities Surveillance Nurses (HFSN) had been carrying stun guns/tasers to work with them. They were also taking them into the offices of providers where they were conducting audits as well.

Upon receipt of the allegation, BIA reviewed Healthcare and Family Services Handbook and various Illinois statutes related to the use and/or possession of a stun gun/taser. BIA found that possession of these items on State property was prohibited. BIA further found that the items were classified as "deadly weapons" under Illinois law and that a valid Firearm Owners Identification Card (FOID) was required in order to possess these items. Based on these findings, BIA contacted the Illinois State Police, Division of Internal Investigations (ISP-DII) to report the possible criminal violations.

ISP-DII reviewed the reports that BIA had received and determined that the alleged offenses were several months old and unless there was a more current date of the items being possessed by the employees they would not proceed.

It should be noted that one of the HFSN who was in possession of a stun gun/taser retired during the course of their investigation. The State's Attorney in that case also declined to proceed criminally. Since she retired, no discipline could be pursued. The other HFSN received a 29 day suspension on November 30, 2016.

- On March 31, 2016, the OIG) received an anonymous complaint, from an employee who claimed to work with a Public Aid Investigator. The complaint reported that they believed the employee may be violating agency attendance policies and procedures, and that they also may be selling real estate on state time because the employee is a licensed realtor.

The investigation determined that the Public Aid Investigator was abusing state time by not being present in the office when they claimed to be, and not at locations in the field where they had requested field work. The employee told investigators that they have never had to sign in at local DHS offices but information obtained from DHS office managers was that all visitors to their facilities are required to sign in.

The investigation determined that the employee was a licensed realtor, and has been associated with a real estate brokerage firm in Chicago. It was also discovered that the employee had a website and a social media presence for a property company. It was also determined that the employee performed secondary employment work for this property company when the employee created a YouTube Video on December 22, 2015, while at work in their cubicle. The Public Aid Investigator received a 29-day suspension on November 9, 2016.

- On July 20, 2016, BIA received a complaint that a Child Support Specialist 1 (CSS1) may have improperly received the child support case of the employee's daughter.

The investigation determined that the CSS1 made changes, deletions and initiated transactions on the daughter's case even after the supervisor explained the case would be reassigned and that this employee should not work on it. This KIDS case event history shows the transactions that were made on the child support case. The CSS1 was aware of DCSS policy related to working on the cases of family and friends.

The investigation determined that the CSS1 abused their position by accessing and making 17 unauthorized transactions on their daughter's child support case during the time period of March 9, 2015 through March 29, 2016. The CSS1 used the state computer to add case notes and made changes to their daughter's child support case. The employee's actions may have caused a delay in their daughter's child support case and hindered the progress of the case by altering

information in the child support database. The CSS1 received a 29-day suspension on March 6, 2017.

- On January 25, 2017, BIA received a referral from a Department of Human Services Local Office Administrator that alleged a Department of Healthcare and Family Services Office Associate, used the State's computer system to review their spouse's DHS medical assistance case. The referral also alleged that the Office Associate used the computer system to e-mail a Human Services Casework Manager about the medical case.

The investigation determined that the Office Associate used the agency computer system to view their spouse's medical assistance case. The employee acknowledged that they had read the Employee Handbook and was familiar with Department Computer Security policy. The Office Associate admitted that they had violated Department policy when they used the agency computer system for personal reasons not associated with their duties within the Office of Inspector General. The Office Associate received a seven-day suspension on April 18, 2017.

## PROGRAM INTEGRITY EFFORTS AND COOPERTIVE INITIATIVES

### **Dynamic Network Analysis Framework Enhancement and New Development**

The Bureau of Fraud Science & Technology (BFST) oversees maintenance and enhancement of the Dynamic Network Analysis (DNA) Framework. Since inception, the DNA Framework was incorporated into the Office of the Inspector General's (OIG's) processes for support both executive level decisions and audit/investigation cases.

The DNA development team continuously revises existing programs and develops new functionalities for the Framework to address state policy and regulation changes, and better address the changing nature of waste, abuse and fraud in the Medicaid program.

In the past year, the development team maintained focus on enhancement of data intelligence and existing DNA functionality and capacity to promote accurate and efficient data searches and data gathering. The goal of these activities is to provide executive users, auditors and investigators information that is richer, of greater relevance, and is in a more semantically meaningful format relative to their workflow in the DNA. The updated DNA Framework includes enhancements noted in the following subcategories.

