



State of Illinois
Department of Healthcare and Family Services
Office of Inspector General

Illinois Department of Healthcare and Family Services **OFFICE OF INSPECTOR GENERAL**

ANNUAL REPORT

Fiscal Year 2019



JB Pritzker, Governor
Bradley K. Hart, Inspector General

OIG Mission

**To prevent, detect,
and eliminate
fraud, waste, abuse,
mismanagement,
and misconduct in the
Illinois Medicaid System.**



OFFICE OF INSPECTOR GENERAL

Illinois Department of Healthcare and Family Services



Bradley K. Hart
Inspector General

I am pleased to submit the Inspector General’s annual report for the Fiscal Year (FY) 2019 to Governor JB Pritzker, the Legislature, and the citizens of Illinois.

The Office of Inspector General (OIG) continues to make great strides in preventing, detecting and eliminating fraud, waste, abuse, misconduct and mismanagement in programs within the Illinois Medicaid Program. Through innovative approaches and application of solid management and leadership principles, the OIG is revolutionizing how our state government meets the needs of the public it serves while maintaining program Integrity to ensure that taxpayer dollars are not fraudulently wasted.

The OIG realized \$198.5 million in operational cost savings for the taxpayers of Illinois. The OIG also received a national global settlement of \$59.2 million resulting in a realized savings of \$257.7 million. This resulted in a return on investment (ROI) of \$10.90 for every \$1 spent. For FY19, a strong focus of the OIG was Long Term Care-Asset Discovery Investigations (LTC-ADI), which reported a total savings of \$136.4 million. Additional areas of focus are the program integrity aspects of managed care and the expansion of the Recovery Audit Contractor (RAC) operations to additional provider types.

The OIG has experienced success despite the lack of available resources. The ROI statistic above is absolute proof that the efforts of the OIG are maximizing value to the taxpayers of Illinois, further justifying the need for OIG expansion. While the OIG ended FY19 with 154 on-board staff, the OIG has reached the pinnacle of ROI which that level of staffing can produce. This forces the OIG to continually reprioritize operations, hiring and system development, while managing growing backlogs. This situation prevents the OIG from enhancing our current capabilities and being proactive with topics and trends in modern healthcare.

The OIG is continuing to identify ways to boost efficiency and cost savings for taxpayers, including developing a triage process for referrals, working collaboratively with Healthcare and Family Services (HFS) Bureau of Managed Care (BMC) to enhance program integrity

contract language in the HealthChoice Illinois contract, and collaborating with law enforcement and managed care special investigations units.

The OIG is charged with program integrity for the Illinois Medicaid Program. This includes recommending changes to Medicaid policy, rules, and contract language. In this report, you will find examples of how the OIG has made great strides in collaborating with the Department in identifying policy changes to safeguard taxpayer funds, as well as making proactive recommendations to further enhance the Department’s program integrity functions.

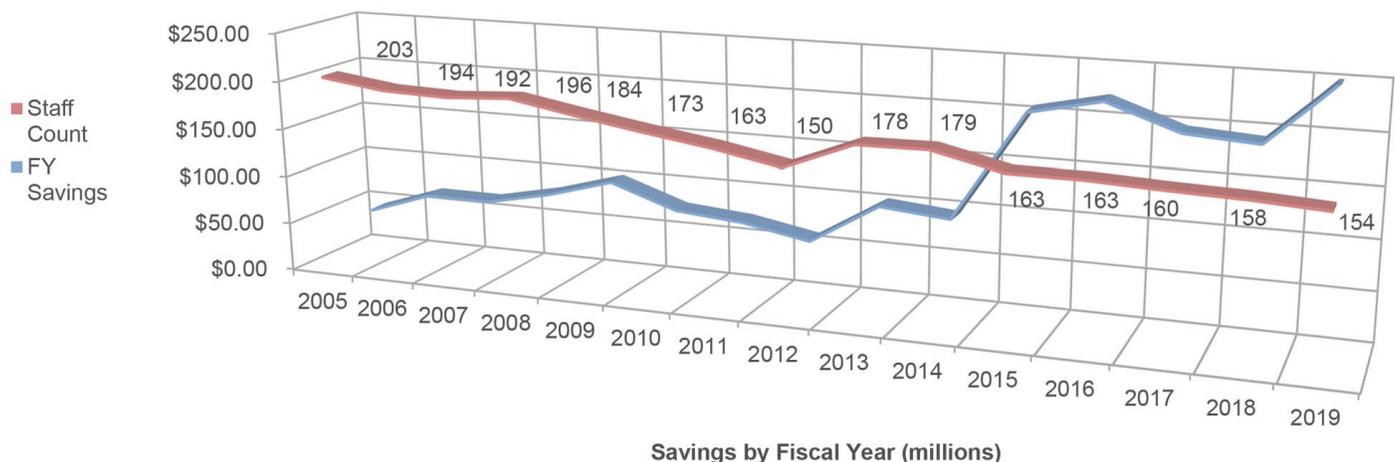
It is with deep sadness that this will be the last report of my tenure as Inspector General. While I may be leaving the post of Inspector General, the results of my appointments speak for themselves. Annual savings have averaged nearly \$200 million per year over the last five years. Since I started in 2011, our total savings for the taxpayers exceeds \$1.39 billion.

The OIG staff is dedicated to safeguarding the fiscal integrity of the Illinois Medicaid Program, as well as ensuring the safety and well-being of the recipients. In FY20, the OIG will continue to achieve positive, demonstrable results in preventing, detecting and eliminating fraud, waste, abuse, misconduct and mismanagement within the Illinois Medicaid Program.

Respectfully,



Bradley K. Hart
Inspector General



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Reinforcing OIG Infrastructure

Education and Training

The Office of Inspector General interacts nationally with a variety of groups and organizations to share expertise and knowledge in the field of fraud, waste and abuse, as well as presenting and discussing current fraud schemes that are not limited to the state of Illinois. OIG staff also attend educational trainings at the National Advocacy Centers Medicaid Integrity Institute (NAC/MII) in Columbia, SC. These seminars and trainings are free to OIG staff and are presented through the collaborative efforts of Federal CMS and the US Department of Justice (DOJ). The OIG is also a participating member of the Healthcare Fraud Prevention Partnership (HFPP), and the National Health Care Anti-Fraud Association (NHCAA). Inspector General Hart is the Treasurer of the National Association for Medicaid Program Integrity (NAMPI).

Inspector General Bradley K. Hart Presentations and Conferences FY19

Statewide DCEO fraud trainings throughout FY19 (Speaker)

NAMPI (Speaker and Treasurer), Austin, TX – August 2018

United Council on Welfare Fraud Conference (UCOWF), Milwaukee, WI – September 2018

MFCU and PI Director's Symposium, Columbia, SC – March 2019

HFPP, Columbia, SC – March 2019

MCO Fraud Prevention Workshop, Chicago, IL – April 2019

Emerging Trends in Medicaid, Beneficiary Fraud, Columbia, SC (Speaker) – April 2019

OIG Staff Trainings at the NAC/MII FY19

Specialized Skills and Techniques in Medicaid Fraud Detection

Program Integrity Partnership in Managed Care Symposium

Provider Auditing Fundamentals Program

Emerging Trends in Medicaid Symposium—Beneficiary Eligibility and Fraud

Program Integrity Fundamentals Seminar



MII – Investigative Skills Planning Group

Coding for Non-Coders

HCPro's Evaluation and Management Boot Camp

Medicaid Provider Enrollment Seminar

HCPro's Certified Coder Boot Camp—Original Version

Trends in Medicaid Symposium: PARIS Data Intensive

Program Integrity Directors' Symposium

Investigative Skills I—The Basics and Beyond

Basic Skills and Techniques in Medicaid Fraud Detection

Collaboration and Training with External Organizations and Partners

NHCAA Prescription Drug Webinar– March 2019

NHCAA Aligning Payment Integrity for Great Results Webinar – May 2019

NHCAA Crossover Dental Fraud Schemes Webinar – May 2019

NHCAA Healthcare Fraud in 2019 Webinar – June 2019

NHCAA Telemedicine & Telemarketing Schemes Webinar– June 2019

SAS: Fighting the Opioid Crisis at the Source: Pharmacies & Physicians Webinar – June 2019

FY19 Financial Highlights

Dollars Recovered

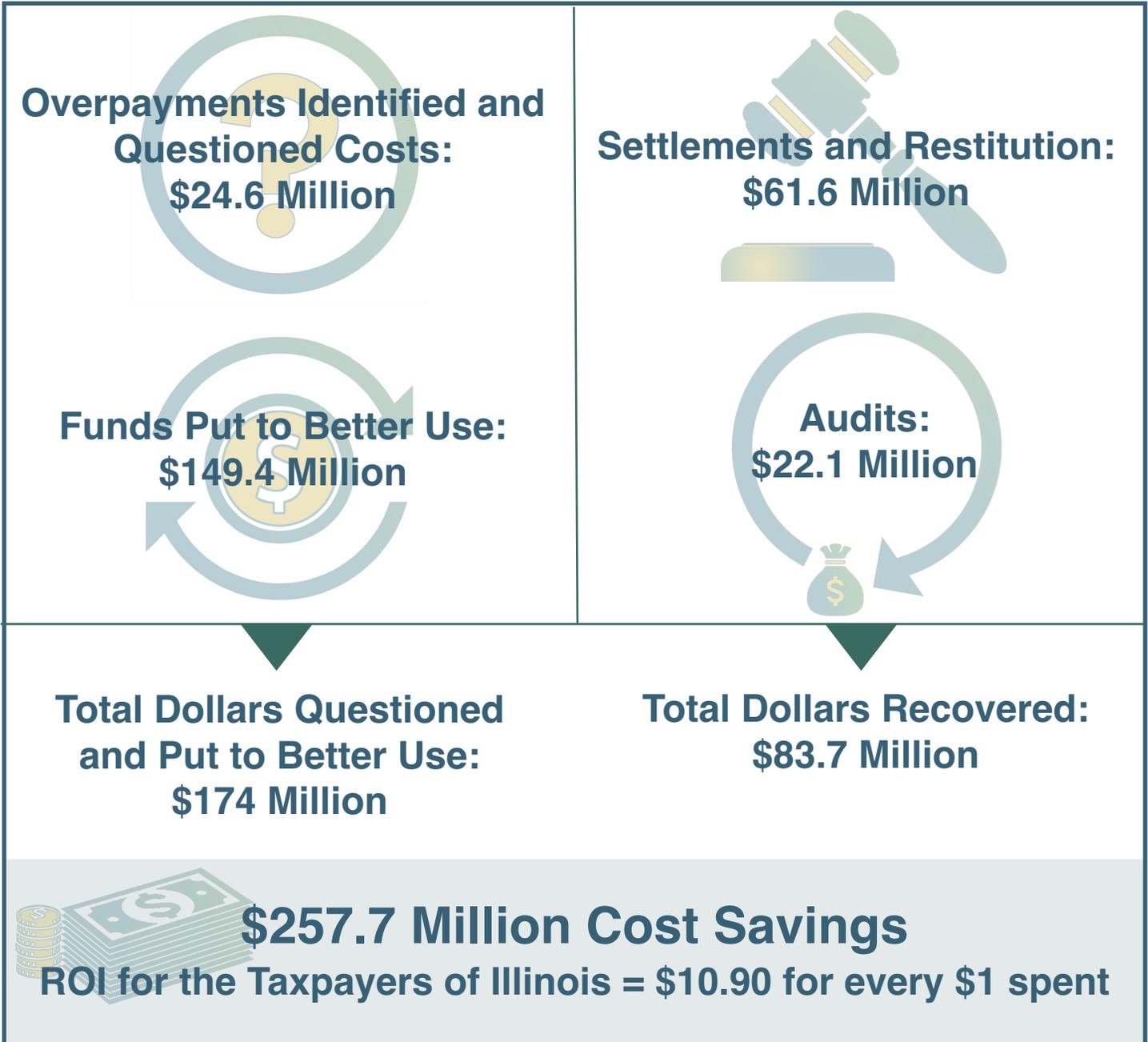
Provider Audits:	\$22,067,571
Global Settlements:	\$61,480,123
Restitution:	\$98,067
Total:	\$83,645,762

Questioned Costs

Provider Audits:	\$16,117,632
Recipients:	\$8,403,950
Restitution:	\$76,821
Total:	\$24,598,403

Funds Put to Better Use

LTC-ADI:	\$136,387,099
Client Program Overpayments:	\$1,106,168
Provider Sanctions:	\$8,965,669
Recipient Restriction Program:	\$102,571
SNAP:	\$2,850,596
Total:	\$149,412,103



See Appendix for breakdown of savings analysis.

FY19 Successes

Fraud Detection Operations: ROI for LTC-ADI reaches \$875 million

Since the program's inception in 2004, the total return of investment for the Long-Term Care-Asset Discovery Investigations (LTC-ADI) unit totals \$875 million. This program began as a Quality Control pilot program and has grown into a major cost savings for the taxpayers of Illinois.

Fraud Detection Operations: \$1.2 Million-Dollar Fraud Scheme Results in Federal Prison Sentence

A Durable Medical Equipment (DME) provider was terminated after his federal healthcare fraud conviction in the Central District of Illinois. Kevin W. Schaul was sentenced to 24 months in federal prison and ordered to pay restitution in the amount of \$582,844 for his scheme to defraud the Illinois Medical Assistance Program by billing for incontinence products that were never purchased by him, nor delivered to Medicaid recipients. Schaul's scheme was discovered because of an OIG audit that extrapolated an estimated \$1.2 million in overpayments. Once the final exit conference was held, Schaul filed for bankruptcy. The OIG is currently working with the Illinois Attorney General's Office in fighting the discharge of this administrative audit amount.

Litigation Activity: \$991K Settlement Secured with Hospice Provider

The Department filed a Recoupment Notice against Seasons Hospice for \$1,983,827 alleging various Medicaid recipient patients were improperly classified as eligible for hospice care. HFS's consultant determined these patients met the criteria for hospice care in approximately 57% of the cases. Applying this reduction to the audit conducted would result in a recoupment of approximately \$853,000. Seasons Hospice made an offer of \$991,913 which represented 50% of the initial recoupment amount. HFS accepted the offer and a lump sum payment was made within 60 days of the execution of the settlement agreement.

FY19 OIG Case Highlights

Provider enrollment and revalidation applications reviewed: 314
OIG referrals to MFCU: 12
Global Settlement Agreements executed: 5
Medicaid Providers terminated, denied, suspended and excluded: 177
Audits completed: 423
Provider audit dollars recovered: \$22 million

Fraud Detection Operations: Topical Creams/Ointment Schemes and Change in Department Policy Resulted in \$3.7 Million-Dollar Savings

In the FY18 Annual Report, the OIG Provider Analysis Unit (PAU) staff identified billing practices by multiple pharmacies statewide involving Lidocaine Cream (5%). Repeated monthly billing of Lidocaine Cream (5%), without supporting diagnoses, were being ordered by physicians with associated ties to specific pharmacies. Recipients received monthly prescriptions for several years, sometimes costing over \$3,000 per month. In 2014, lidocaine accounted for \$1.5 million in paid claims, whereas by 2016 the paid claim history had risen to \$7.7 million.¹

Previously, there were no restrictions on maximum quantities allowed or any requirement for prior authorization, resulting in multi-million-dollar payments for this expensive topical prescription. In FY18, HFS negotiated a lower price for this product and implemented quantity restrictions and restrictions on the number of days' supply allowed to be dispensed at one time. It was estimated that this change in policy would result in cost savings of approximately \$1.1 million for the time of July 2017 through December 2017.² In April 2019, the OIG performed a pre- and post-cost analysis at the one-year anniversary of edit implementation. As a result of the applied changes, the cost analysis show a \$3,689,587 reduction for the amount paid over the one-year period. This project has led PAU nurse analysts to investigate similar abuses.

¹ HFS Internal Newsletter The Gemba dated September 2019 – Edition 6.

² Calculation based on actual number of scripts written during that timeframe, versus what the new regulations and limitations would have allowed had they been in place during that time frame.

Internal Fraud Detection Operations: HFS Employee Resigns and has Federal Prison Sentence Increased for Providing False Documents to Court

During a Bureau of Internal Affairs (BIA) interview in August 2018, an Office Specialist resigned from HFS employment after a State Journal-Register article stated she was convicted of embezzling more than \$47,500 from a previous employer. Prior to the BIA interview, the employee was found guilty of embezzlement and provided the court three letters of recommendation during the sentencing hearing. The three letters requested a lenient prison sentence for the employee. One of the leniency letters was allegedly written by the employee's supervisor, an HFS employee. The judge presiding over the case initially sentenced the employee to 15 months of prison as part of a plea agreement, considering the leniency letters. The federal parole officer assigned to the employee's case contacted BIA and requested that the letters be verified. BIA interviewed the employee's supervisor and determined the letter was not written by the supervisor. BIA contacted the parole agent about the forged letter of recommendation that was submitted on behalf of the employee. BIA staff accompanied the employee's supervisor to federal court where the supervisor testified. The judge added six months to the employee's prison sentence for providing false documents to the court.

Fraud Detection Operations: Over \$1 Million in Assets Discovered During Asset Discovery Investigations

During the review of an application for long-term care benefits, the analyst determined that the applicant established three revocable trusts in 1991 containing farmland and rental properties with the intention to transfer beneficial interest to her two children after her death. However, the trusts were revocable and were, therefore, available for the applicant to use for her long-term care. The value of the excess resources totaled \$1,998,518. In addition, the applicant also transferred farm land to her children within the five-year lookback, resulting in a penalty of \$1,303,210.

Fraud Investigation: Client Eligibility Case Uncovered \$30K in Overpayments

A client eligibility referral was received by the OIG alleging that a SNAP recipient was living with the father

of her two youngest children. A Bureau of Investigations (BOI) investigation into the matter was completed in March 2019 which confirmed that the recipient's employed boyfriend had lived with the SNAP recipient since the birth of their first child in January 2015. The investigation was then submitted to the Bureau of Collections for overpayment calculation, where it was determined that the SNAP recipient's failure to accurately report her household composition and income allowed her to fraudulently receive \$30,800 in SNAP benefits for the period of April 2016 through January 2019. This case is being considered for criminal prosecution.