#### ***REFACTORIZING OF DNA ARCHITECTURE***

To improve performance and efficiency of the DNA system, the development team made several changes to the system framework and architecture. One of the challenges of providing quality information to end users is the nature of the tremendous amount of service data in the enterprise data warehouse (EDW). Pre-summarization of such data is a common technique used in such situations, but fine-tuning the process requires deep operational understanding and requires an iterative process due to complexity. The development team redesigned the pre-summarized data resource to incorporate the various data sources from the previous release into one business-driven, unified structure. Consequently, features previously unique to certain modules are now available application-wide, adding further context-aware functionalities to modules, and creating communication channels between them. This includes such functionality as retrieving information at different aggregation levels, for example, drilling down from the statewide level to the provider level.

The re-designed data structure improves overall system performance and reduces users' wait time. It also provides features such as auto-searching and auto-filtering to help users quickly access information for review. In addition, the periodic data update procedure was streamlined to allow the DNA system to consistently, receive up-to-date information.

The SAS request handler component was rewritten to take advantage of the new design for pre-summarized data resources. Communication between the web services component and the SAS procedures now use the new, unified format to transmit richer data. The authentication process and session management are faster, compared to the previous version, in spite of the implementation of more

security measures, such as the improved encryption strategy on user files and automatic cleaning of temporary query results to protect sensitive data. Request balancing and cache mechanism are improved as well, increasing performance speed for features such as auto completion and data export.

The DNA development team adopted the latest advancements in technology to improve both user experience and efficiency. The previous DNA user interface was revamped and shifted to a single page application (SPA) approach to provide consistent experiences, richer client side interactions, new data visualization formats and faster response time for users. The AngularJS framework was selected to work with the existing web services component to achieve this change.

Several modules were built to facilitate current and future application development. One example is an error-monitoring module; when a request fails, the module will collect debug information and notify the development team in real time, depending on the request type and configurations, to support more timely response from the DNA team.

#### ***EARLY WARNING DEVELOPMENT***

One of major addition to the current DNA framework is the early warning module. The module combines various critical indicators to identify exceptions to the norm and predict potential abuse and fraudulent activities by at-risk providers based on providers' recent five years billing and payment activities.

To define the at-risk severity of each provider, the BFST development team scrutinizes the physician and dentist provider types with unusually:

- higher payment
- higher volume of recipients
- higher services compared to peers
- higher value of common clients (provided services to the same recipients on the same day) than other providers
- too many prescriptions involving controlled drugs or narcotic drugs for recipients
- questionable procedure code billing patterns compared to their peers, etc.

The overall rank is generated based on these indicators. The higher the rank of the provider in the early warning system, the greater the attention needed for further analysis. Since the payment distribution and patterns of fraudulent activities vary significantly by provider types, the provider types of physician and dentist are constructed in the current module.

#### ***EXECUTIVE REPORTING ENHANCEMENT***

Executive reports provide glance statewide overview for selected topics, which helps executive users understand the Medicaid service and payment trend over a period of years. These overviews also help in

identifying whether the service and payment of certain procedures have abruptly increased, necessitating further analysis to identify reasons for the increase.

The DNA development team scheduled weekly updates to generate the executive summaries. To adapt Illinois' recipient transition from traditional Fee-for-Service (FFS) to Managed Care, the BFST team added Capitation versus MCO payment information for display of the statewide capitation and MCO payment distribution from 2013 to 2016. In addition, this information provides drill-down functionality and a heat map of individual MCO contracts to reflect payment trends and change of recipient counts.

Another addition to the executive reports is a top 20 procedure codes and procedure code groups with the most change in payment within a range of one year to five years. This helps users locate the most active procedure codes and groups in the most recent five years.

#### ***PROFILES AND REPORTS ENHANCEMENT***

The Provider Profile Report and Recipient Profile Report are the most complex and comprehensive reports in the DNA framework. The Provider Profile Report combines information from various data sources and applies statistical approaches for a comprehensive view of a targeted provider in various categories of services in the Medicaid program under review. The Recipient Profile Report provides analysts an overview of the recipient's history and potential patterns to support analysts with decisions on whether further investigation is necessary.

These profile reports are more and more widely used by the auditors and investigators since the reports meet various users' expectations and needs and improve workflow efficiency. In FY 2017, approximately 8,960 reports, including Provider Profile, Recipient Profile, and WARP reports, were generated, roughly a 30% increase compared to FY 2016.