Litigation Activity: Personal Assistant and Transportation Provider Disenrolled Due to Fraudulent Billing Findings

The Department filed a Notice of Termination action against Tiara Ford, both a Personal Assistant (PA) enrolled in the Illinois Department of Human Services Home Services Program (HSP) and a Transportation Provider enrolled in the Illinois Medicaid Program. The OIG alleged the PA submitted fraudulent time sheets and billed for home-based services which were never provided to a relative and/or because she double-billed for her PA services while simultaneously providing transportation services to other Medicaid recipients, which is in clear violation of her provider agreement as well as Department policy, rules and regulations. The evidence at her contested hearing showed the PA was hired to provide home care services for a family member in 2008, and subsequently formed a solely owned and operated transportation company in 2015. This company was conditionally enrolled by the Department to provide non-emergency transportation services (Go with the Flo Transportation Corporation) to other Medicaid recipients. During the transportation company's one-year period of conditional enrollment, the PA submitted HSP time sheets seeking payment which either overlapped or were entirely during the time she claimed she was driving. Since it was impossible for the PA Vendor to be at two places at the same time, the PA was either inaccurate in reporting her PA time sheets or she left her family member's home to perform transportation services which violated the administrative code and constituted double-billing. As a result, the Department disenrolled the transportation company and terminated the PA.

FY19 Successes

Litigation Activity: Mental Health Provider Denied Enrollment Due to Criminal History

A Final Administrative Decision was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to deny Lighthouse Professional Counseling Center's application to participate in the Illinois Medicaid Program as an Early Intervention Services provider. HFS-OIG filed a Notice seeking to deny the application of the provider because two of its managerial employees are convicted felons. One of the managerial employees was convicted of Aggravated Criminal Sexual Abuse/Victim<13 and the other managerial employee was convicted of robbery. HFS-OIG proceeded to file a Denial of Application action. After the Applicant failed to request a hearing in writing and failed to appear at the scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended a decision to deny the application of the provider to the Illinois Medicaid Program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation and denied the application of the provider.

Fraud Investigation: \$40K in Overpayments Identified

An eligibility investigation was completed that alleged a client was married to her "landlord," who had been receiving monthly Chicago Housing Authority housing vouchers (rental payments) for the client since 2005. The allegation was founded, and it was recommended an overpayment be processed by DHS. DHS returned two SNAP overpayments in the amounts of \$40,215 for the period of November 2010 through November 2018 and \$853 for the period of January 2019 through July 2019. Due to the multi-agency fraud, the Cook County State's Attorney accepted this case for prosecution.

Recoupment/Restitution: \$59.2 Million Global Settlement Received

The OIG received a global settlement payout for \$59.2 million dollars. The OIG consistently receives national settlements through the National Association of Medicaid Fraud Control Unit – Global Settlement Team.

On average, Illinois normally receives about \$6 million per year. In FY19, the OIG received a settlement from Abbott Pharmaceuticals for \$59.2 million. This amount is an anomaly, but still an important aspect of the OIG's return on investment.

Fraud Investigation/Litigation Action: Personal Assistant Terminated Due to Felony Convictions and Murder Indictment

In conjunction with the Bureau of Investigation (BOI), a Final Administrative Decision was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Marcus Spates, a Personal Assistant (PA) provider. HFS-OIG immediately suspended the PA and filed a Notice seeking to terminate the PA based on the PA's prior criminal felony convictions and his recent indictment for the offense of First-Degree Murder. After the PA Vendor failed to request a hearing in writing and failed to appear at his hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate the provider from the Illinois Medicaid Program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation and terminated the provider.

Litigation Activity: Physician Terminated for Improper Prescribing

A Final Administrative Decision (FAD) was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Dr. Thomas Kulb from the Illinois Medicaid Program. HFS-OIG immediately suspended the provider and filed a Notice seeking to terminate the Provider based on the Illinois Department of Financial and Professional Regulation's decision to make Dr. Kulb's medical license permanently inactive because the provider had improperly prescribed controlled substances. HFS-OIG proceeded to file an immediate suspension and a termination action.



Medicaid Program Integrity Spotlight



Risk Analyses

The OIG has identified multiple areas for program integrity concerns and is proactively addressing them, both internally and with our external fraud, waste and abuse counterparts. The Medicaid Program Integrity Spotlight (MPIS) section highlights risk areas and issues which the OIG has identified as vulnerabilities for Medicaid program integrity. By highlighting areas of concern, the OIG is focused on finding creative, collaborative and effective solutions for program integrity issues in hopes of being a role model for Illinois' Medicaid Program and program integrity units around the nation.

Collections: Out of State Vendors/Individuals

As reported in the FY18 OIG Annual Report, the OIG's resources for collection of any outstanding debts are limited when providers move out of state. The Bad Debt Unit generally receives no response from providers. The Illinois Attorney General's (AG) office continues to be limited in their assistance in our collection efforts due to the lack of funds required to hire an out-of-state attorney/AG. Notification or potential termination from the Medicaid Program, however, at times has no bearing on providers or individuals who are not licensed, such as medical transportation providers. These types of providers, who are not licensed like medical providers, can abandon their debt in Illinois by relocating out of state and can seek employment in other fields. These providers may own property or other viable assets, but the OIG Collections Unit cannot pursue these cases because the individual no longer resides within Illinois jurisdiction.

The OIG Collections and Bad Debt Unit continue to have no mechanism in place to perform offsets on Managed Care Organization (MCO) providers that owe a debt to the Department. The Bad Debt Unit's sole option for repayment is by check, which requires providers to voluntarily refund the overpayment in a timely manner. This makes management of the repayment process extremely challenging.

Collections: Federal Tax Refunds

The OIG's Bad Debt Unit does not have the ability or authority to intercept Federal tax refunds. State tax refunds can be withheld as a result of a C-33 being entered with the Illinois Office of the Comptroller. HFS-

Child Support has the authority to intercept Federal tax refunds. The OIG is investigating the manner and means to which the State could proceed with intercepting Federal tax refunds, but obtaining the authority would likely require a legislative change.

Managed Care: Program Integrity Concerns

The OIG continues to work with HFS-Bureau of Managed Care (BMC) staff to discuss workable solutions to program integrity (PI) and data integrity (DI) issues. The OIG continues to research issues regarding the quality and timely filing of encounter data as well as payments being made by MCOs to providers who are under payment suspensions by the OIG. This greatly hinders all data analysis at the OIG level, as well as for our state, local and federal law enforcement partners for criminal and civil healthcare fraud prosecutions.

In FY19, Federal CMS Center for Program Integrity (CMS-CPI) met personally onsite with BMC staff, OIG staff, and with staff from three of the Illinois Medicaid contracted managed care plans. From the meetings, CMS-CPI provided recommendations covering program and staff communication needs and a data-centered focus for more PI presence in the managed care program.

Acting upon these recommendations from CMS-CPI, the OIG, in conjunction with our law enforcement counterparts, completely revised its Fraud Waste and Abuse section of the FY19 MCO contract. The OIG provided contractual language to clarify its role in PI over MCOs, while working collaboratively with the Department and the plans on identifying the ways to fight fraud, waste and abuse to save taxpayer monies. The contractual changes are still under consideration, which poses a concern regarding PI and DI, especially as managed care takes dominance in the Illinois Medicaid Program.

The OIG is also seeing a lack of compliance to HFS policies regarding the withholding of monies for providers who are under official Department payment suspensions. The OIG is seeing claims data which indicates that the MCOs are paying providers, when the Department would otherwise not (and has advised the plans to not pay). From a nationwide perspective, nonconformity with PI between HFS and MCOs creates an incongruence that stifles proactive

Medicaid Program Integrity Spotlight



PI enforcement and hinders the efficient operation of PI in general.

HCBS (Home Community Based Services) Waiver Program: Program Integrity Concerns

Nationwide, personal care service programs are known for fraud, waste, and abuse. This provider type is notorious for fraud schemes such as: services not-rendered, collusion with the recipient, check splitting, and sexual/physical abuse. The risks to Program Integrity are fiscal, administrative, and legal. This risk was presented in the FY18 OIG Annual Report and has been previously highlighted by Federal Department of Health and Human Services (HHS)-OIG in prior program reviews, as well as in a White Paper entitled “Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services” published in 2017.¹

A 2016 HHS-OIG investigative advisory report entitled “Patient Harm Involving Personal Care Services (PCS),” recommended that CMS take regulatory action to establish safeguards to prevent fraudulent or abusive providers from enrolling or remaining as PCS attendants, to protect the PCS program from the risk of fraud, patient harm, and neglect.²

Given the present enrollment process, the OIG does not receive the applications for review of any DHS-DRS Personal Assistants (PA) until after the provider has started providing services and has potentially been paid. The OIG has proposed multiple solutions to the problem including making this provider type high-risk providers which would require fingerprint-based background checks. The OIG continues to work collaboratively with DHS to guarantee access to care for those that need services so that they can remain in their homes, while preventing the abuse of the system through fraudulent means.

The OIG is working continually with DHS, HFS and the labor union to negotiate the manner and means of the performance of background checks to establish procedures

for Division of Rehabilitation Services-Home Services Program (DRS-HSP or HSP) enrollment, which were completed in the fall of 2019.

Statistical Initiative: Opioids

The OIG continues to collaborate with statistical experts regarding the development of an opioid cohort to track the morphine milligram equivalents (MME) usage of opioid abusers and prescribing providers. It is expected that the efforts of this development will allow the OIG to more quickly delineate the potential misuse of opioids on an individual level and educate the relevant prescribers of their actions.

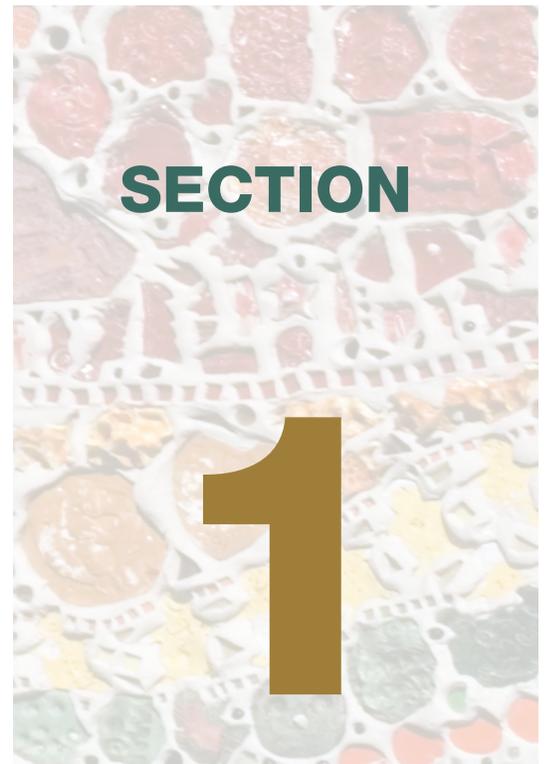
The MME is a key element in the OIG’s opioid initiative. This factor is being used in a historical data universe model which combines the new Provider 360 and Recipient 360 databases, along with established program deliverables such as the Recipient Restriction Program and other data repositories such as the IDFP license (status) extract. The Bureau of Fraud Science Technology statistician contractor is developing a statistical weight derivative model from Illinois historical service data for a new predictive analysis model to identify high fraud, waste and abuse (FWA) probability examples for both patients and service providers. This model will take key elements from known healthcare violations (supervised outliers), and unknown violations (unsupervised outliers) for analyzing the relationship and attributing cause for these data anomalies for further detailed analysis. These models will be added to the DNA tools used by all OIG staff.



¹ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/vulnerabilities-mitigation-strategies.pdf>

² <https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf> and <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>

Administration



Administration

Fiscal Management, MRA and FAE

The Administration Section works to build infrastructure for the OIG, which supports enhanced efficiency and effectiveness for investigations, audits and reviews. The Administration Section also acts as a liaison with our fraud, waste and abuse partners by providing increased communication, information exchange and investigative support.

Administration staff support the OIG with policy and procedure development, staff training and coordination of strategic planning. The Administration Section is made up of multiple units: Fiscal Management, Personnel and Labor Relations, the Fraud Abuse Executive (FAE) and Management, Research and Analysis (MRA).

Fiscal Management

The duties of the Fiscal Management Unit include overseeing all fiscal matters, including general collections, bad debt recovery, procurement, selected personnel timekeeping and budget responsibilities. Since the OIG budget is projected annually, Fiscal Management staff monitors the expenditures and requests additional funds as needed for special projects and initiatives. In FY19, a new Fiscal Management Unit supervisor was hired and has implemented some additional changes in how the collection process is handled.

The Fiscal Management Unit is made up of General Collections and Bad Debt Recovery. General Collections tracks overpayments identified as a result of OIG audits on Medicaid Providers, Provider settlements and court ordered restitution. This process involves establishing accounts receivable and monitoring of accounts until the debt is collected.¹ If the debts are not collectable, they are forwarded to Bad Debt Recovery. In FY19, General Collections monitored, on average \$52 million in open receivables, established \$16 million in new receivables, and collected \$22 million.

A new Enterprise Resource Planning (ERP) system will be implemented in FY20 and will replace the current Public Aid Accounting System (PAAS). Fiscal Management staff have been working very closely with the Bureau of Fiscal Operations and the ERP Vendor staff to perform testing of

FY19 Fiscal Highlights

Collections:

Open Receivables: \$52 million

New Receivables: \$16 million

Collected: \$22 million

the conversion of OIG collection PAAS data to the new ERP system. Training has been held for Fiscal Management staff to learn the new ERP system and to ensure that all applicable processes and data elements are put into place to ensure a smooth transition from the old PAAS system to the new ERP system. There will be more training sessions scheduled in the future. It is anticipated that the new ERP system will be implemented in January of 2020.

Fiscal Management has implemented new collection letters and a new 15-day demand letter that will go out to Medicaid Providers who owe money to HFS and have not worked out a payment plan to make payments on debt owed to the Department. These new collection and 15-day demand letters inform the providers on how much is in arrears to the Department and informs them that if they do not contact the Collections unit within the 15 days to either pay the debt owed in full or to make payment arrangements, that they can be terminated and/or debarred from participation within the Medicaid Program. This new process has resulted in an approximate 15% success rate in increasing the amount of collections achieved or in providers making a payment arrangement. If the provider does not make payments or make payment arrangements, then the provider and owner information is sent to the OIG-Office of Counsel to the Inspector General (OCIG) for termination/debarment proceedings. In addition to the implementation of new collection and 15-day demand letters, the Fiscal Management staff have worked closely with OCIG in implementing an affidavit process whereby if the provider does not cooperate with the collection process, then the affidavit will assist OCIG in their administrative hearing processes for settlement, termination and/or debarment from the Medicaid Program.

Fiscal Management is responsible for procuring and monitoring of all contracts, interagency agreements, and vouchering for the OIG. The OIG secures procurement

¹ The federal government receives their Federal Financial Participation portion at the time the receivable is recorded in the Department's accounting system.

and continually monitors approximately 50 contracts and 13 interagency agreements per year. The OIG contracts with external entities to provide consultation services in a variety of capacities, such as Medical and Statistical Consultants, CPA and other Auditing transcription and court-reporting services.

The Bad Debt Recovery Program pursues delinquent accounts of HFS providers when general collection efforts have been unsuccessful. These providers owe the Department monies as a result of actions taken against them related to program integrity activities. When a case is received, it is reviewed for provider status. If the provider is found to be actively enrolled, the Office of Counsel to the Inspector General (OCIG) will place future payments on hold until the outstanding debt is addressed.

All bad debt cases are monitored in the CASE tracking system. A C-33 Involuntary Withholding Request is completed with the Illinois Office of the Comptroller (IOC), which allows the IOC to intercept any other state monies that may become payable to that provider and redirect the monies to the OIG. Any monies redirected to the OIG will be applied to the provider’s delinquent account.

Providers are referred to a collection agency if applicable. The collection agency attempts to collect the debt through all means available under Illinois law. If collection efforts are unsuccessful after 90 days, the collection agency efforts cease. An investigation to determine the provider’s available financial status is initiated. These investigations require deep research into a variety of state and federal proprietary databases, which can uncover property ownership and assets, employment, and bankruptcies, as well as relevant tax information.

Referrals to the Attorney General for Collection Action

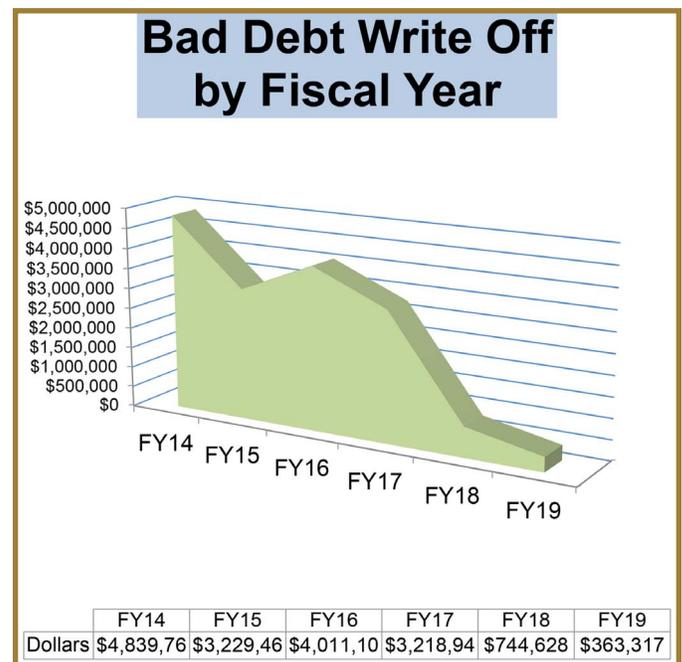
If property ownership and/or employment are established, a collection action is requested through the Illinois Attorney General’s Office. The Attorney General’s efforts may include wage garnishment, if wages are sufficient enough to justify deduction² and liens on personal property. A Collection Action Referral is prepared in accordance with the guidelines set forth by the Attorney

General’s Office. These referrals include all investigative and historical documentation that has been discovered during the entire investigation process. This can include provider enrollment documents, all communication between the Department and the provider, and any legal documents obtained during any administrative hearing. If the Attorney General’s Office is successful in obtaining funds from the provider and/or owner, these funds are collected by the Attorney General’s Office and routed to the OIG and applied to the debt.