The DNA development team continuously updates the existing profiles and routines based on end users' input and feedback. Additional aggregated information was added to the reports, along with the introduction of a broader range of data sources to address policy changes.

Beginning in October 2015, the new ICD-10 procedure codes and diagnosis codes were loaded to EDW. The DNA team found most ICD-9 diagnosis codes were replaced by the new ICD-10 codes, but only a small portion of ICD-10 procedures codes were adopted. Therefore, the DNA team revised the related programs to solve this transitional issue and allow both ICD-9 and ICD-10 codes to co-exist in the current system.

In recent years, an increasing number of Illinois Medicaid recipients have enrolled in an MCO. The DNA development team continuously modifies programs to include MCO claim information in the analysis of provider profiles, recipient profiles, and recipient claim detail reports.

Previously, the BFST development team established a post mortem routine to identify the claims of deceased recipients submitted by any type of provider. The data sources to validate recipient death information come from Illinois Department of Public Health (IDPH) (), Enterprise Data Warehouse (EDW), Long Term Care Minimum Data Set (MDS) and Medicare. IDPH data is considered the primary data source for this information since it is the most reliable in accuracy. In FY 2017, the OIG made efforts to obtain the death master file (DMF) from the Social Security Administration. In adding the monthly updated death master file, additional claims were identified as questionable.

The DNA development team also revised the Peer Review prescribing report to give end users more flexibility in selection criteria to filter claims for review.

### ***NETWORK LINKAGE TEMPLATE ENHANCEMENT***

The BFST development team integrated Link Explorer/Designer, a third-party link analysis and visualization tool, into the DNA framework. This tool allows users to investigate information by establishing connections to data sources, setting relationships among objects, dragging and linking icons, and viewing the results through charts and reports. Link Explorer/Designer provides various types of graphical representations to help users uncover patterns and networks.

In the previous DNA release, a template of provider level exploration was established for end users to explore and inspect whether a provider shared the same office and phone number with other providers, and how the providers were networked with each other (whether the same payee is used or services were provided to the same group of recipients).

In FY 2017, the DNA team continued to add additional information to the existing template. For instance, the summary of controlled drug prescriptions and audited cases of providers were included. Through visualization charts, auditors or investigators may be drawn to a provider who prescribed too much of a narcotic drug or a provider who is linked to another provider who was previously audited.

Building a recipient level template is relatively challenging because of the tremendous amount of claim data involved. Therefore, the DNA development team has decided to choose waivers as a pilot group for the Link Explorer template. It is beneficial to view recipient related information in a centralized location, including basic demographic information, location migration, MCO enrollment, service and payment information.

### **Prescription Drug and Opiate Abuse Initiative**

The OIG continues to analyze Medicaid client community in conjunction with prescription drug use to identify potential opiate fraud. Combinations of opioid narcotics, benzodiazepines and other controlled substances commonly known as “Cocktails” or “The Holy Trinity” are taken together to heighten euphoria. These medications are highly addictive by themselves, but when mixed with other drugs or alcohol they can be deadly.

From FY 2017 analysis, the OIG has identified 8,721 clients as potential candidates for benefit restrictions. From FY 2016 analysis, approximately 70% of just over 10,000 clients received prescription restrictions. To identify restrictions, the OIG Analysts are limited to reviewing 200 cases per month due to staff resources.

Past selection criteria, for Opiate research included anyone receiving three prescriptions in EACH category (narcotic, anti-anxiety drug and muscle relaxant) over 18 months and included clients in managed care organizations (MCO) and fee-for-service (FFS). The OIG is now reviewing 24 months of data and have changed the selection criteria to any client receiving 6 prescriptions in each of the three categories over 24 months as there were recipients receiving the 3 prescriptions appropriately over the 18 month review period). The OIG staffs also monitor clients where Medicaid eligibility has lapsed for an additional six months, in case of eligibility reinstatement.

### **Home Health Agency Enrollment Reviews**

The Office of Inspector General (OIG) is currently reviewing requests for enrollment of new home health providers into the Medicaid Provider Program and re-validating enrollment for existing home health providers. The enrollment/re-validation process requires documentation from the home health provider and an onsite physical inspection. These on-site physical inspections will be conducted by an OIG BMI Health Facilities Surveillance Nurse (HFSN) within the Peer Review unit.

The OIG Peer Review staff will perform an initial onsite review and periodic onsite reviews of home health providers. These reviews will be conducted to ascertain whether a home health provider has the necessary equipment, and maintains adequate medical documentation to meet the applicable requirements for participation in the Medicaid Provider Program and to evaluate effectiveness in rendering safe and acceptable home health services. These requirements are found in the [Administrative Code Section 245.200 Services – Home Health](#).

Home health services provided by these agencies must meet acceptable standards as outlined in state and federal guidelines by:

- Verification of training and credentials of agency staff;
- Reviewing compliance with agency policies and procedures;
- Reviewing medical records of patients for care provided and assessing outcomes;
- Reviewing quality assurance programs.

The OIG staff will begin the on-site physical inspection in the month of September 2016 and will focus on one facility as a pilot project. After the pilot project is completed, the OIG staff will continue with assessing the new Home Health agencies and have a tentative plan to complete the physical inspections for all the new Home Health Agencies by the end of November 2016.

## **Cooperative Initiatives with the Illinois State Police's Medicaid Fraud Control Unit**

The OIG and MFCU have created a well-functioning and committed partnership. As part of this relationship, OIG follows consistent standards for the evaluation of fraud referrals to MFCU. The OIG, in collaboration with MFCU, developed a standard referral form that ensures high quality cases having reliable evidence of fraud are referred to MFCU. This includes cases identified with overpayments discovered during an internal audit, as well as cases, which, based on data analytics, reveal aberrant billing practices that appear unjustifiable based upon normal business practices.

The OIG provides referrals to MFCU based on approved performance standards and updates MFCU on ongoing audits and investigations. Once a referral has been forwarded and accepted, it is vital that the communications continue so that actions do not occur that could potentially jeopardize a criminal case or collection of an overpayment. Updates between the units occur regularly through a variety of communication methods, including meetings, periodic written reports, and access to databases.

On an ongoing basis, the OIG offers education and training to MFCU, both informally and formally, pertaining to the Medicaid program. This collaboration has improved MFCU's efficiency and overall ability to investigate and prosecute Medicaid fraud cases.

The OIG holds regular meetings with MFCU, which enables close coordination of information sharing between MFCU and the OIG. The meetings have resulted in an increased number of quality fraud referrals to the MFCU. The meeting agenda facilitates the identification of new fraud trends, increased accountability, and overall improves the productivity of the two units.

The OIG and a smaller established group also meet monthly with the Narrative Review committee to discuss specific fraud referrals. The leadership for both the OIG and MFCU is present at the meetings. As part of this ongoing initiative, the appointed FAE from OIG serves as the liaison between the units, and is responsible for selecting and scheduling meeting dates and times to ensure that future meetings occur on a regular basis.

## **The Department's Third Party Liability Program**

The Third Party Liability (TPL) program reduces costs in the Medical Assistance Program by identifying third parties liable for payment of enrollees' medical expenses. These efforts help the Department maintain a full range of covered medical services and help ensure access to quality healthcare for enrollees. Third party resources include private health insurance, Medicare, Civilian Health and Medical Plan for the Uniformed Services, workers' compensation, and estate and tort recoveries.

The Department requires individuals to report TPL coverage when applying for Medical Assistance as a condition of eligibility. Although one of the primary sources of TPL identification is through client interviews during the intake and redetermination processes, the Department also identifies potential third

party resources through a variety of methods, including contacting employers and relatives, through data exchanges with health insurance carriers, review of court dockets and data exchanges with the Illinois Workers' Compensation Commission. The Department also requires medical providers to bill third parties prior to billing the Department for most services (cost avoidance), and assists enrollees in coordinating benefits between their private health insurance coverage and Medicare.

The TPL program saved taxpayers approximately \$607,833,153 in Medicaid federal cost avoidance and recovered \$97,774,801. During FY 2017, these savings and recoveries resulted from identification of third party resources, avoidance of payments on claims with a known responsible third party, benefit recovery efforts through subrogation of paid claims, as well as estate and tort action collections. The Department works to maximize TPL utilization and to integrate TPL recovery with the managed care program.

The Health Insurance Premium Payment Program, a component of the TPL program, pays cost effective health insurance premiums for Medicaid enrollees with high cost medical conditions, which reduces costs to the Medical Assistance Program. Pregnancy and lung disease were the most frequent high cost medical conditions for which premiums were paid. Many enrollees in this program continue their health coverage through the Consolidated Omnibus Reconciliation Act (COBRA) when their employment terminates, rather than applying for Medicaid.