Referrals to the Attorney General for Bad Debt Write-Off

When all collection efforts have been exhausted, a request is submitted to the Attorney General’s Office to have the debt certified as uncollectible. Certain situations prevent pursuit of an outstanding debt, including: a discharge in bankruptcy, dissolution of a corporate debtor, or death of an individual debtor with no estate. A case packet is prepared and sent to the Attorney General’s Office for processing. If the Attorney General’s Office deems the debt uncollectible, the previously established receivable is reduced by the amount certified as uncollectible and written off.³

The OIG began an initiative in 2014 to tackle the backlog of bad debt cases outstanding for the prior decade.



² 735 ILCS § 5/12-801 et seq.

³ The state receives their FFP portion at the time the receivable is written off.

Administration

Initially, the cases were processed in order of largest debt to the Department. The process has reduced the backlog, which has resulted in the recovery of previously paid federal funds.

Over the last three years, the OIG has worked extensively on building a strong working relationship with the

Attorney General's Office to actively pursue these cases. Both agencies have established an efficient process to coordinate referrals. Collection efforts can often be unsuccessful, but through this increased collaboration with the Attorney General's Office, the OIG has had increased success rates of overpayment fund recovery.

Management, Research and Analysis (MRA)

Management, Research and Analysis (MRA) was established to conduct and coordinate highly complex technical processes that impact healthcare fraud. MRA performs these duties through designing and evaluating specialized research projects related to discovering fraudulent behavior and coordinating the collection of data to develop fraud detection routines for inclusion in the CASE Management system. Additionally, MRA staff is responsible for reporting findings and making recommendations based on the results from research studies and data analysis in an effort to impact healthcare fraud and to aid in increasing efficiency within all of the OIG. MRA is also responsible for evaluating program policies and procedures relating to Medicaid fraud, and serves as the OIG liaison with Agency staff to facilitate attainment of project or study goals on monthly statistical reports for all OIG bureaus. The MRA Manager is the liaison with the Managed Care Organizations (MCOs) and oversees the Fraud, Waste and Abuse Executive (FAE).

Given the restructuring of the MRA section in FY18, resources were allocated to increase communication with the MCOs and proactively research risks and vulnerabilities for the Department, as well as highlighting areas for improved efficiencies. A risk-based essay entitled "Illinois Medicaid Program Integrity Risk Mitigation: Vulnerabilities in the DHS Home and Community-Based Services Waiver Program" was written and distributed internally. It was used for both inter and intra-agency discussions pertaining to program integrity (PI) risks associated with the DHS-DRS Waiver Program. Similar essays will be developed in FY20 based on identified risks to the Department and overall PI of the Illinois Medicaid Program.

As the OIG liaison, the MRA section works closely with the MCOs to facilitate improved communication and increased information sharing between them and the



Department. Additionally, MRA staff work closely with the HFS Bureau of Managed Care (BMC) to address and identify areas of concern regarding PI for the Department. The OIG holds monthly case review meetings, which are attended by representatives from the MCOs, Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU), and the OIG units who review and analyze fraud, waste and abuse cases. These case review meetings bring together a variety of key players in the PI arena, and bridge the gap between MCOs, law enforcement and the Department. In these meetings, MCOs present trends, schemes and specific allegations of fraud for all partners involved to review and discuss. Some of these allegations and cases discussed can be further reviewed for any potential criminal, civil or administrative actions.

The OIG previously met quarterly with the MCOs and HFS-BMC as a group to review any concerns and questions, and to provide updates on any departmental or policy issues. In FY19, the meetings were scheduled monthly instead of quarterly in order to increase communication. This allows the Department, as well as

our law enforcement counterparts, to openly discuss specific topics and investigations which may be of an urgent or ongoing nature and which may have commonality across different payers or books of business. Additionally, new processes and reporting methods have been implemented and are being tracked and monitored, which allows for greater interaction and information sharing between the MCOs and the Department.

New in FY19 was the implementation of monthly correspondence between the OIG and the MCOs, to act as a checks-and-balances to ensure the plans are aware of any cases under payment suspensions and any cases under any criminal or civil investigation. This new communication has been well received.

As noted in the Medicaid Program Integrity Spotlight

Fraud Abuse Executive (FAE)

The Fraud Abuse Executive (FAE) is the primary liaison with state and federal law enforcement entities, as well as other governmental regulatory agencies and counterparts, as it relates to the Illinois Medicaid Program. This relationship involves direct communication with external agencies such as the Illinois Attorney General's Office and the Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU). The FAE evaluates and transmits fraud, waste and abuse referrals to MFCU, as well as other governmental agencies, depending upon the allegation.

The OIG supports other law enforcement counterparts such as key entities within the US federal government: Department of Health and Human Services Office of Inspector General (HHS-OIG), CMS, Federal Bureau of Investigation (FBI), U.S. Department of Justice (USDOJ), U.S. Attorney's Offices, and the National Association of Medicaid Fraud Control Units (NAMFCU). The FAE coordinates the disposition of global settlement agreements generated by the National Association of Attorneys General, HHS-OIG and the USDOJ. Working together with these agencies regarding potential cases and allegations of Medicaid fraud, waste and abuse, the FAE coordinates data collection and analysis, as well as research regarding provider enrollment documentation.

The FAE also identifies key departmental staff members and other governmental staff members to work with state

section (MPIS), in FY19, the OIG submitted contract changes to amend the current managed care contract for a robust PI presence. The submitted contractual changes were partially approved, which still poses concerns regarding PI/DI, especially as managed care takes dominance in the provision of Medicaid care in Illinois. Through data analysis, the OIG is continually finding areas of concern regarding PI and is consistently addressing these with the MCOs and with the Department.

MRA also works to ensure that all OIG staff (and respective law enforcement partners) have access to and are trained on OIG programs, policies and procedures. In FY19, staffing related issues for the OIG did not permit an annual cross training session to be held, however another collaborative cross training session will be scheduled for 2020.

Highlights

External referrals: 47

Global Settlement Agreements: 1

Referrals to MFCU: 12

Data requests from law enforcement: 80⁴

MCO Information and data requests from law enforcement: 47

Referred to BAL for termination: 28

and federal law enforcement entities to provide specific information regarding policy and programs. These staff members may be asked to provide witness testimony at criminal and civil proceedings, as it relates to the Illinois Medicaid Program.

The FAE monitors all actively pursued law enforcement cases, and upon completion, coordinates internal administrative actions as necessary. Administrative actions include audit reviews, Peer reviews and payment suspensions, as well as possible termination from the Illinois Medicaid Program. The FAE is the liaison between law enforcement and the OIG and ensures that providers are administratively sanctioned if any criminal or civil cases result in convictions. After legal processes result in convictions of providers, the FAE works in conjunction with OCIG to administratively terminate these providers

⁴ This total represents EDW data requests from law enforcement entities to OIG, which may include encounter data.

Administration

from the Illinois Medicaid Program.

The OIG is statutorily required to suspend payments to Medicaid providers when the OIG determines a credible allegation of fraud exists.⁵ 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 Save Medicaid Access & Resources Together (SMART) Act (PA 97-0689). Ending FY19, the OIG is withholding payments from providers with credible evidence or allegations of fraud, totaling over \$174,000 dollars.⁶

Personal Assistants and waiver provider fraud is one category of providers which the OIG and law enforcement act upon regularly, both at a state and national level. In FY19, the FAE referred 28 PA cases to OCIG for termination and BOI referred 25 cases. As noted in the FY18 OIG Annual Report, this provider type is notorious for fraud schemes. In FY18, the FAE and Inspector General Hart worked tirelessly on a tremendous backlog of PA cases which were the result of many administrative issues, one

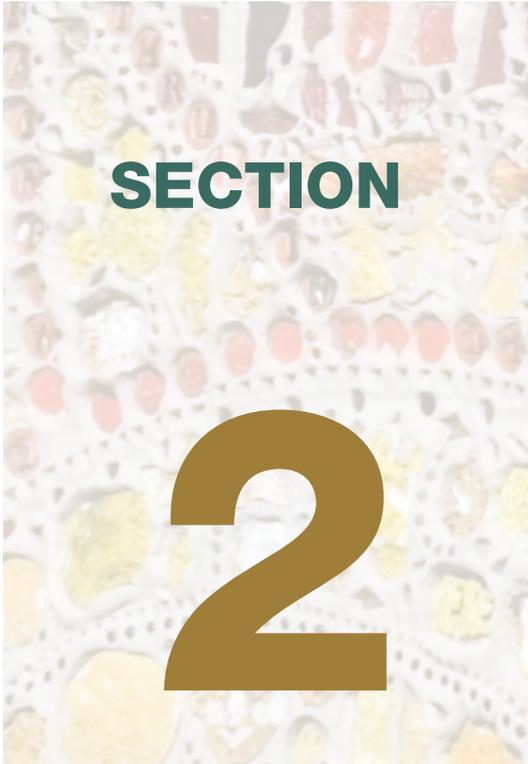
main issue being lack of OIG staffing. As noted above in the MRA section, a risk-based paper was developed and used in further discussions regarding the concerns with this waiver program. In FY19, the OIG worked directly with DHS–DORS to change the enrollment process to more appropriately apply PI principles to the program.

The FAE continues to work closely with our sister agencies and law enforcement partners as it relates to program violations or potential criminal and illegal activities. The FAE is responsible for tracking referrals sent from the OIG to other agencies. Referrals can be made to other Illinois state regulatory agencies such as the Illinois Department of Financial and Professional Regulation (IDFPR), the Illinois Department of Public Health (IDPH), DHS, as well as to Federal CMS and HHS-OIG and the DEA. These referrals can result from OIG provider committee reviews, audits, review cases or Provider Analysis Unit (PAU) cases, in which provider education, licensing concerns or billing concerns have been identified and need to be addressed by another jurisdiction.

⁵ 42 CFR § 455.23 Suspension of payments in cases of fraud.

⁶ This dollar amount does not include MCO payment information or monies held by sister agencies and represents all Fee for Service (FFS) held payments as of the end of FY19.

Bureau of Fraud Science and Technology



Bureau of Fraud Science and Technology

Fraud Science Team/Technology Management Unit

The Bureau of Fraud Science and Technology (BFST) is responsible for the introduction, development, maintenance, and training of staff on new technologies. 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 case tracking, and document management system developed specifically for the OIG. BFST also manages healthcare 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).

All BFST initiatives center around the OIG mission to insure program integrity, while evaluating data integrity. The CASE investigative tool is being upgraded for additional functionality using newer technology and extending usage options to entities outside of the OIG that have similar program responsibilities.

FST/TMU

The Fraud Science Team (FST) develops fraud detection routines to prevent and detect healthcare 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) and Teradata SQL, utilizing the Department Data Warehouse along with other third-party data sources. FST also identifies program integrity solutions, prepayment claims processing edits, policy innovations, operational innovations, fraud referrals, desk reviews, field audits, and self-audit reviews. BFST takes systematic approaches to plan and implement the integration of sampling selection and audit reporting, DNA-CASE integration, statistical validation, executive information summaries, and other analysis that will improve the OIG’s operational and decision-making processes.

The Technology Management Unit (TMU) is responsible for all computer related transactions within the OIG, coordinating with the Department of Innovation &

Technology (DoIT) on network access as well as hardware and software requests. Database design and development, web development, computer training, and technical support are also essential functions provided by TMU. Functions completed by TMU are key to the success of the various units within the OIG.

TMU coordinated the resolution of 3,902 OIG Help Desk inquiries in FY19. Another function of TMU is to complete data requests from federal, state, and local law enforcement agencies. In FY19, 92 data requests were completed, many of which will result in dollars being returned to the state through court decisions and settlements. TMU staff assisted with the testing and conversion to the Office 365 platform. TMU also assisted with ongoing testing and implementation of new features and software related to the Enterprise Data Warehouse (EDW). Staff have continued testing on the State’s Enterprise Resource Program (ERP) project with an expected go-live date of January 1, 2020. Despite ongoing vacant positions and staff shortages, TMU has continued to deliver a high-level of technical consultation, programming and support services to the OIG.

Dynamic Network Analysis (DNA) Framework Enhancement

BFST oversees maintenance and enhancement of the Dynamic Network Analysis (DNA) Framework. As Illinois transitioned its managed care program to the member-centric HealthChoice program, Medicaid services and payment patterns experienced significant changes. As a result of these changes, the DNA development team adapted policy and regulation changes, revised existing modules and added additional features to the DNA system. The ultimate goal of the DNA is to provide robust and comprehensive data analytics for auditors and investigators to strengthen their capacity to combat Medicaid fraud, identify waste and abuse, and ensure that invaluable tax dollars are spent on Illinoisans in need.

In FY19, the DNA system had more than 16,600 inquiries submitted, which is a 19% increase from FY18. This indicates that DNA users are becoming more familiar with the system and rely on it for relevant information. The most frequently used reports are the provider profile, recipient profile, recipient claim details, marriage divorce report, Welfare Abuse Recovery Program (WARP) report, peer review report and provider inquiry reports. The

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design of these customized reports came directly from managers, auditors, and investigators proficient in report content; this suggests the DNA reports were useful in improving productivity and efficiency.

Under BFST's direction, the DNA development team continuously enhances the DNA system. In FY19, added to the system were the following features and analyses:

Provider Profile Enhancement

The provider profile, which was previously based primarily on Fee For Service (FFS) adjudicated claims, required updating to adapt to the trend of services switching from FFS to MCO adjudicated claims. All routine calculation algorithms initially applied to FFS services now have a counterpart in MCO services, including transportation related routines (duplicate billing routine, transportation during an inpatient stay routine and loaded mileage routine). To display a complete picture for a given provider, a breakdown by procedure codes and diagnosis codes exists for both FFS and MCO services.

Typically, the provider profile report contains comprehensive content about a specific provider, including demographic information, address or satellite address, payee, national provider identifier (NPI), claim summary, and error code summary. The information extraction and claims data processing necessary to generate the report is time-consuming. To address demand, the DNA team developed a sectional provider profile. This profile presents information to users only interested in a common client report, four more days report (one provider providing services to the same recipient at least four days in a week), weekend and holiday report (the provider providing services on weekend or holidays) more effectively and efficiently. In addition, Provider Profile Time Dependent Billing (TDB) Analysis adds more flexibility for users to enter a random threshold for service hours.

Executive Summary Update

The executive summary reports depict an overall picture with a "birds-eye" view to identify important trends, or high-level outliers. These views are critical to grasp performance levels across various program types and service contractors. The MCO/Capitation executive report presents the variance in capitation payments issued to managed care contractors to actual reimbursed services for the recent five years, which includes the new Health

Choice client population effective January 1, 2018. The MCO/FFS Summary executive report portrays transitional trend from Fee-for-Service (FFS) to the managed care model and presents payment, clients and service count data. The new Claim Submission Lag report portrays claim submission lag from actual service rendered months. This report helps to visualize the distribution of submitted claims by health plans, provider types and service months. The data metrics are presented in both table and chart formats, showing MCO and FFS payment, services, and recipient counts both monthly and accumulated.

The new Opioid Monitoring Report trends statewide client opioid usage by specific drug for the recent five years. Additionally, this report also lists the critical Morphine Milligram Equivalents (MME) categories of the dispensed prescriptions for the recent five years. The Morphine Milligram Equivalents (MME) tool was developed to convert various prescription opioids and strengths into one standard value based on morphine and its potency. MME calculations are grouped into three categories indicating the risk of opioid overdose. These risk groups include: 0-50 MME per day (medium risk), 50-90 MME per day (high risk) or greater than 90 MME per day (extreme risk).

Provider 360 database

The DNA team developed the provider 360 database to scrutinize providers from various perspectives. Besides the demographic information of the providers, more claim related information is included based on different provider types. Related information includes FFS payment, MCO payment, services count, and recipient counts. These indicators are applicable for all provider types, while the duplicated bills, transportation during inpatient stay claims, and loaded mileage claims are three unique indicators for transportation providers. The common client routine (the network analysis to detect groups of providers sharing the same recipient on the same day), time dependent billing procedure routine (the calculation of the estimated time to render all services based on their corresponding service time from the Centers for Medicare and Medicaid Services (CMS) guidelines), and narcotic drugs abuse routine (the study of individual providers with high dose prescriptions of narcotic drugs or controlled drugs for recipients in comparison to their peers), are specifically designed for individual practitioners. Additionally, calculations for distance between recipient and provider for the durable medical equipment (DME) providers based on specific procedure code groups and the

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corresponding recipient age groups required use of the Mahalanobis distance statistical model. All these indicators' matrices computations available in the provider 360 database can support auditors and investigators with effectively and efficiently locating potential outliers based on the corresponding provider types.

Recipient 360 Database

The DNA team also implemented the Recipient 360 Database. Even though recipients vary in age and residence (geographical location), they share many common indicators. Hence, application of generic measures to the statewide recipient population, such as FFS payment, MCO payment, claim counts, number of services by rendering providers, counts of office visits, ER visits, prescriptions, narcotic drugs, controlled drugs, and recipient demographics (age, gender, and county), can occur. In addition, some geographically related disease information, such as asthma treatment in highly polluted suburban areas, dental procedure codes in high fluorine-containing water areas, may be considered. Using the statistical time series model, after creation of the recipient data matrix, calculations of the payment and service patterns occurred. Moreover, the accuracy of the model increases with time after plugging in more and more data.

Recipient Restriction Routine Revision

The Recipient Restriction Program identifies Medicaid recipients who excessively use healthcare services. For coordination of care, a recipient can be restricted to a single primary care physician and/or a single pharmacy for up to 24 months. Normally, it is very challenging to identify the "excessive" usage. Development of a series of criteria illustrate individual Medicaid services usage. Recipients residing in a nursing home or extended care facility are not considered in this version of the restriction program algorithm. By default, the recipients enrolled in

managed care are included in restriction logic, but they can be easily excluded with a predefined option. Second, all services received by eligible recipients in 24 months are calculated by different categories. The term of "excessive" will be determined by factors such as office visit counts, the number of ER visits based on inpatient and outpatient records, the counts of pharmacies used to pick-up prescriptions, narcotic drug prescriptions, controlled drug prescriptions, and the counts of the prescribing practitioners. According to OIG management directions, the criteria of the recipient restriction program is updated to align with recent policy changes and reflect the ongoing national opioid crisis, which put greater restrictions on narcotic drug and controlled drug prescriptions.

Opioid Analysis Update

The DNA development team continues to improve the opioid calculation after adopting the toolkit from the Office of the Inspector General of the U.S. Department of Health & Human Services. Validation of the outcome of morphine milligram equivalents (MME) occurred on over 1,300 drugs. To improve accuracy on recipient opioid level and identification of recipients at risk of opioid misuse or overdose also involved application of up-to-date conversion factors.

MME is a key element in the opioid initiative in OIG. This factor is being used in a historical data universe model which combines the new Provider 360 and Recipient 360 databases, along with established program deliverables such as the Recipient Restriction Program and other data repositories such as the IDFPR license (status) extract. The BFST statistician contractor is developing a statistical weight derivative model from Illinois historical service data for a new predictive analysis model to identify high fraud, waste and abuse (FWA) probability examples for both patients and service providers. This model will take key elements from both known violators or supervised outliers, and unknown, or newly identify outliers for analyzing the relationship of these flagged violators and assigning cause for further detailed analysis. These models will be added to the DNA tools used by all OIG staff.

The DNA team also developed the "Vegas Cocktail" (cocktail) routine to monitor controlled drug abuse. The cocktail is a combination of concurrent opiates, benzodiazepines and muscle relaxant prescriptions being dispensed to the same individual. Often, the risks of



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simultaneously taking these three classes of drugs may outweigh the potential benefits due to potentially lethal side effects. Under the current status of the statewide opioid crisis, the latter two types of drugs, meeting genuine needs separately, make the regimen difficult to identify. After development of the routine, an individual recipient with overlapping time-periods involving those three types of drugs results in a flag. More doses and longer overlap period increase a recipient's rank on the list. Even if the cocktail regimen evolves into other, multiple types of drugs, an update to the routine can occur with the corresponding drug specific therapeutic class code. Not only identifiable are recipients with a possible drug issue, but also prescribers routinely prescribing the controlled drugs.

Redesigned Recipient Inquiry

Previously, the module provided the capacity to search recipient data sources and displays basic demographic information as the result. The updated design provides much more information, including eligibility details, address history, death information (when applicable), and is integrated with Link Explorer. The redesign also

includes a claim summary feature, which identifies MCO and FFS payments and services data for the most recent five years. Users can choose to view the overall numbers or breakdown for one or more claim types. Users can also switch between the yearly view and monthly view and visualize the trend on a bar chart. The performance of the inquiry has also improved.

User Authentication Improvement

Added directly in the DNA system is the capacity to update expired data warehouse credentials. The credential allows access of Medicaid data sources by multiple internal tools, including the DNA system. Additionally, the credential has an expiration policy and needs updating periodically. Previously, users would have to run a dedicated desktop client to check the service status, whereas the new feature streamlines user workflow by integrating an authentication system to provide notifications when user attention is required, displaying an interface to update the information. The feature also detects potential service conflicts and provides instructions accordingly.



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Provider and Recipient Analysis Section (PRAS)

Within the Provider and Recipient Analysis Section (PRAS) of BFST is the Provider Analysis Unit (PAU) and the Recipient Analysis Unit (RAU). PAU is the triage unit for incoming Medicaid provider referrals and for monitoring medium and high-risk provider-types one year prior to full enrollment (180/365 monitoring program). The Unit is comprised of five registered nurses and a nurse manager. Through the relationship with HFS-OIG and the NAC/MII, OIG staff is able to obtain valuable and prestigious educational training which adds value to the OIG. One of the nurse analysts recently completed all three MII courses and passed the national Certified Program Integrity Professional (CPIP) exam. Another nurse analyst is also preparing for the same exam.¹

Provider Analysis Unit

PAU nurse analysts provide clinical expertise for OIG investigations into researching aberrant billing practices by Medicaid providers. The nurse analysts perform in-depth analysis of billing records to determine if claims and services are appropriate. Targeted data run queries are also requested to identify billing outliers. Billing trends, payment amounts, business inter-relationships and pharmaceutical prescribing patterns are all reviewed and compared to similar providers within the same specialty.

After review of each provider, the findings are presented at the OIG's Narrative Review Committee (NRC). NRC is comprised of Inspector General Hart, managers of PRAS, Peer Unit, Audit Unit, OCIG and includes representatives from MFCU. Cases are presented to determine if the providers warrant additional investigation for any of the issues below:

- Quality of care concerns
- Potential risk of harm to the patient
- Fraudulent activities
- Billing or prescribing "outliers"

FY19 PRAS Highlights:

- 248 provider referrals received
- 115 medical providers analyzed
 - 48 cases presented to Narrative Review Committee
 - 1 provider sent Narcotic Letter of Concern
 - 67 cases closed with no further action warranted as allegations were unsubstantiated

180/365 day monitoring program:

- 244 providers monitored and analyzed
 - 126 enrolled as participating providers
 - 17 disenrolled
 - 115 cases currently being monitored during their 365-day monitoring process.

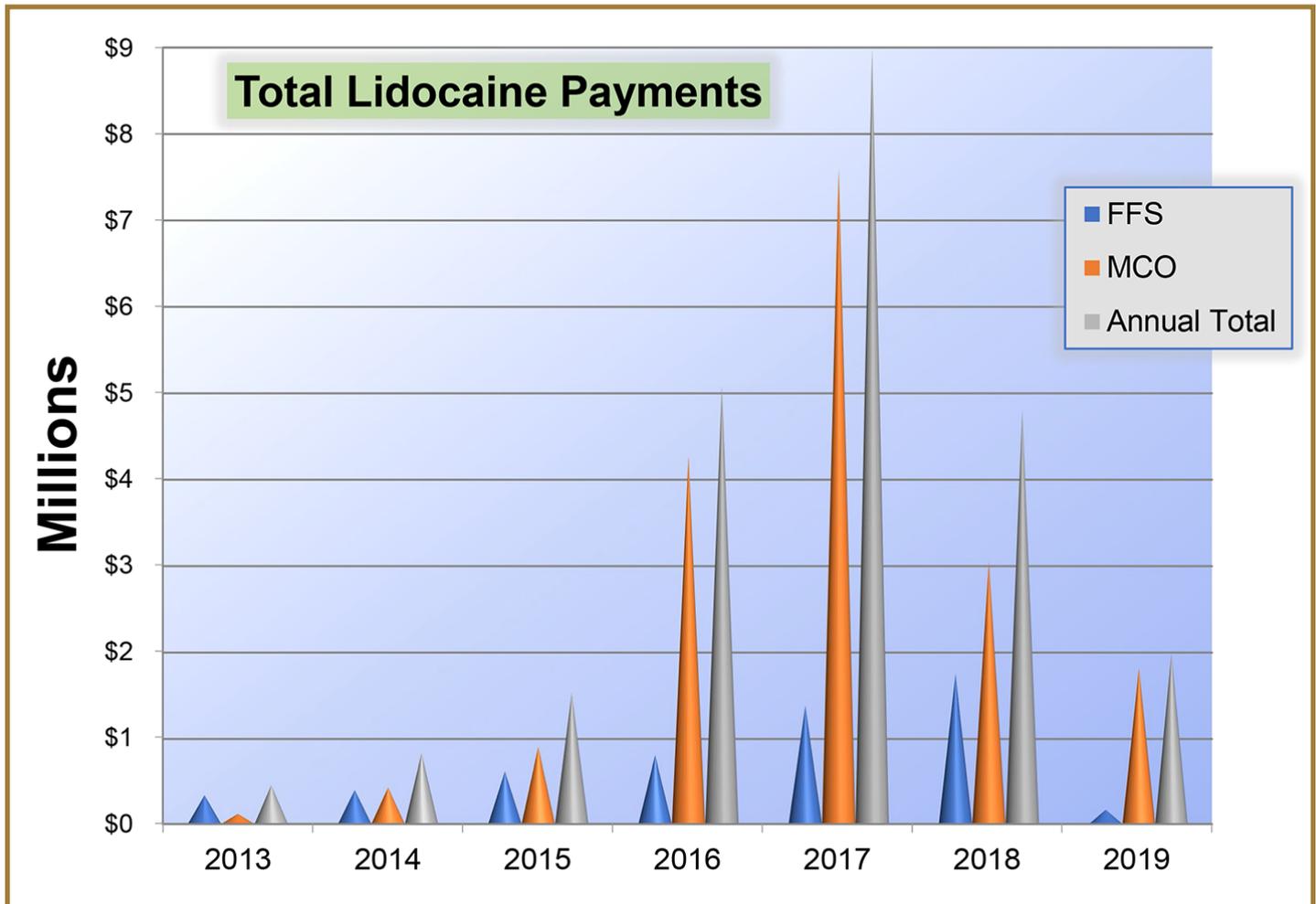
Actions recommended by the NRC may include:

- sending a letter of concern to the provider
- referral for an audit
- referral for a focused Peer Review
- referral to law enforcement for suspected criminal violations
- referral to other federal or state agencies, depending on violation
- recommendation for denial/disenrollment or additional monitoring of moderate/high risk providers (180/365)
- recommendation to HFS administration for a policy change as evidenced by the following scenario:

As noted previously in the FY19 Successes section of this report, in FY18, PAU Nurse Analysts identified billing practices by multiple pharmacies statewide involving Lidocaine Cream (5%). Repeated monthly billing of Lidocaine Cream (5%), without supporting diagnoses, were being ordered by physicians with associated ties to specific pharmacies. As a result of the applied changes, analysis showed a \$3,689,587 reduction for the amount paid over the one-year period. This project has led PAU Nurse Analysts to investigate similar abuses.

¹ CPIP is a prestigious certification held by very few Medicaid analysts across the country. The intense training (offered free to OIG staff through a collaboration between US DOJ and the State of Illinois) includes fundamental courses and examinations exploring common and emerging healthcare fraud schemes and how to investigate, gather evidence, and prepare cases for prosecution.

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180/365

New Provider Verification (NPV) involves pre-enrollment monitoring or “365-day conditional enrollment” of non-emergency medical transportation (NEMT) providers, as well as other moderate and high-risk provider types such as durable medical equipment and laboratories for one year prior to full enrollment.

OIG Investigators complete on-site inspections of the NEMT providers to verify business legitimacy and perform an inspection of vehicles used to transport clients to and from medical appointments. This initial inspection also includes fingerprint-based background checks, verification of licenses, insurances, safety certificates and corporate standings.

During the initial 180-day probationary period, the analyst monitors any provider billing patterns to determine or detect any potential billing abnormalities or aberrant behaviors. The analyst will often contact providers to inquire and offer guidance at the mid-point of their enrollment process.

Prior to completing 365 days of conditional enrollment, the analyst again analyzes billing patterns, looking for any of the same issues. If no concerns are identified, the provider is fully enrolled as a Medicaid provider. If problems are identified, the provider may be granted a 180-day or 365-day extension of the initial agreement or may be disenrolled, depending on issues identified.

Bureau of Fraud Science and Technology

Recipient Analysis Unit (RAU)

The purpose of the Recipient Restriction Program (RRP) is to identify, detect and prevent abuse of medical and pharmaceutical benefits, based on set parameters in federal and state regulations, as well as HFS policy. RRP uses the DNA Predictive Analytic model and profile-reporting system for data that identifies overutilization of services by enrolled recipients. Other referral sources include tips regarding potential recipient fraud or abuse from the OIG website, Medicaid Fraud Hotline and calls to the RRP hotline.

When recipients utilize multiple prescribing providers and multiple pharmacies they are at a significant risk for adverse and potential life-threatening situations. The RRP is designed to promote recipient safety through care coordination, often referred to as a “lock-in” or restriction program. Specific indicators will trigger restriction program intervention, and, in the case of a fee-for-service recipient, a single primacy care provider. The OIG has established protocols for the identification, restriction, monitoring and periodic evaluation of recipients suspected of abusing pharmacy benefits or over-utilizing covered medical services. Previously, one RAU analyst was dedicated part-time to evaluating recipients who have been identified through data analytics or by referrals, as being prescribed the “Vegas Cocktail.”² However, in FY19, two full time analysts reviewed and evaluated all cases for opiate overuse and/or abuse, inducing the Vegas Cocktail.

The OIG continues to provide ongoing support and guidance to our MCO partners in their development of restriction programs.

FY19 RAU Highlights:

- **4,349 cases reviewed**
 - **116 Individual recipient fraud referrals received**
- **89 new recipients restricted in FFS**
- **382 new restrictions recommended to MCOs**
- **1,930 total number of FFS restrictions as of 6/30/18**
- **Total Medicaid recipients reviewed but not restricted (FFS and MCO)**
 - **746 due to recipient’s eligibility cancelled**
 - **41 due to recipient death**
 - **158 due to recipient restriction released (in compliance)**
 - **2,997 due to no restrictions warranted (appropriate utilization)**
- **Total cost avoidance for RRP: \$102,571³**

² Vegas Cocktail is a combination of concurrent opiates, benzodiazepines and muscle relaxant prescriptions being dispensed to the same individual.

³ Due to patient restriction logic being re-evaluated and receiving updates during the year, the number of reviews not resulting in restrictions was inflated. This logic will be reviewed in the upcoming year for more efficient and effective use of staff resources.

Bureau of Internal Affairs



Bureau of Internal Affairs

The **Bureau of Internal Affairs (BIA)** investigates misconduct of State employees and contractors, while also monitoring the safety of employees and visitors in Department buildings. BIA's monitoring includes security oversight of HFS, which involves conducting threat assessments received against state employees, Department assets, and Department buildings.

The Bureau is also tasked with researching criminal history information of all applicants. BIA ensures compliance with State regulations as it pertains to new employee hiring with background checks, which are required for all staff who need access to proprietary data sources. The Bureau is also responsible for monitoring of employee Internet traffic and usage of State resources. It utilizes a variety of investigative methods to identify fraudulent staff activity and misuse of State resources and time. BIA has the capability to run computer forensic examinations on HFS computers when an investigation warrants such action.

Investigative reports are completed and shared with the agency's division administrators, the Bureau of Labor Relations, and when necessary, state and federal authorities. Once an investigation is complete and the report is published, the Division Administrator or Labor Relations are required to report back any action taken within 30 days to BIA.

BIA Initiatives

On February 1, 2019, an online complaint form initiative was introduced. This initiative allows people to report wrongdoing in a more accurate, convenient, and timely manner. Although complaints to BIA can still be made via paper or telephone, the online complaint form allows employees and citizens to report their concerns directly from a computer or mobile device. The new online complaint form also allows complainants to attach documents that support their allegations. During FY19, 44 new online complaints have been received and reviewed. The complaint form can be found here on the HFS website¹.

¹ <https://www.illinois.gov/hfs/oig/Pages/ReportMisconduct.aspx>

² Open cases as of July 1, 2019 (start of FY20).

³ During FY19 BIA closed two cases that have been on hold pending criminal outcomes. The two criminal cases averaged 958 days per case. BIA's average case processing time without the delayed criminal cases was 106.36 days.

FY19 BIA Highlights:

Total Staff: 11

Open/Active Cases: 9²

Total Cases Opened: 560

Total Completed Cases: 559

Average Case Processing Time:

Background Investigations: 4 Days

General Investigations: 155 Days³

Significant Internal Affairs Cases

Office Assistant Resigns after BIA Computer Seizure

In December 2018, during routine monitoring of the Departments internet use, it was determined that an Office Assistant was utilizing the Department's internet access for personal use. The employee's violation of the HFS Computer Security and Internet Policy consisted of online shopping, viewing YouTube videos, conducting non-work-related searches, and accessing pornographic web content. On January 2, 2019, the HFS computer assigned to the Office Assistant was seized by BIA investigators. On January 4, 2019, HFS Labor Relations received a telephone call explaining that the employee wanted to resign when the employee found out that BIA had seized their assigned state-issued computer. The employee resigned as a result of the BIA investigation.

BIA Time Analysis Results in 7 Day Suspension

In September 2018, BIA received a complaint alleging that a Senior Public Service Administrator (SPSA) was abusing state time and falsifying their ethics timesheets. BIA analyzed the employee's HFS Ethics Time Sheets (HFS 163MC), door access logs, security camera recordings, and computer logons. BIA reviewed the timeframe from August 20, 2018 through November 11, 2018. The analysis revealed inconsistencies with the employee's recorded arrival times and reflected approximately thirty-five (35) time related discrepancies for a total of 1,181 minutes or 19.68 hours. During the interview the employee, admitted that entering incorrect

arrival times on their Ethics Time Sheet was a violation of HFS policy. The employee received a 7-day suspension effective February 4, 2019.

HFS Employee Operates State of Illinois Vehicle on Suspended License

In August 2018, an HFS Executive I was arrested and charged with Driving Under the Influence of Alcohol (DUI). The employee reported the arrest to HFS management on August 15, 2018. At the time the employee reported the arrest their Illinois Driver's License was not suspended. On September 29, 2018, the employee attended court for the first appearance and was advised that their driver's license was suspended. The employee did not notify management of the status change to their driver's license and continued to operate State of Illinois vehicles. On October 17, 2018, the employee made false statements to their immediate supervisor indicating the employee's attorney helped get the DUI case dropped. On October 17, 2018, the employee was observed driving a State of Illinois vehicle with a suspended license. The employee received a 15-day suspension for violation of HFS policies.

Public Service Administrator Discharged for Fake College Transcripts

In November 2018, BIA received a complaint about a Public Service Administrator (PSA) alleging the PSA purchased and submitted a fictitious college transcript. The fake college transcript was submitted during the hiring process showing the required credits the employee needed for their current position. BIA's investigation included collecting documentation and statements from the alleged university, conducting interviews of Healthcare and Family Services employees, and an interview of the employee. During the investigation, BIA found that the university "does not have any record of [Redacted] attending any classes or enrolling into any programs at [Redacted] University." BIA also found that the courses listed on the transcript provided by the employee were not available at the university when the employee allegedly attended the school. Due to this, BIA found that the employee submitted a fraudulent college transcript and gave false statements during the hiring process for their promotion. Additionally, BIA found that the employee provided false or misleading statements during their investigative interview. The employee was discharged.