## **Federally Mandated Initiatives**

### ***RECIPIENT VERIFICATION PROCESS (RVP)***

To meet the federal requirements of [CFR 433.116/455.20](#), a telephone process to verify paid claims was implemented in November 2015. A total of 500 claims are selected each month for verification. From July 2016 to April 2017, the quality control reviewers continued to contact the recipient of the service via phone. In May 2017, the process was changed to the sending of letters to the recipient with a request to respond. Recipients were given an email address and a telephone number to utilize in verifying the receipt or non-receipt of the service. As of June 30, 2017, a total of 9500 claims have been selected for verification with 51% verified as being received and 1% verified as having not been received.<sup>7</sup> Negative responses were analyzed by the OIG for possible referral to the Medicaid Fraud Control Unit.

The remaining 48% could not be verified (no response from client, letter returned, client could not remember, etc.) Follow-up on the returned letters resulted in the discovery of a new address in which another letter was sent, an email to the administrating local offices to verify the address and take the appropriate action and the adjustment of the universe/sample selection.

### ***PAYMENT ERROR RATE MEASUREMENT (PERM) FFY15***

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<sup>7</sup> Verified from the recipient stating either "yes" or "no" they did not receive the service.

[The Improper Payments Information Act \(IPIA\) of 2002](#) requires Federal agencies to review annually, programs susceptible to significant improper payments to estimate the amount of improper payments, report those estimates to Congress, and submit a report on actions the agency is taking to reduce the improper payments.

Medicaid and the Children's Health Insurance Program (CHIP) were identified as programs at risk for significant improper payments. CMS measures Medicaid and CHIP improper payments through the Payment Error Rate Measurement (PERM) program. Under PERM, reviews are conducted for both Medicaid and CHIP programs in three component areas: Fee-For-Service (FFS), managed care organizations (MCO), and eligibility. The results of these reviews are used to produce national program improper payment rates as well as state-specific program improper payment rates. The PERM program uses a 17-state, three-year rotation cycle for measuring improper payments, so every state is measured once every three years. Illinois is a Cycle 1 state. Cycle 1 states were measured in FY 2015 and will be measured again after the other two cycles.

In light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the Affordable Care Act, the PERM eligibility component measurement is on hold for FY 2014 – FY 2017. As a result, Illinois's FY 2015 cycle did not include an eligibility review and Illinois's state-specific improper payment rates include only FFS and managed care component review results. The re-introduction of the eligibility component is anticipated to take effect before Illinois's next cycle. Therefore, Illinois's next PERM cycle will include an eligibility review and Illinois's state-specific improper payment rates will include FFS, managed care, and eligibility component review results.

From July 2016 to March 2017, the OIG coordinated and monitored the completion of the PERM medical record and data processing reviews as well as coordinated the completion of the corrective actions plans for both Medicaid and CHIP. The FFY15 data processing and medical record reviews resulted in the following:

- Illinois's overall improper payment rate estimate was 4.51% for Medicaid (fee-for service was 6.91% and managed care was 0.55%). The overall improper payment rate estimate for CHIP was 8.47% (fee-for-service was 11.51% and managed care was 0.00%).
- Of the 17 states in Cycle 1, for Medicaid, Illinois was below the average improper payment rate estimate of 5.7% with a rate of 4.51%. For CHIP, Illinois was above the average of 8.2%, with a rate of 8.47%.

### ***MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC)***

From its implementation in 1978 until 1994, states were required to follow the MEQC regulations in [42 CFR part 431, subpart P](#) – Quality Control that was known as the traditional MEQC program.

Every month, states reviewed a random sample of Medicaid cases and verified the categorical and financial eligibility of the case members. Sample sizes had to meet minimum standards, but otherwise were at the states' option. For cases found ineligible, the claims for services received in the review month were collected, and error rates were calculated by comparing the amount of such claims to the total claims for the universe of sampled claims. The state's calculated error rate was adjusted based on a federal validation subsample to arrive at a final state error rate. This final state error rate was calculated as a point estimate, without adjustment for the confidence interval resulting from the sample methodology. States with error rates over 3 percent were subject under those regulations to a disallowance of Federal Financial Participation (FFP) in all or part of the amount of FFP over the 3 percent error rate.