HFS Office Coordinator Resigns after Accessing and Photographing Child Support Case Screen

In November 2018, BIA received a complaint that an Office Coordinator used a personal cellular telephone to take photographs of Graphical User Interface Key Information Delivery System (GUI KIDS) screens. It was further alleged that the employee accessed their mother's child support case. BIA investigators interviewed the employee on December 5, 2018. During the interview the employee admitted to accessing their mother's child support case. The employee also admitted to photographing the child support note case screen and texting the photo to their mother. The employee admitted to BIA investigators that the employee's actions violated HFS policy. During their interview, the subject resigned from HFS.

HFS Employee Falsifies CMS 100 Employment Application

In December 2018, BIA Investigators interviewed a Program Integrity Auditor Trainee for failing to provide accurate information on the employment application (CMS 100) that was used as a basis for the employee's hiring. The employee selected "No" to the question of having been fired from a job. Prior to the interview, BIA investigators learned that the employee had been previously employed and fired by the Department of Human Services. During their interview, the subject resigned from HFS.

Program Integrity Auditor II Resigns after Submitting Forged Medical Documents

In May 2019, a Program Integrity Auditor II submitted a letter of resignation to HFS after a lengthy BIA and Illinois State Police investigation. During the investigation, BIA determined that the employee had submitted forged medical excuses from a Department of Veteran's Affairs (DVA) clinic. BIA investigators located nine documents purported to be on official DVA letterhead excusing the employee from work. BIA investigators verified with DVA that DVA did not provide the nine documents to the employee. DVA further verified that there was no record that the employee attended the clinic on eight of the nine days in question. The BIA investigation determined that the employee falsified time, forged VA documents, and violated numerous HFS policies. Due to the BIA investigation, the employee resigned.

Bureau of Investigations



Bureau of Investigations

Investigations, SNAP Fraud Unit, NPV, WARP

The Bureau of Investigations (BOI) investigates allegations of suspected fraud, waste and abuse against the SNAP, TANF, Child Care Fraud, Eligibility Fraud, Provider Fraud and Medicaid system by both recipients and providers. The BOI may pursue criminal prosecution or administrative sanctions against any recipient or provider. The Bureau is comprised of four units: Investigations, SNAP Fraud, New Provider Verification (NPV), and Welfare Abuse Recovery Program (WARP).

Investigations

During the process of investigating allegations of provider and recipient fraud, the Bureau works together with state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies.

Eligibility Fraud

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. Investigation results are provided to Department of Human Services Bureau of Collections (DHS-BOC) to calculate the recoupment of overpayments. In cases with large overpayments or aggravated circumstances, the OIG prepares cases for criminal prosecution and presents them to a state's attorney or a U.S. Attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits. Cases that are considered for criminal prosecution but fail to meet prosecutorial merit are administratively closed and returned to DHS for collection activity.

Significant SNAP Cases

An eligibility investigation was completed that alleged a client was not reporting the father of her children and his income as part of her household to DHS. The investigation revealed the client failed to report the father's earned wages while residing in her household from June 2014 through July 2018. The client and the father lived together at three different residences during the timeframe in question. The evidence which confirmed the father of the children was in the household included his employment records, lease information, Illinois Income Taxes, school verifications, Voluntary Acknowledgements of Paternity and Secretary of State Records. The client reported that

FY19 Investigation Highlights:

Identified Overpayments: \$5.9 million
Client Eligibility Completed Cases: 627 (of these 447 were founded and 180 were unfounded)
Referred for Prosecution with the State's Attorney: 13
Open/Active Cases: 3,255
Personal Assistant Cases Completed: 115
Onsite Visits Completed: 176
Child Care Completed Case: 1
Child Care Overpayments: \$55,535
Total Staff: 27

the father of her children did not live with her, despite him being listed on her lease. An estimated SNAP overpayment was calculated at \$37,082 for the period of June 2014 through July 2018.

An eligibility investigation was completed that alleged a client, who was married to her "landlord," had been receiving monthly CHA housing vouchers (rental payments) for the client since 2005. The allegation was founded, and it was recommended an overpayment be processed by DHS. DHS returned two SNAP overpayments in the amounts of \$40,215 for the period of November 2010 through November 2018 and \$853 for the period of January 2019 through July 2019. Due to the multi-agency fraud, the Cook County State's Attorney accepted this case for prosecution.

An eligibility investigation was completed that alleged a SNAP client did not report the following to DHS: the responsible relative was living in the home of the client, had gainful self-employment, and was not residing at the assistance unit address. The results of the investigation were submitted to the DHS local office for calculation. The SNAP overpayment was calculated to be \$37,094 for the period of May 2012 to October 2018.

Child Care Fraud

Investigations are conducted when recipients or providers are suspected of misrepresentation of facts regarding their eligibility for the Child Care Program. Recipient fraud can occur for a variety of reasons: earnings from providing child care are not reported as income, child care needs are misrepresented, or child care payments are stolen or

Bureau of Investigations

diverted. Provider fraud occurs when claims are made for child care not provided or for care provided at inappropriate rates. The results of these OIG investigations are provided to the DHS Bureau of Child Care and Development (BCCD). In cases where an overpayment has been identified, it is referred to DHS-BOC to establish the debt and refer it to the Illinois Office of the Comptroller for involuntary withholding. Additionally, should the debt become delinquent, it is referred to a private collector. Cases involving large overpayments or aggravated circumstances of fraud cases are often referred for criminal prosecution to a State's Attorney or a U.S. Attorney, or to the DHS-BOC for possible civil litigation.

Significant Child Care Case

An investigation was completed for a child care case, which revealed that a child care recipient was married in October 2015, and then lived with her employed spouse from October 2015 through March 2019. The recipient never reported her marriage, and her failure to accurately report her household composition enabled her to fraudulently receive an estimated child care overpayment totaling \$55,535 for the period of November 2015 through March 2019.

New Provider Verification (NPV) On-Site Review

BOI investigators are charged with conducting on-site reviews of high-risk Medicaid providers. Investigators conduct on-site reviews of transportation and Durable Medical Equipment (DME) providers. The main goal of these reviews is to ensure that the provider exists, that their location of business is valid, and that all paperwork to conduct business in Illinois has been properly filed with the appropriate entities.

Medical Card Fraud

Investigations are conducted when recipients or providers are suspected of misuse or misrepresentations concerning medical programs. Recipient fraud occurs when recipients are suspected of misusing their medical cards or when medical cards are used improperly without their knowledge. Examples of recipient fraud

include: loaning a medical card to an ineligible person, visiting multiple doctors during a short time period for the same condition, obtaining fraudulent prescriptions, selling prescription drugs or supplies for personal gain, or using emergency room services inappropriately. Founded cases are referred to the Recipient Restriction Program.¹

Personal Assistant (PA) Providers

The BOI's role is to review PAs who have a criminal background. As discussed in the MPIS section of this report, this waiver provider type is notorious for fraud schemes. Given the present enrollment process, the OIG does not receive applications for review of any waiver provider until after the provider has started providing services and has potentially been paid. The BOI conducts research on criminal history and determines if the PA has a disqualifying criminal offense. The administrative code authorizes the Department to terminate or suspend a provider's eligibility to participate in the Medical Assistance Program, terminate or not renew a provider's agreement, or exclude a person or entity from participation in Illinois Medicaid, when it determines there is criminal history to support such action. When providers are identified for termination, they are referred to the Office of Counsel to the Inspector General (OCIG) for administrative termination.



¹ During FY19, there were no Medical Card Fraud Investigations conducted.

Bureau of Investigations

SNAP Fraud Unit

Within the BOI, the SNAP Fraud Unit works diligently to ensure the integrity of the federal Supplemental Nutrition Assistance Program (SNAP). Recipients who intentionally violate SNAP rules and regulations 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 on SNAP cases is calculated based on the average amount of food stamp standards during the overpayment period multiplied by the length of the disqualification period.

New Provider Verification (NPV)

The New Provider Verification Unit has been working diligently to streamline and improve the efficiency of processing high and moderate-risk provider referrals from the HFS Provider Enrollment Services (PES) Unit. Monthly coordination meetings have greatly increased the clarification of duties and responsibilities between the units. Additionally, PES collection of documentation submitted by providers enrolling and revalidating has improved timely processing of applications by the OIG. New policies, procedures and coordination of investigations ensure all parties maintain continuity of purpose. The Interagency Agreement (IGA) with the Department of Public Health to share onsite visit survey information will greatly reduce the burden of OIG staff from duplicating onsite visits of high-risk Home Health Agencies. Additionally, the IGA eliminates the cost of travel reduced time out of the office for OIG staff. The Bureau of Investigations continues to perform onsite visits of other high-risk providers of Durable Medical Equipment and Non-Emergency Transportation.

The process of reviewing New Provider Verification (NPV) cases includes reviewing and investigating fingerprint-based background checks, verifying licenses, insurances, corporate standings, and conducting on-site visits. Depending on the provider type, the Bureau of Investigations (BOI) conducts the onsite readiness review. During on-site visits, the business's location and existence is confirmed; information provided on the enrollment application, including ownership information, is verified; and the business's ability to service Medicaid clients is assessed.

FY19 SNAP Fraud Unit Highlights:

Referrals Received: 2,116
Case Reviews Completed: 2,127
Identified Overpayment: \$2.9 million
Cost avoidance: \$2.5 million
Disqualification Hearings Held: 843
Disqualifications: 1,100
Open/Active cases: 3,572
Total Staff: 4
Administrative Hearing Decisions Rendered: 498
(446 of these decisions were found in favor of the OIG)

FY19 NPV Highlights

Total Staff: 4
New Provider Verification Applications Reviewed: 314
Providers Denied: 14
Providers Enrolled: 108
Applications Returned: 58
Enhanced Screening: 134
Provider Revalidation Applications Reviewed: 72
Providers Denied/Terminated: 2
Providers Revalidations Approved: 52
Applications Returned: 10
Enhanced Screening: 2

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 provider category. High-risk provider types are determined by federal CMS and may be expanded by the individual states, based upon their systems' needs. Federal CMS currently lists Durable Medical Equipment (DME) providers and Home Health Agencies (HHA) as high-risk providers. Illinois has added Non-Emergency Medical Transportation (NEMT) providers to its high-risk category. High-risk providers also include providers who have prior OIG sanctions or owe a debt to the Department.

Enrollment may be denied by the OIG 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
- the applicant's non-compliance with fingerprinting or documentation requirements

Bureau of Investigations

- 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
- providing false information to the Department.

Per the Affordable Care Act (ACA), HFS, as 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 and are appropriate to the risk level as described above in the NPV process. If providers are non-compliant with requests for additional documentation during the revalidation process, the OIG has implemented steps of action, including but not limited to, payment suspensions and terminations.

Welfare Abuse Recovery Program (WARP)

Within BOI, WARP serves as the central fraud intake unit for the entire OIG. WARP processes fraud and abuse referrals received directly from local Department of Human Services (DHS) offices which allege potential fraud by recipients and providers. Referrals are also received by the public via a hotline, an online intake referral form, as well as direct referrals from state and federal agencies and law enforcement entities.

WARP conducts thorough research on suspected fraud referrals by accessing multiple databases from a variety of sources including, but not limited to, DHS, Secretary of State, Illinois State Police (ISP), Department of Public Health (IDPH) vital records, Illinois Department of Employment Security (IDES) and the Division of Child Support Services (DCSS). WARP takes multiple steps in gathering, reviewing, and analyzing information regarding the referral and processes the referral in the OIG's case tracking system. WARP ultimately determines how and where to route cases within the OIG for further review, based on the findings.

Cases can be closed due to lack of merit or information or sent to BOI investigators for further review and investigation. Cases can also be sent to a DHS - Family Community Resources Center (DHS-FCRC) for additional follow up or sent to DHS-BOC to establish a dollar amount and time frame for an overpayment. When DHS-BOC receives a referral, they respond to the OIG with the appropriate overpayment amount and timeframe of the overpayment.

In FY19, WARP received a total of 9,587 allegations of potential fraud, waste and abuse. These inquiries were received through phone calls, internet, mail, and e-mail. Of these, 336 cases were reviewed and a total of \$1,106,168 in SNAP and TANF overpayments were established.

FY19 WARP Highlights

Referrals Received: 9,587

Staff: 5 (with additional three Graduate Public Service Interns)

Recipient Program Overpayments Established:

BOC Local Office SNAP: \$1,062,683

BOC Local Office TANF: \$43,485

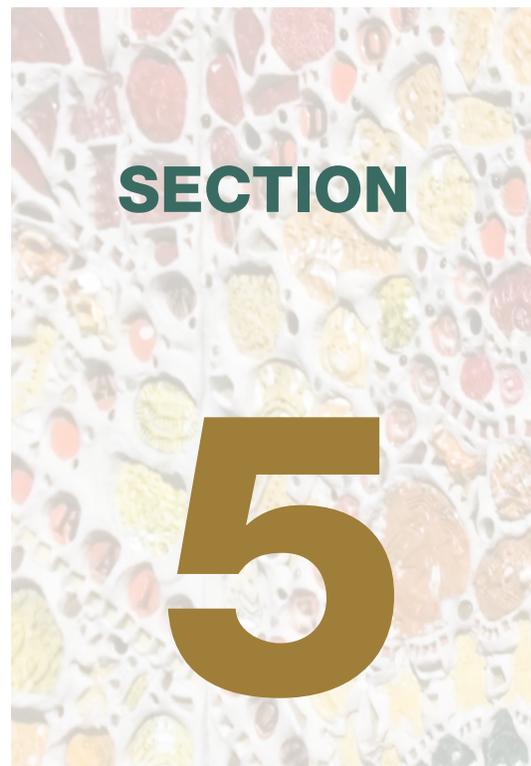
Total: \$1,106,168

All allegations of recipient fraud are set up by WARP and are researched and vetted through a variety of proprietary State and Federal databases. Some referrals can be completed without an interview or field visit based on current case information, electronic verification, employment verification, school verification and court orders. Given the volume of fraud referrals received, the backlog of pending investigations into allegations remains large.

Last year's CMS Rapid Results project proved to be successful, reducing the backlog of outstanding referrals from 17,398 as of July 2018 down to 1,819 as of February 2019. The backlog began to increase however, when the additional position which had been created was subsequently vacated. The new workflow was successful, but given the reduction in staffing, the ability to keep up with the constant intake of referrals while addressing the increasing backlog will be challenging. As of the end of FY19, the backlog increased to 2,349 pending referrals.

WARP was able to additionally reduce the backlog in August 2018 by utilizing system matches and data gathering tools. This process allowed for an exorbitant number of referrals received from the United States Department of Agriculture (USDA) to be consolidated into a single file. The system was able to auto-create cases for staff which greatly improved efficiency in the review process by speeding up the time it takes to review a case.

Bureau of Medicaid Integrity



Bureau of Medicaid Integrity

Audits, LTC-ADI, Peer, Quality Control (QC)

The Bureau of Medicaid Integrity (BMI) performs compliance audits, quality of care reviews and special project reviews of providers in addition to conducting quality control eligibility reviews and Long-Term Care-Asset Discovery functions. The sections within the Bureau include: Audit, Peer Review, Long-Term Care Asset Discovery Investigations (LTC-ADI) and Central Analysis/Quality Control (QC).

Audits

The Audit Section of BMI conducts program integrity audits on all provider types enrolled as Medicaid providers and who receive reimbursement from Healthcare and Family Services. The Audit Section is also responsible for the oversight of the Certified Public Accountant vendors, the Universal Program Integrity Contractor (UPIC) and the Recovery Audit Contractor (RAC) program as required by the Affordable Care Act (ACA).

The OIG performs pre-payment and post-payment audits, to ensure that the Department makes appropriate payments to providers, as well as to prevent and recover overpayments. Through these audits, the OIG ensures compliance with State and federal law and Department policy. All Medicaid providers, claims, and services are subject to audit. The OIG uses several factors in determining the selection of providers for audit, including, but not limited to, data analysis; fraud and abuse trends; identified vulnerabilities of the Program; external complaints of potential fraud or improper billing; and a provider's category of risk.

In general, the OIG's internal audits fall into the following categories:

- **Desk Audits** involve audit findings based mostly on the use of data analytics and algorithms that electronically analyze specific billing and reimbursement data. The OIG verifies the data outcomes using applicable law, regulations, and policy.
- **Field Audits** require a manual review of medical or other documentation by auditors. Field Audits also use data analytics, but require a more thorough verification process by qualified professionals.

FY19 Audit Highlights

Audits Initiated: 244

Audits Completed: 423

Re-Audits: 2

Total Overpayments Collected: \$13.7 million

- **In-House Field Audits** mirror the same processes and procedures as a desk audit except that the auditor or team of auditors conducts an on-site visit prior to the audit being commenced.
- **Self-Audits** involve audit findings based upon external and/or internal referrals or by internal OIG data analytics. Self-Audits require the provider to review all audit documents and schedules to determine agreement and/or disagreement with potential overpayment findings. A reconciliation process is implemented until all audit findings are validated and finalized.
- **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. The Self-Disclosure Protocol Notice can be found at the following link.¹
- **Audit Sampling and Extrapolation** OIG audits may involve the use of sampling and extrapolation. Using statistical principles, the OIG selects a valid sample of the claims during the audit period in question and audits the provider's records for only those claims. The OIG then calculates an overpayment amount by extrapolating the findings of the sample to the overall universe.

External Contract Vendor Auditors

Certified Public Accountant (CPA) Audits

Certified Public Accountant (CPA) Audits currently assist the BMI Audit Unit in performing financial audits of Long-Term Care facilities. These audits are conducted on-site by the CPA firms/vendors and finalized by the BMI Audit staff.

¹ <http://www.illinois.gov/hfs/oig/Documents/ProviderSelfDisclosureProtocol.pdf>.

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Recovery Audit Contractor Audits

Federal law requires states to establish programs to contract with Recovery Audit Contractors (RAC) to audit payments to Medicaid providers. The OIG uses RAC vendors to supplement its efforts for all provider and audit types. Payment to the RAC vendor is a statutorily mandated contingency fee based on the overpayments.

Universal Program Integrity Contractor (UPIC) Audits

Universal Program Integrity Contractor (UPIC) Audits utilize the OIG's partnership with the federal Centers for Medicaid and Medicare Services' Center for Public Integrity (CMS-CPI). CPI offers states the use of UPIC auditors, to perform targeted audits at no cost to the state.

Audit Section and the External Audit Vendors

In FY19, the Bureau's Audit Section and the External Audit vendors completed a total of 423 audits on Medicaid providers to ensure compliance with Department policies. The Audit 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 via installment payments received from the provider. In FY19, the total amount of overpayments collected was \$13.7 million which is comprised of overpayments identified in FY19 and installment payments received from prior year audits.

FY19 Audit Initiatives

• Audit Package Implementation

The Audit section has implemented new audit package templates that are to be used for every provider type audited and every type of audit performed. These new packages are streamlined to bring forth efficiency, effectiveness and transparency of the audits to the provider(s). The audit packages will include all legal authorities, policies and procedures in addition to detailed description of the audit findings. With the implementation of these new audit packages, the audit conferences have run more efficiently and effectively and have resulted in fewer appeals from the providers on the audit finding(s).

• Electronic Health Record Audits

The Illinois Department of Healthcare and Family Services is required to comply with the provisions of

the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act). The Illinois Department of Healthcare and Family Services (Office of Inspector General) is mandated to implement an annual Electronic Health Information Technology Auditing Plan to ensure that all Eligible Professionals (EPs) and Eligible Hospitals (EHs) successfully demonstrate meaningful use of certified EHR technology. The OIG performs audits of a random sample of all EP/EH providers to ensure that providers who have attested to the adoption, implementation, or upgrade (AIU) of certified EHR technology have the adequate documentation to support the AIU efforts and to ensure that appropriate federal incentive payments for EHR implementation have been made to these provider(s). In FY18, the OIG performed 63 audits of EHR eligible professionals for AIU certification. All providers during this audit period attested and were certified as meeting federal AIU requirements.

In FY20, the OIG will continue efforts to audit EHR providers for AIU requirements in addition to beginning efforts to audit eligible professionals and eligible hospitals for Meaningful Use (MU) requirements. The OIG is planning on conducting audits of at least 10% of all EP and EH providers and 100% of providers who are determined to be high-risk providers (as determined by risk scores defined in the HFS-OIG EHR Audit Plan).

• Hospital Global Billing Payments

In FY19, the OIG performed 63 audits to identify and potentially recover \$70,326 in overpayments made by the Department to hospitals who billed the professional component of a laboratory or X-ray service in addition to a physician billing the professional component for the same recipient on the same date of service with the same procedure code. The hospitals, as a part of this initiative, have made successful efforts to fix their internal billing systems to ensure that these global billings do not occur in the future. The OIG is also working with these hospitals in receiving global billing self-disclosures to remedy this duplicate payment situation.

Importantly, beyond recovering overpayments, the Global Billing Initiative established a positive and transparent process that allows the hospitals to review

Bureau of Medicaid Integrity

their own internal billing processes. Further, as a result of the self-audit, several hospitals implemented changes to their internal billing processes to prevent overpayments from occurring in the future. As a result, the Global Billing Initiative process has resulted in an estimated cost-avoidance amount of approximately \$500,000 in FY19.

• **Prevent Payment for Deceased Recipients**

In FY19, the OIG continued initiatives focused on areas of identified Program vulnerabilities. This includes preventing payments and recovering overpayments made for deceased recipients. In FY19, the OIG had 13 audits remaining to complete. FY19 identified and recovered \$1,058 in overpayments made by the Department for deceased Medicaid recipients. Further, the OIG conducted outreach to provide education on healthcare fraud laws and Department regulations pertaining to the improper billing for payments for deceased recipients. 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. Importantly, as part of the OIG evaluation of these cases, the OIG identifies instances of credible allegations of fraud and appropriately refers the cases to law enforcement partners for further criminal investigation.

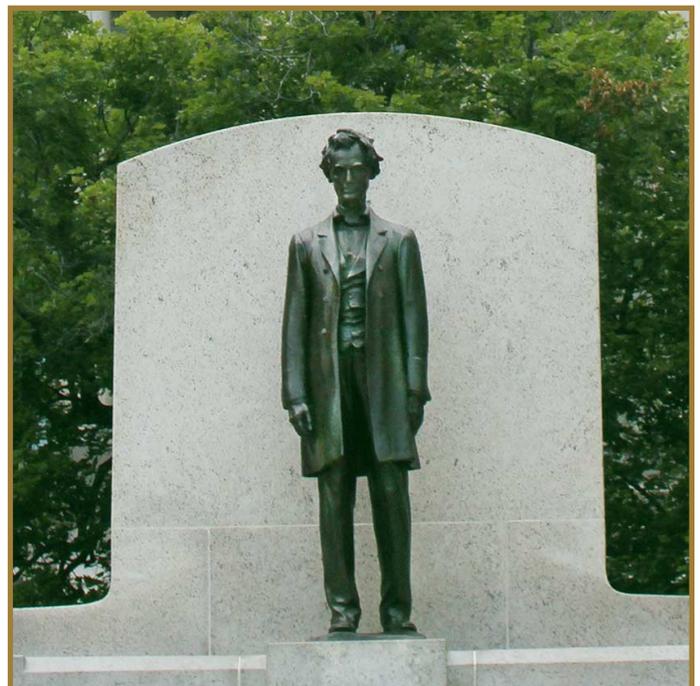
• **Transportation Audits**

In FY19, the OIG performed 93 audits to identify and recover \$111,129 in overpayments made by the Department for transportation providers who billed for services during an Inpatient Stay not covered by HFS policy, duplicate transportation billings and loaded mileage billings. Loaded mileage is where there is more than one recipient in the same vehicle at the same time/trip and the provider bills HFS for both recipients. According to HFS policy, the transportation provider can only bill for one recipient and therefore, the billings for the additional recipient is a loaded mileage overpayment. The OIG continues to run this algorithm audit on a yearly basis and is currently working with Transportation providers to ensure HFS policies are followed and these types of erroneous billings do not occur in future billings to the Department.

FY20 Audit Initiatives

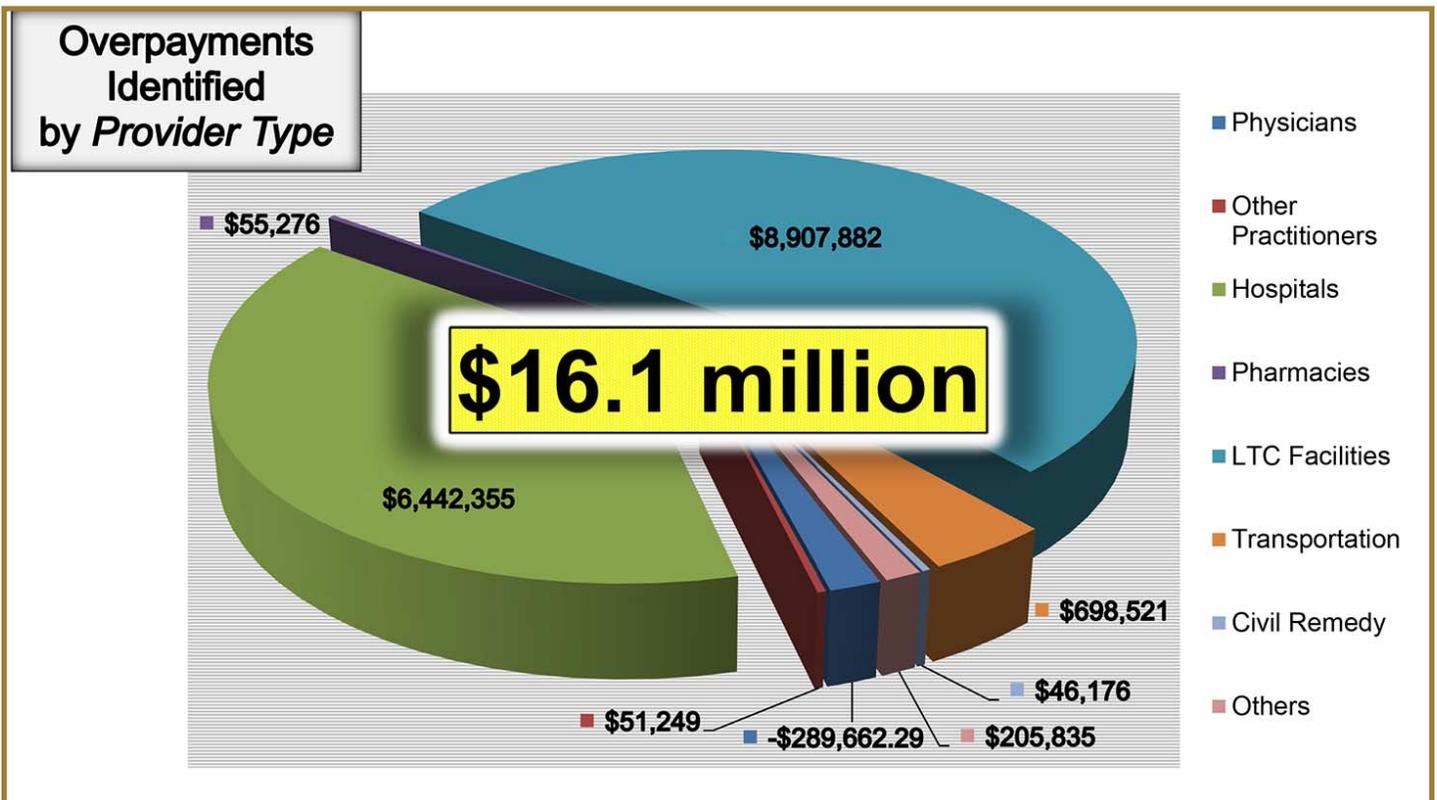
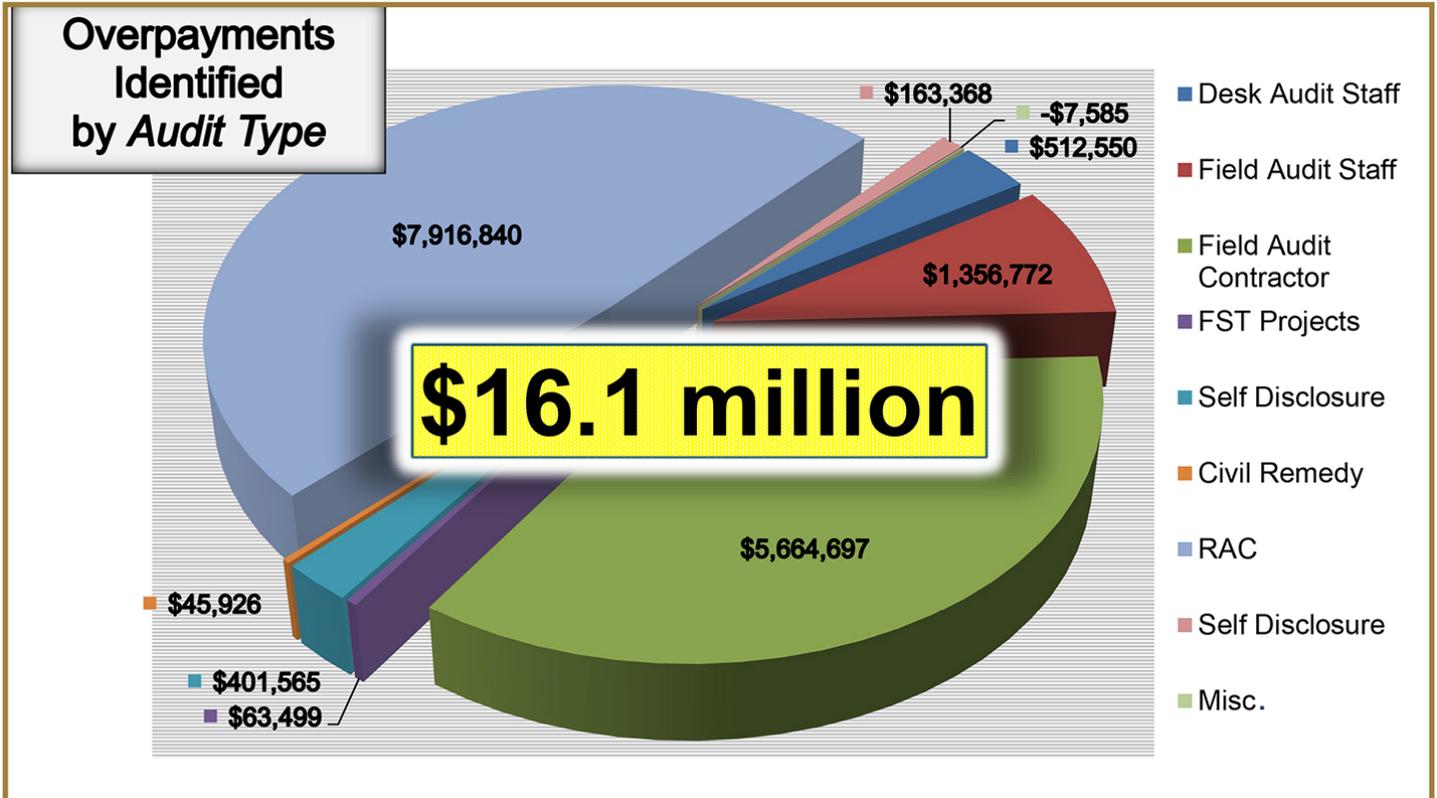
In addition to the continuation of the FY19 audit initiatives, the following will be added to the FY20 audit initiatives:

- **Behavioral Health, Laboratories and Hospice Audits** - the Audit Section will be working with the Universal Program Integrity Contractor (UPIC) to identify overpayments made to providers of Behavioral Health, Laboratories and Hospice services. These audits will be expansive field audits that will be conducted in a joint effort to combat fraud, waste and abuse in these provider types.
- **Durable Medical Equipment Audits** - the Audit Section will be conducting audits on Durable Medical Equipment (DME) providers to identify issues of non-compliance with HFS policy and procedures. The audits will be focusing on services provided that are direct-shipped to the recipients, wheelchair, wheelchair supplies, diabetic supplies and other types of services.
- **Expansion of Long-Term Care Audits** - the Audit Section, in conjunction with the CPA vendors and the RAC vendor, will be conducting financial audits on a wider population of LTC facilities across the State of Illinois.