At HHS's Departmental Appeals Board (DAB), the HHS's final level of administrative review, states prevailed in challenges to disallowances based on the MEQC system in 1992. The DAB concluded that the MEQC sampling protocol and the resulting error rate calculation were not sufficiently accurate to provide reliable evidence to support a disallowance based on an actual error rate exceeding the 3 percent threshold. Although the MEQC system remained in place, states were allowed to conduct "MEQC pilots" that did not lead to the calculation of error rate (or, therefore to disallowances). These pilots review specific program areas to determine whether problems exist and produce findings the state agency can address through corrective actions, such as policy changes or additional training. Currently 39 states operate MEQC pilots, while 12 maintain the traditional MEQC program.<sup>8</sup>

The OIG has been conducting the MEQC pilots since its offering in 1994. As of FFY14 and throughout FFY16, in lieu of conducting the pilots, CMS provided guidance for a three-year review of cases affected by the implementation of the Affordable Care Act. The pilots are intended to evaluate the performance of both the automated processes and caseworker actions as well as to correct eligibility errors and to identify discrepancies.

These reviews consist of two components, reviews of eligibility determinations (pulling a sample of eligibility determinations made by the state and perform an end-to-end review from initial application/point of transfer to the final eligibility determination) and testing cases (running test case data provided by CMS through the UAT section of the state's eligibility determination system.)

During FY 2017, the OIG completed three sets of test cases (second six months of FFY14 – Round 2 and the first and second six months of FFY15 – Rounds 3 and 4). The results of Round 2 and 3 were submitted to CMS along with a corrective action plan and were approved. The last set of test cases (Round 4) is pending approval of the corrective actions provided by the state. Results of the test cases led to system corrections, adjustments and redesigns. Eligibility reviews for the second six months of FFY15 (Round 4) were conducted by a CMS contractor, resulting in a review of 149 cases with 40

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<sup>8</sup> The PERM final rule eliminates the option for the states to conduct traditional MEQC in the PERM "off years" and requires the completion of MEQC pilots.

payment errors and 16 technical deficiencies. The OIG provided an on-site location for the contractor to utilize the state's eligibility systems, provided technical assistance, assisted with the collection of verifications and responded to each payment error and technical deficiency identified prior to the finalization of the results. The OIG completed a corrective action plan that was approved by CMS in April 2017. Also during FY 2017, the OIG's Quality Control Reviewers completed 169 of the 249 eligibility reviews for the first six months of FY 2016 (Round 5). To prepare for the FY 2019 PERM eligibility reviews, the QC reviewers used the same review tools that were used by the CMS contractors in the previous round. Results of these reviews will be submitted to CMS and followed by the completion of a correction action plan to correct any payment errors or technical deficiencies identified.

***HARMONIZATION OF THE PERM AND MEQC ELIGIBILITY REVIEWS***

The PERM final rule proposed in June 2016 (finalized in July 2017) provides guidance to harmonize the MEQC program with the PERM program. The PERM will be conducted every 3 years and the MEQC will be conducted in the years the states are not conducting PERM or the PERM "off years". States will be allowed flexibility in choosing their MEQC pilots unless their PERM payment error rate is over the 3% threshold for two consecutive cycles. In that instance, CMS will require the state to comply with CMS guidance to tailor the case reviews to a more appropriate MEQC pilot that would be based upon State's PERM eligibility findings. The final rule cites that the states may be eligible for a good faith waiver if they comply with both the pilots and the corrective action plans. During FY 2018, the OIG will be preparing for the implementation of the PERM FY 2019, which will include data processing, medical record and eligibility reviews.

## STATE STATUTORY MANDATES

The Inspector General reports to the Governor by statute [305 ILCS 5/12-13.1\(a\)](#). The OIG's statutory mandate, authorized by [305 ILCS 5/12-13.1](#) is "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 the Department
- 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 other 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's activities over the past year

## FEDERAL MANDATES AND PROGRAM PARTICIPATION

The OIG is also responsible for Program Integrity functions mandated under federal law, including:

- 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 claim post-payment reviews ([42 CFR 447](#))

## APPENDIX A - 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.

### **FY 2017**

\*In the Legacy system when processing a pharmacy claim, rejected claims were priced; however, in the new Pharmacy Benefit Management System (PBMS) only payable claims are priced. So, even though the refill too soon (RTS) edit is enabled in the new PBMS using the same logic as in the Legacy system, we are unable to calculate the dollars associated with the claims that are rejected with an RTS edit in the new PBMS.