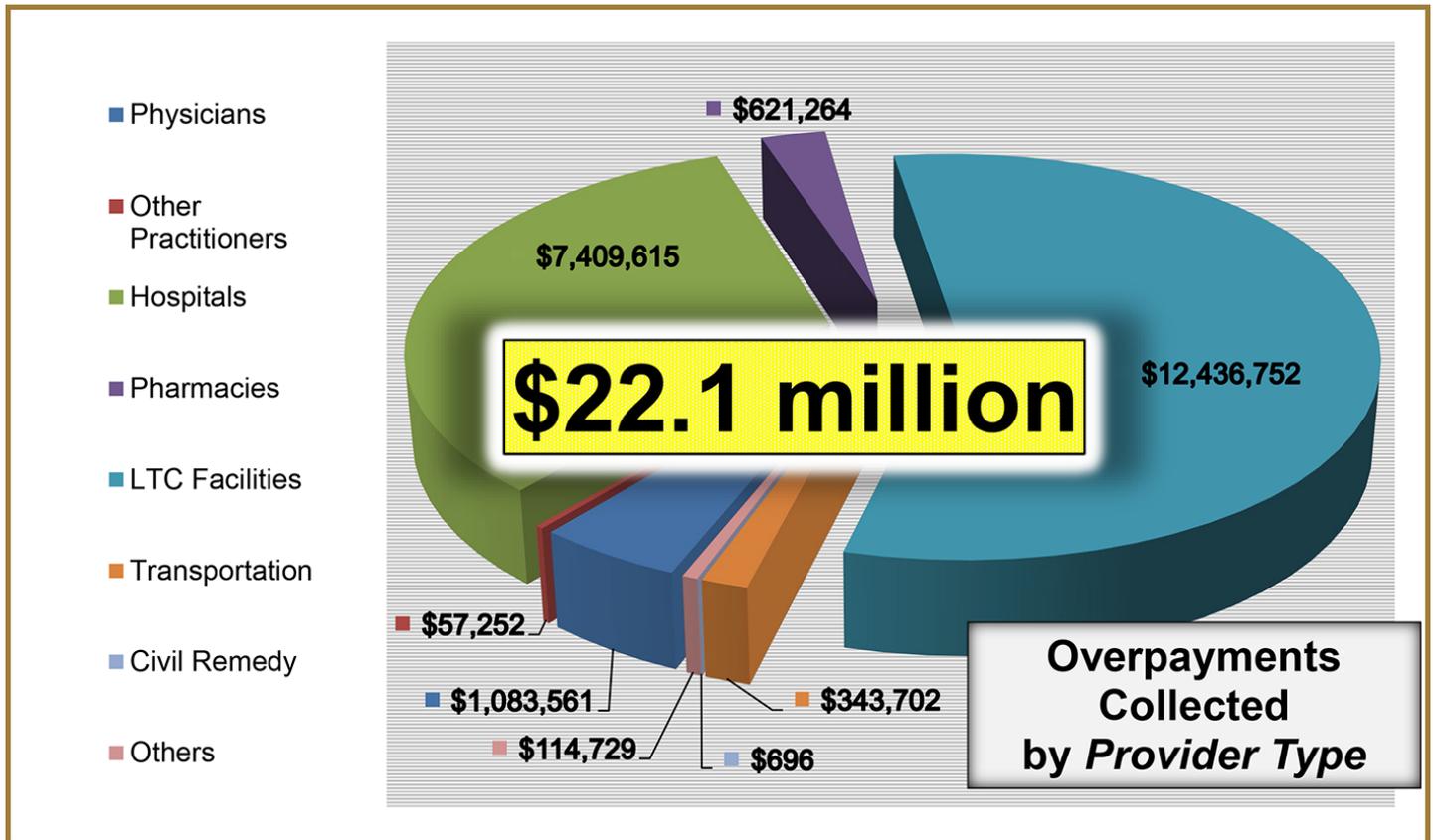
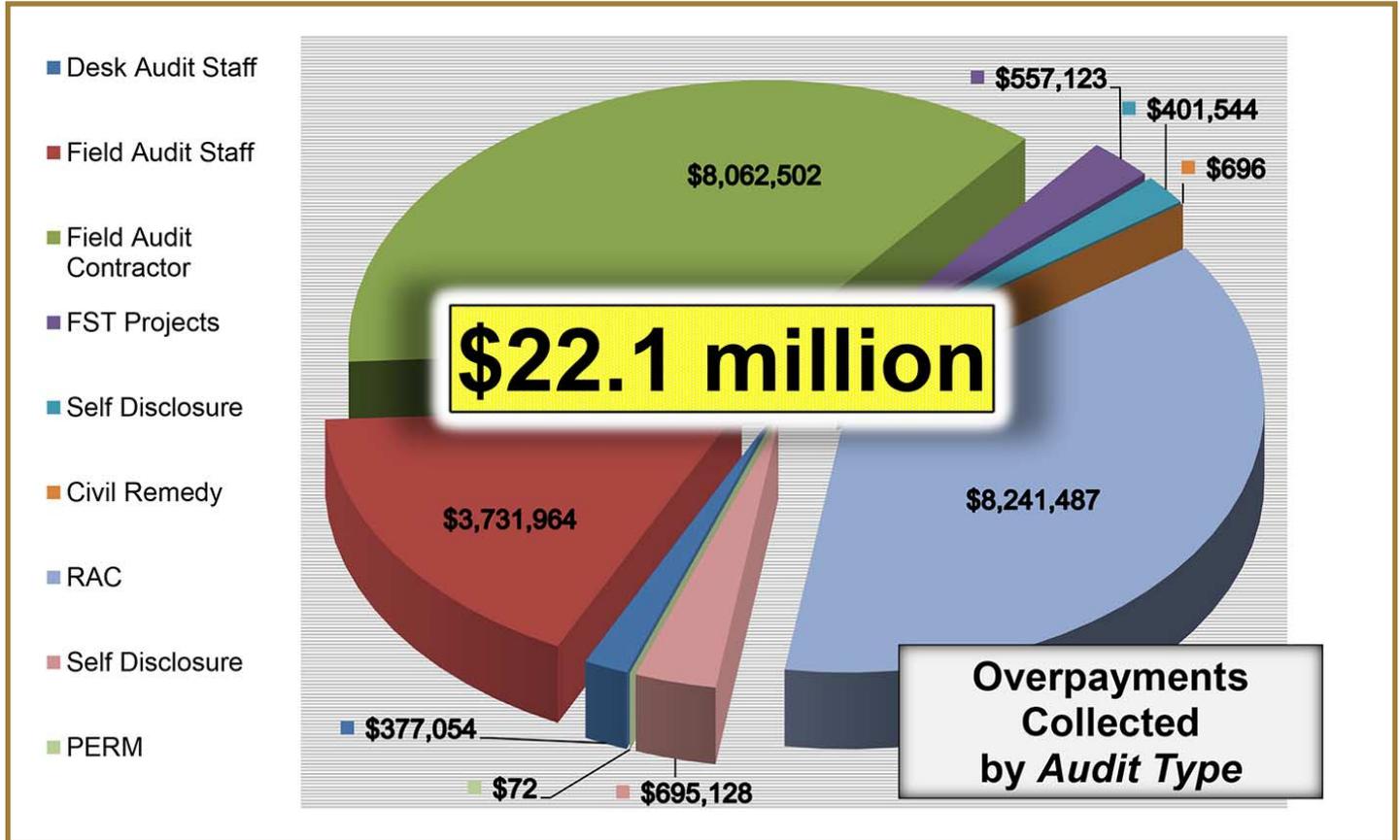


Bureau of Medicaid Integrity

The following charts identify the number of audits and the number of overpayments identified and collected in FY19 broken down by both provider and audit type.



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LTC-ADI

The Department is responsible for the Medicaid Long-Term Care (LTC) Program for approximately 55,000 eligible Illinois residents in over 738 nursing facilities. Illinois residents can apply to have the State pay for their long-term nursing home services. Individuals are eligible for such assistance if they have less than \$2,000 in resources and have not made unallowable transfers in the last five years. While all states are required to perform asset transfer look-back reviews pursuant to the Deficit Reduction Act of 2005, Illinois is the only state in the nation with a dedicated Long-Term Care-Asset Discovery Investigations (LTC-ADI) Unit of this size. This is also the only unit to have a review look-back period of five years on asset reviews. As such, Inspector General Hart presents nationally about the successes of the Unit, its processes, and its cost savings to the taxpayers of Illinois.

The unit is responsible for ensuring that LTC residents requesting coverage for LTC services are eligible and in compliance with federal and state regulations before they receive State assistance. The goal of the unit is to ensure that individuals applying for LTC services do not have excess resources or unallowable transfers of resources, which would allow them to pay for their own nursing

FY19 LTC-ADI Highlights

Applications processed: **2,171 applications**

Total savings of **\$136,387,099**

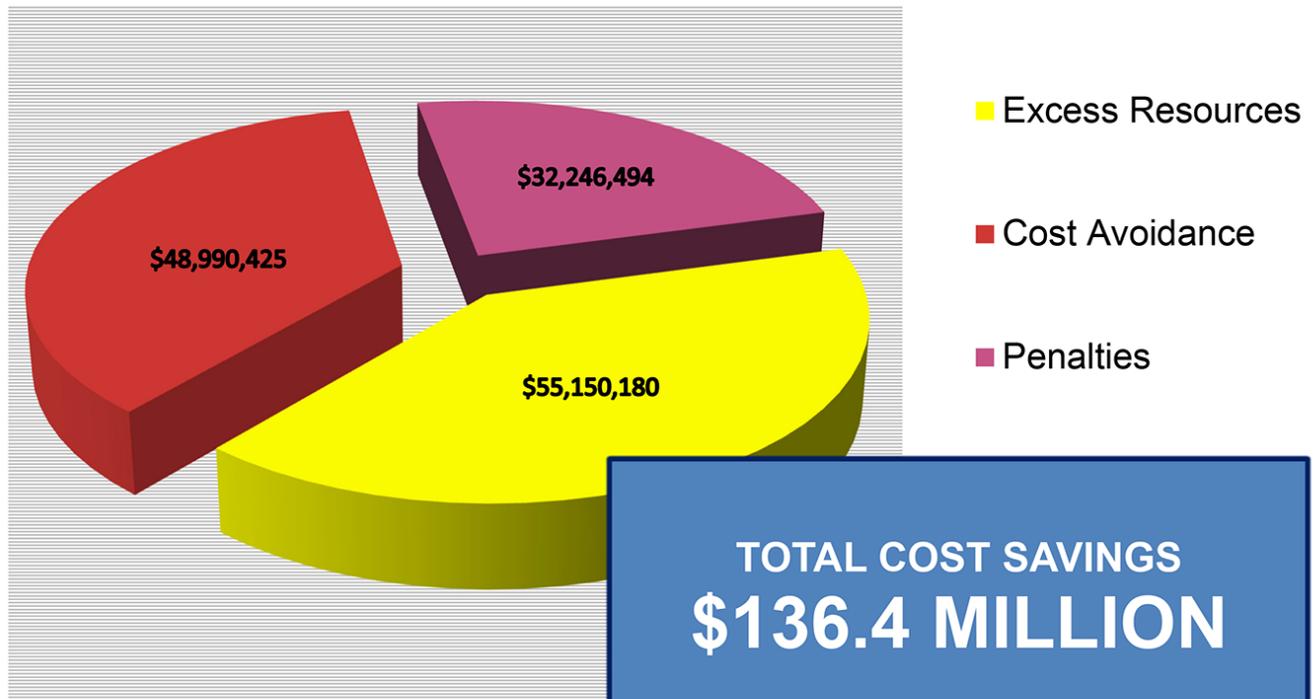
ROI of **\$42.39** for every \$1 spent

home care. By preventing improper conduct related to eligibility, the LTC-ADI Unit ensures program funds go to qualified applicants who have no other means to pay for their own care. Applications are referred to the OIG from the DHS Family Community Resource Centers (FCRCs) as a result of meeting specific criteria. LTC-ADI analysts complete reviews of financial records and applicant information up to five years back from the date of the application for benefits. Directives are made and then provided back to the FCRCs to allow DHS to send out notices advising applicants of their eligibility for the program.

What are excess resources?

Excess resources are any asset or resource that one has available to use as payment for the cost of their care, over the \$2,000 allowed per statute. For example, if an individual has an investment account, it should be used to pay for their care.

Long Term Care - Asset Discovery Investigations



(Continued on page 40)

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If an individual has excess resources they will be required to spend down the value of the resources before the State of Illinois will pay for their care.

Common statements made by applicants when the analysts determine they have excess resources:

“I have to use my investment account to pay for my care?”

“I thought that since the property was in a trust that I protected it.”

“But what about my inheritance?”

“I didn’t report on my application that I had farm ground, because I want my kids to inherit it.”

“I shouldn’t have to use all my 401k funds to pay for my husband.”

FY19 Case Examples of Excess Resources

During the review of an application submitted by a nursing home for an applicant, an analyst determined minimal information was disclosed regarding her assets. Further research uncovered that the applicant owned 158 acres of farm ground, farm machinery and livestock. The total amount of excess resources available to the applicant was \$1,011,170, which were available to be used toward paying for long-term care benefits.

One applicant’s family applied for benefits on behalf of the applicant. Upon review of the application by the analyst, it was discovered that the applicant was receiving farm income of \$32,000 per year. It was also determined that the applicant had 120 acres of rolling black farm ground that could be liquidated to fund nursing home care for several years. The total amount of excess resources for the applicant was \$1,415,180.

After a thorough review by an analyst of an application, it was determined that the applicant set up an irrevocable trust in 2008, prior to the five-year review and put his 83.88 acres of land into this trust. The items in the trust were deemed available to be used by the applicant for long-term care benefits. This case was appealed, and the Bureau of Administrative Hearings upheld the

Department’s decision, indicating that the applicant had \$623,022 of excess resources available to use for care.

An analyst reviewed an application which reported no resource information for the applicant. During the review process, it was discovered that the applicant owned an investment and bank account with a value of \$26,000, in addition to a condo with a value of \$103,860. Given these available resources, it was determined that the total amount of resources that are available for the applicant to use for their care was \$129,860.

A review of an application filed by a nursing home on behalf of an applicant, listed only one bank account for the applicant in the amount of \$2,214. Upon further review of the bank statements, the analyst discovered three new accounts and stock which was traced back through several deposits made into the bank account. It was determined that the applicant had \$138,046 that was available to use to pay for their nursing home care.

What is an unallowable transfer?

An unallowable transfer is a transfer of an asset or a resource prior to applying for benefits. These types of transfers are a common tactic of concealing assets. For example, if an individual owns a property and transfers it to a relative prior to applying for LTC benefits, this would be an unallowable transfer. If an unallowable transfer occurs, a penalty period will be imposed for the applicant for attempting to divert assets. A penalty period is the period of time that the State will not pay for long-term care benefits to the applicant. The length of the penalty period is calculated by the dollar amount of the penalty and divided by the private pay rate, resulting in the total number of months of the penalty.

Common statements made by applicants when the analysts determine they have made unallowable transfers:

“I took all my mom’s money because I thought she was going to die...she didn’t die...but I wasn’t expecting to have to pay the nursing home.”

“My mom wanted our family to take a vacation.”

“That was our family’s farm; we are entitled to it.”

“Dad used his retirement account to help out our family; that is what he wanted.”

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FY19 Case Examples of Asset Concealment/Unallowable Transfers

Upon review of bank statements for an application, the analyst found that someone withdrew large amounts of money and that the bank issued a debit card in the applicant's name while she was institutionalized. The applicant had been admitted to the nursing home prior to the five year look back. The debit card was used daily while she was in the nursing home. A penalty was imposed for the misuse of funds totaling \$203,803.

An analyst reviewed an application and determined that the applicant had paid caregivers for up to 19 hours per day during a period when the applicant resided in a long-term care facility. Caregiving expenses alone totaled between \$3,000 to \$5,000 per month. The case was appealed, and the applicant's attorney argued that fair market value was received for the services provided and that additional caregivers were necessary for appellant to be comfortable in the facility. However, the applicant was unable to show any medical need for the caregivers. The Bureau of Hearings upheld the penalty of \$353,838 imposed by LTC-ADI.

An applicant's brother filed an application for benefits. Upon thorough review of the bank statements, the analyst proved that the applicant's brother, also the POA for the applicant, was transferring funds to his own account. A total of \$156,000 was transferred to the brother's account, leaving the applicant without any funds to pay his nursing home charges. A penalty was assessed for \$156,000.

Upon review of documentation by the analyst, it was revealed that prior to an applicant applying for benefits, the homestead property was transferred to her son. The applicant then subsequently paid the son rent to live in that same property. While paying rent on the son's property, the applicant updated the house with new wood flooring, carpeting, new cabinets and new appliances using personal funds. The applicant also gifted money to the son as well as a friend. Total amount of penalty for the remodeling expenses and the gifting was \$289,592.

During an application review, the analyst found that an applicant had owned an oil business a few years before applying for long-term care benefits. The applicant sold the business for fair market value of \$100,000. However,

the analyst did not see a deposit of \$100,000 into the applicant's account and subsequently determined that the funds were deposited into an account owned by another family member. A penalty was imposed for this case in the amount of \$100,000.

Upon review of an application, the analyst uncovered that the applicant's family visited with an Elder Law Attorney prior to filing the application for benefits, and (without the help of the attorney), created an Irrevocable Trust approximately two years prior to filing the application for LTC benefits. Multiple assets were added to the trust including the house. The value of resources put into the trust totaled \$245,777 for which a penalty was assessed for the entire amount.

An analyst review of an application uncovered that an applicant's daughter owned an art gallery, that was funded by the applicant's money in the amount of \$3,000-\$5,000 per month. A review of assets determined that no money or art was ever returned to the applicant. The case was appealed and eventually the nursing home withdrew the appeal as they could not show that the applicant had received fair market value. The total penalty imposed on this case was \$246,683.

An analyst discovered that an applicant had transferred their interest in real property and an investment account to her community spouse. The community spouse then transferred those resources to a revocable trust. The trust provided that upon his death, the resources would be distributed to his children. The applicant's community spouse passed away during the review period. Accordingly, the OIG imposed a \$199,084 penalty. The applicant's attorney argued that transfers to the community spouse were allowable and that a penalty could not be imposed based solely on the death of the community spouse. The Bureau of Hearings determined the community spouses' actions to establish a revocable trust (which was available to the applicant during his life, but unavailable upon his death) was a transfer of resources and thereby upheld the penalty of \$199,084.

Processes

The LTC-ADI Unit assumes responsibility for all appeals during the appeal process, as well as for all spend down and penalty issues that have been determined by the unit. The unit also assumes the additional responsibility of granting Hardship Waivers to

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individuals whose welfare might be irreparably affected by the application of a penalty. Hardship Waivers act to waive either a penalty, partially or entirely, if it is determined by a committee within the unit that specific conditions are met. The individual receiving the waiver is responsible for submitting evidence that proves a hardship exists.

LTC-ADI is proactively working on researching new and revised workflow methods to implement. The processing of long-term care benefit applications has been a “hot topic” for years; however, the process is cumbersome for both the applicants and the analysts. Reviews are often lengthy and can extend for many months, as applicants must spend time obtaining the necessary documentation before the analysts can review the documents.

Senate Bill #2913 was passed in the General Assembly and signed into law on August 2, 2018, which streamlined the processing of non-complex applications; however, this did not affect the LTC-ADI unit’s processes. During FY19, the Department implemented a policy known as “Provisional Eligibility” (PE) pursuant to an injunction order in *Koss v. Eagleson*. Under PE, the Department must approve pending applications for long-term care benefits when it fails to decide on the application within federally mandated timeframes.

Currently, the LTC-ADI unit consists of 24 staff members, including: a manager, clerical staff, analysts, supervisors, and an attorney. The clerical staff assist with research and obtaining documents, such as applications or verifications of assets, from the Integrated Eligibility System (IES).

Once all documents have been collected, they are provided to the analysts for examination to determine if any resources are available to the applicant to spend towards their care or if any unallowable transfers of resources occurred in the prior 5 years. Often, the analysts must request additional information from the applicants, which can cause significant delay in the processing of the applications. The analysts are responsible for completing a directive for each case which is sent to the DHS office for processing. Supervisors review the work of the analysts, train new staff, and assist with the hearing process. The LTC-ADI Attorney is responsible for providing legal counsel on all legal issues such as trusts, wills, divorce, separation, spousal refusal, and spousal transfer.

As stated above, the LTC-ADI unit often faces legal issues in the public eye. The nature of the review process itself is lengthy. Any delays in the process of applicants providing resources and documentation to the unit further exasperates the delay in processing the applications. The application and financial reviews are laborious and tedious. The average amount of time it takes for each case to be reviewed by an analyst is 8-10 hours. The LTC-ADI unit regularly works overtime to minimize delays in processing. The OIG’s headcount is very limited and staff turnover is also an issue for the unit. Many alternative workflow processes have been utilized to reduce the backlog and create efficiency. Currently, the unit has the most successful process in place for both efficiency and accuracy given the influx of approximately 250 new cases received every month.



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Peer Review

The Peer Review Section conducts quality of care reviews and monitors utilization of services rendered to Medicaid recipients from records submitted by a provider/applicant. Quality of care concerns are summarized in the categories of risk of harm, medically unnecessary care or care in excess of needs, and grossly inferior quality of care. Risk of harm is identified when there is a risk to the patient that outweighs the potential benefit of the service. Medically unnecessary care or care in excess of needs is identified when the care provided to the patient is not medically necessary and/or in excess of the patient's needs. Grossly inferior quality of care is identified when "flagrantly bad care" is provided to a patient. Peer Review conducts reviews of physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. Peer Review cases can originate from hotline/complaints, referrals from the Provider Analysis Unit, Recipient Restriction Unit, Audit Unit or other agencies such as the Illinois Department of Financial and Professional Regulation (IDFPR), Illinois State Police (ISP), or Illinois Department of Public Health (IDPH).