Refill Too Soon	
Total Number of Scripts	9,400,955
Amount Payable	\$649,231,583
Scripts Not Subject to RTS	20,267
Amount Payable	\$4,704,083
Scripts Subject to RTS	9,380,688
Amount Payable	\$644,527,500
Rejected Number of Scripts	634,772
Estimated Savings	*

## APPENDIX B – AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

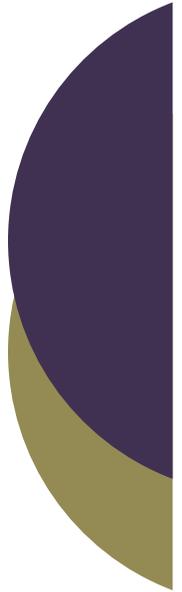
Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of 2017 Annual Report [OIG's Website](#). The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably.

APPENDIX C – ACRONYMS

AABD	Aid to the Aged, Blind or Disabled (AABD) program
ABT	Available Benefit Time
ACA	Affordable Care Act
ADH	Administrative Disqualification Hearing
ALJ	Administrative Law Judge
ASU	Administrative Service Unit
BAH	Bureau of Administrative Hearing
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
BOC	Bureau of Collections
BOI	Bureau of Investigations
CAS	Central Analysis Services
CASE	Case Administration and System Enquiry
CCP	Community Care Program
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CHOW	Change of Ownerships
CIA	Corporate Integrity Agreement
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Reconciliation Act
CP	Custodial Parent
CPA	Certified Public Accountant
CPA-LTC	Certified Public Accountant-Long Term Care
CVU	Central Verification Unit
DCSS	Division of Child Support Services
DHS	Department of Human Services
DII	Division of Internal Investigation
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
DRS	Division of Rehabilitation Services
DUI	Driving under the influence
EBT	Electronic Benefit Transaction
EDG	Eligibility Determination Group
EDW	Electronic Data Warehouse

EHR	electronic health record
FAE	Fraud Abuse Executive
FBI	Federal Bureau of Investigations
FCRC	Sangamon County Family & Community Resource Center
FFY	Federal Fiscal Year
FOIA	Freedom of Information Act
FPI	Fraud Prevention Investigations
FRS	Fraud Research Section
GIS	geographic information system
DHFS	Department of Healthcare and Family Services
HHS	Department of Health & Human Services
HMS	Health Management Systems
HSP	Home Services Program
HUD	Housing and Urban Development
IDFPR	Illinois Department of Financial and Professional Regulation
IDOR	Illinois Department of Revenue
IHAP	Inpatient Hospital Audit Program
ILCS	Illinois Compiled Statutes
IPIA	Improper Payments Information Act
IPV	Intentional Program Violation
IRS	Internal Revenue Services
ISP	Illinois State Police
LAN	Local Area Network
LEA	Local Education Agency
LTC-ADI	Long Term Care-Asset Discovery Investigations
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid fraud control unit
MIG	Medicaid Integrity Group
MII	Medicaid Integrity Institute
MMIS	Medicaid Management Information System
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MQRC	Medical Quality Review Committee
MTG	Medicaid Transformation Grant
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
PACIS	Public Aid Client Inquiry System

PCP	Primary Care Provider
PERM	Payment Error Rate Measurement
PIP	Provider Incentive Payments
PIU	Program Integrity Unit
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
SSA	Social Security Administration
SB	Senate Bill
SCHIP	State Children's Health Insurance Program
SIPV	Suspected Intentional Program Violation
SLF	Supportive Living Facility
SMART Act	Save Medicaid Access and Resources Together Act
SMD	State Medicaid Director
SMDL	State Medicaid Director Letter
SNAP	Supplemental Nutrition Assistance Program
SOS	Secretary of State
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
TCN	Document Control Number
TMS	Technology Management Section
TMU	Technology Management Unit
TPL	Third Party Liability
UIB	Unemployment Insurance Benefits
UIR	Unusual Incident Report
US	United States
WARP	Welfare Abuse Recovery Program



2200 Churchill Road, A-1  
Springfield, Illinois 62702  
217-524-6119

401 S. Clinton  
Chicago, Illinois 60607  
312-793-2481

<https://www.illinois.gov/hfs/oig>

Welfare/Medicaid Fraud Hotline  
1-844-ILFRAUD (453-7283)