Peer Review also re-reviews cases where providers have been previously reviewed and quality of care concerns were identified, but were not serious enough to terminate the provider. Peer Review will review the provider again to see if the concerns have been rectified. If a provider was terminated, suspended, or withdrew from the Program and submitted his/her enrollment application in IMPACT, a reinstatement case will be created and sent to the Peer Review to conduct a quality of care review. If a potential provider submitted his/her application in IMPACT, but had a red flag such as a discipline on their license, an enhanced enrollment case will be created and sent to the Peer Review to conduct a quality of care review.

The Peer Review staff reviewer can visit the provider's office to obtain recipient records or may request the provider send the office records to OIG. A written report documenting the quality of care concerns and the recommendations is subsequently completed by the staff reviewer. Possible recommendations may include case closure with no concerns; case closure with minor deficiencies identified and sending a letter to the provider identifying these minor concerns; or a referral to a consultant for further review of potentially serious concerns. The consultant will review the office records

FY19 Peer Review Highlights

Total Cases Open and Assigned: 120

Full Peer Review: 46

Modified Peer Review: 0

Reinstatement Review: 4

Enhanced Enrollment Review: 4

EQ Health Review: 66

and will submit a written report to the OIG identifying quality of care concerns along with a recommendation to the Department. The consultant may recommend that a letter be sent to the provider outlining quality of care concerns and recommendations when minor concerns are identified. If the consultant has identified more serious quality of care concerns, the Department will request that the provider attend a Medical Quality Review Committee (MQRC) meeting to discuss the care provided and attempt to clarify or discuss the concerns identified with the provider. The MQRC committee will consist of two to three consultants of like specialty. If the provider is board certified, at least one committee member must be board certified in the same branch of medicine. The MQRC makes a recommendation to the Department prior to the conclusion of the meeting and after the provider is dismissed. The committee may recommend that the provider be sent a letter identifying concerns that the provider should correct in his/her practice, suspension, corporate integrity agreement in lieu of termination, termination, denial of reinstatement, denial of enrollment, or referral to the Audit Section if potential compliance issues are suspected. In addition, a referral may be sent to IDPH and/or the IDFPR for related regulatory actions.

Total Cases on Tickler or Needing Assigned: 103

Full Peer Review: 99

Modified Peer Review: 2

Reinstatement Review: 2

Enhanced Enrollment Review: 0

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QC (Quality Control) Federally Mandated Reviews

Since the early 1980s, the State has been mandated by the Federal Centers for Medicare and Medicare Services (CMS), to conduct reviews of eligibility determinations as set forth in 42 CFR § 431 Subpart P. At the onset of this mandate, the reviews were conducted by the Department of Public Aid (DPA) and consisted of all three federal programs – Aid to Families with Dependent Children (AFDC), Food Stamps and Medicaid. Currently HFS (formally DPA) conducts the Medicaid reviews (Medicaid Eligibility Quality Control – MEQC). DHS is responsible for the Supplemental Nutritional Assistance Program (SNAP) and AFDC quality control reviews.²

Medicaid reviews performed from the 1980s to the early 1990s were considered traditional reviews, meaning they were standardized reviews of a random sample of all Medicaid eligibility determinations in the universe. In the early 1990s, CMS offered the States the option of conducting reviews targeted at troubled areas. The OIG took advantage of this offer and began conducting reviews of troubled areas as identified through previous traditional reviews. Two current OIG programs were created as a result of these reviews – the New Provider Verification process that visits, surveys, investigates and monitors high-risk providers and the Long-Term Care Asset Discovery Investigations (LTC-ADI) – an investigation of asset transfers prior to the approval for LTC services. LTC-ADI has resulted in hundreds of millions of savings to the State.

In 2012, QC was mandated by CMS to conduct eligibility reviews for the Payment Error Rate Measurement (PERM) program as set forth in 42 CFR § 431 Subpart Q. These reviews occur every three years and are conducted by all states. They are designed to develop a national payment error rate, as well as correct errors identified and minimize their reoccurrence through a Corrective Action Plan (CAP). The CAP requires the coordination of both the Department and the Department of Human Services (DHS), and is monitored by CMS for completion. The OIG works with CMS contractors to identify the universe, finalize the sample, gather case records and review the cases.³

As required by 42 CFR § 455.20 and § 433.116, the OIG operates the Recipient Verification Procedure (RVP). Letters are sent to 500 recipients each month to verify

whether services billed by providers were received. The universe of paid claims is identified each month and 500 claims are randomly selected. Recipients are requested to e-mail or phone the OIG office with their response as to whether they received the service. The “no” responses are analyzed and considered for further action (provider audit, focused provider review, referral to Medicaid Fraud Unit, etc.).

During FY19, QC performed reviews for MEQC, PERM and RVP which resulted in the following:

- 94 of the remaining 997 MEQC eligibility reviews of Medicare eligible recipients to ensure they were covered under the State’s aid to the Aged, Blind and Disabled (AABD) program and not incorrectly placed into the Affordable Care Act (ACA) population as federal matching funds are higher for the ACA program. Of the cases 997 reviewed, 65 (6%) were determined to be AABD eligible. Findings were sent to the administrative local offices responsible for each of these 65 cases with instructions for correcting.
- 6,498 letters sent to recipients to verify the receipt of services. Of the letters sent, the OIG received 1,224 responses. 1,177 recipients (18%) stated “yes” they received the services, 31 recipients (less than 1%) stated “no” they did not receive the services and 16 recipients (less than 1%) stated they were “not sure” they received the services. For the remaining 5,274 (81%) letters sent, no response was received from the recipients.
- 978 PERM eligibility reviews for the review year (RY) 2019. These reviews were completed by a federal contractor. QC staff collected the case review documentation and reviewed the findings. CMS will issue the final report in November 2019. PERM error rate findings and reports can be found here on the CMS website.⁴ QC continues to work with CMS to complete a CAP, due February 2020, to prevent and/or eliminate future errors.
- 114 MEQC RY20 reviews of Medicaid and Children's Health Insurance Program before (CHIP) applications, renewals, denials and cancellations (closed cases). A total of 800 cases are required to be reviewed for federal reporting on or before August 2020.

² The AFDC program changed to the Temporary Assistance to Needy Families (TANF) in 1996.

³ PERM also includes medical record and data processing reviews which are coordinated by the OIG. The OIG also coordinates and ensures the completion of the Corrective Action Plan (CAP) for these reviews as well.

⁴ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIPCompliance/PERM/PERMErrorRateFindingsandReport.html>

The Office of Counsel to the Inspector General

SECTION

6

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 Department programs and operations, as well as providing all legal support for the OIG's internal operations. OCIG represents the OIG in administrative fraud and abuse cases involving Department programs. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements between providers and the Department. OCIG renders program guidance to the OIG Bureaus, as well as to the health care industry as a whole, concerning healthcare statutes and other OIG enforcement activities.

OCIG drafts and monitors legislation and administrative rulemaking that impacts fraud, waste, abuse and the overall integrity of the Illinois Medicaid Program. OCIG is also responsible for the enforcement of provider sanctions and represents the Department in provider recovery actions; actions seeking the termination, suspension, or denial of a provider's Program eligibility; state income tax delinquency cases; civil remedies to recover unauthorized use of medical assistance; and legal determinations affecting recipient eligibility for the OIG's LTC-ADI unit. Finally, OCIG assists with responses to Freedom of Information Act and subpoena requests.

In FY19, OCIG terminated, denied, suspended or excluded 177 providers, individuals and entities from participation in the Illinois Medicaid Program. Searchable exclusions lists are available on the OIG Website. Providers and owners who are terminated or debarred from the Program are restricted from participating in the Program and may not be employed by any entity receiving payment by a Federal or State healthcare program. Of the 177 providers terminated, denied, suspended, or excluded, 87 were Personal Assistant. OCIG also completed 90 Personal Assistant (PA) terminations and/or recoupment cases with the Bureau of Administrative Hearings (BAH). OCIG investigated, processed and won 298 recoupment cases, of which 4 were new post mortem recoupment cases.

FY19 OCIG Highlights

Hearings Initiated

Termination Cases: 81

Term/Recoup Cases: 35

Recoupment Cases: 117

Final Actions

Termination Cases: 173

Voluntary Withdrawals: 2

Recoupment Cases: 298

Debarment:* 13

Reinstatement Actions

Denied Applications: 4

Reinstatement Cases: 5

Disenrollment Cases: 15

Payment Withholds¹: 24

Total Medical Provider Sanction Dollars

Funds Put to Better use: \$8,965,669²

FY19 OCIG Highlight Cases – Settlements

Doctor to pay \$1.6 Million in Settlement to the Department

The Audit Section conducted an audit of Dr. Sam Lipshitz and found he billed for services provided by other doctors and that his medical records did not substantiate medical necessity for the services provided. The Department finalized a settlement agreement for \$1.6 million to be paid over five years. As part of the agreement, Dr. Lipshitz may not bill the Department until the \$1.6 million is paid in full. Additionally, a significant monitoring program was established to ensure that the repaid funds will not be derived from future erroneous billings.

¹ This number represents new payment withholds imposed during FY19 under all provisions under the jurisdiction of the OIG including noncompliance with Department requests.

² Includes cost savings of \$760,920 and \$8,204,749 in rejected billings.

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FY19 OCIG Highlight Cases - Terminations-Exclusions-Denials

Transportation Vendor Terminated Based on \$11K False Billing Scheme

In April 2019, a Final Administrative Decision (FAD) was issued by the HFS Director adopting an administrative law judge's recommendation to recover funds from non-emergency transportation provider, Cardinal VIP Transportation, for improper claims. During this audit period, the Department erroneously paid the provider \$11,204. Improper claims consisted of billing during an inpatient stay, loaded mileage and duplicate billing. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, the administrative law judge granted HFS-OIG's motion for a default and recommended the grounds asserted in the notice. The provider filed exceptions to the recommendation and the Department filed its response to the provider's exceptions. The Director reviewed the recommended decision and the exceptions. Based upon the review, the administrative law judge's decision was affirmed.

Doctor Terminated Based on Healthcare Fraud Kickback Scheme

In February 2019, Dr. Nalini Ahluwalia was terminated as the result of a criminal conviction for a healthcare fraud kickback scheme totaling \$33K. The Department ruled that the termination shall be effective for five years.

Doctor Terminated Due to Inactive Licensure

In December 2018, OCIG immediately suspended Dr. Sheldon A. Levine, D.O., alleging that his eligibility to participate in the Program should be terminated because his medical license was placed in permanent inactive status by IDFPR for sexual misconduct with patients. The administrative law judge recommended that his participation in the Program be terminated. The Director adopted the administrative law judge's recommendation and terminated Dr. Levine.

Convicted Felon Personal Assistant Terminated

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Lisa Stern, a PA, based on a prior criminal conviction for Felony Aggravated Battery. HFS-OIG proceeded to file an immediate suspension and a termination action. After Ms. Stern failed to request a hearing in writing, failed to appear at her hearing, and otherwise failed to proceed at her scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate the provider from the Illinois Medicaid Program.

Physician Denied Enrollment

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to deny Dr. Yvon Nazon's application to participate in the Illinois Medicaid Program. HFS-OIG filed to deny the application Dr. Nazon as he did not possess an Illinois medical license because it had previously been suspended by IDFPR. HFS-OIG proceeded to file a Denial of Application action. After the Applicant failed to request a hearing in writing, failed to appear at his hearing, and otherwise failed to proceed at his scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to deny Dr. Nazon's application to the Illinois Medicaid Program.

Doctor Terminated Due Healthcare Related Fraud and Kickbacks

In June 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Dr. Sonjay Fonn. HFS-OIG immediately suspended the provider and filed a Notice seeking to terminate the Provider based on IDFPR designating the provider's license to be on permanent inactive status because the provider had allegedly engaged in health care fraud. Fonn was civilly charged in the Eastern District of Missouri for Healthcare related fraud and kickbacks. The jury found him guilty, but the United States Attorney's Office is currently awaiting the final judgment from the Judge overseeing the proceedings. In addition, Fonn has

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begun legal processes which are still pending against Illinois Medicaid Recipients for “balance billing.” The Illinois Attorney General’s Office has been notified and is beginning to assist these Illinois residents.

Doctor Terminated Due to Inactive Licensure

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge’s recommended decision to terminate Dr. Jacinta Gillis. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the provider based on IDFPR’s refusal to renew the provider’s license because her medical license had been indefinitely suspended in Florida. HFS-OIG proceeded to file an immediate suspension and a termination action. After the provider failed to request a hearing in writing, failed to appear at her hearing, and otherwise failed to proceed at her scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate Dr. Gillis from the Illinois Medicaid Program.

Physician Denied Enrollment

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge’s recommended decision to deny the application of Franklin Harrison, D.O. HFS-OIG filed a Notice seeking to deny Harrison’s application due to his failure to produce documents to the Department despite repeated requests by the Department. HFS-OIG proceeded to file a Denial of Application action. After Dr. Harrison failed to request a hearing in writing, failed to appear at his hearing, and otherwise failed to proceed at his scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to deny the application of Dr. Harrison to the Illinois Medicaid Program.

Doctor Terminated Due to Suspended Licensure

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge’s recommended decision to terminate Dr. Natasha Shallow from the Illinois Medicaid Program. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate based on IDFPR’s suspension of the provider’s license because the provider’s medical license had been suspended in Montana. HFS-OIG proceeded to file an immediate suspension and a termination action.

After the provider failed to request a hearing in writing, failed to appear at her hearing, and otherwise failed to proceed at her scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate Dr. Shallow.

Doctor Terminated Due to Healthcare Related Fraud Conviction

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge’s recommended decision to terminate Lynn Zoiopoulos, D.O. HFS-OIG immediately suspended the provider and filed a Notice seeking to terminate the provider based on IDFPR’s suspension of the provider’s license because the provider had pled guilty to healthcare fraud. After the provider failed to request a hearing in writing, failed to appear at her hearing, and otherwise failed to proceed at her scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate Dr. Zoiopoulos from the Illinois Medicaid Program.

Doctor Terminated Due to Improper Prescribing

In February 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge’s recommended decision to terminate Dr. William McMahon. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the Provider based on IDFPR’s suspension of the provider’s license because the provider had improperly prescribed controlled substances. After the provider failed to request a hearing in writing, failed to appear at his hearing, and otherwise failed to proceed at his scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate Dr. McMahon from the Illinois Medicaid Program.

Doctor Terminated Due to Healthcare Related Fraud Indictment

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge’s recommended decision to terminate Dr. Omeed Memar. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the provider based on IDFPR’s suspension of the provider’s medical license because the provider had been indicted for healthcare fraud. HFS-OIG proceeded to file an immediate

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suspension and a termination action. After the provider failed to request a hearing in writing, failed to appear at his hearing, and otherwise failed to proceed at his scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate Dr. Memar from the Illinois Medicaid Program.

Doctor Terminated Due to Charges of Criminal Sexual Assault

In January 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Dr. Fabio Ortega. HFS-OIG immediately suspended the provider and filed a Notice seeking to terminate the Provider based on IDFP's suspension of the provider's medical license because the provider was charged with Criminal Sexual Assault. HFS-OIG proceeded to file an immediate suspension and a termination action. After the provider failed to request a hearing in writing, failed to appear at his hearing, and otherwise failed to proceed at his scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate Dr. Ortega from the Illinois Medicaid Program.

Doctor Terminated Due to Healthcare Related Fraud Conviction

In June 2019, a FAD was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Dr. Neil Sharma from the Illinois Medicaid Program. HFS-OIG filed a Notice seeking to terminate the provider because the provider pleaded guilty to healthcare fraud. The provider's attorney appeared at the hearing and stipulated to the provider's guilty plea for healthcare fraud. The OIG requested the administrative law judge to issue a recommended decision to terminate Dr. Sharma from the Illinois Medicaid Program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation and terminated the provider.

FY19 Highlight Cases – Long Term Care Asset Review

The Illinois Department of Human Services Bureau of Hearings (DHS-BAH) upheld the OIG's decision to impose a penalty period based on an applicant's transfer of real property to her daughter without receiving fair market

value. After review of the application, the OIG determined the applicant transferred her interest in real property valued at \$120,000 to her daughter without receiving any compensation. The applicant argued that the transfer should be allowable as a caregiver child transfer. The OIG argued that the applicant was not eligible for the caregiver child transfer as the daughter did not reside with the applicant or provide care to her in the two years immediately prior to her institutionalization. The parties agreed that applicant resided in an assisted living facility prior to her admission to long term care. The issue on appeal was whether her admission to the assisted living facility meet the definition of institutionalization to deem the transfer as allowable. In the final administrative decision, DHS-BAH found the applicant had not shown that the assisted living facility met the federal definition of nursing facility and, therefore, was not considered institutionalized. Accordingly, the transfer of the homestead to the caregiver child did not meet the requirements to be considered allowable as the daughter had not resided with her mother and provided care to her in the two years immediately prior to her institutionalization. The final administrative decision upheld the penalty in the amount of \$120,000.

DHS-BAH affirmed the OIG's decision to penalize an applicant for the following unallowable transfers. During the look back period, applicant made transfers of monetary gifts to his daughter in the amount of \$158,906, transferred mineral rights to his daughter in the amount of \$117,336, and sold real property for \$31,843 less than its fair market value. The applicant argued that the transfers to his daughter were regular gifts made for reasons other than to qualify for assistance and that the real property was transferred for its fair market value. In its Final Administrative Decision, DHS-BAH rejected the applicant's argument that the transfers made to his daughter were made for a reason other than to qualify for medical assistance, finding that it would be unreasonable for applicant to believe he would not need his resources to pay for his long-term care. DHS-BAH also rejected the applicant's argument that the real property was transferred for its fair market value, finding that the applicant could not produce a real estate appraisal and accordingly, the OIG's use of the county tax assessment for the value of the real property was the most reliable estimate of the fair market value. The amount of the penalty upheld was \$308,085.

Acronyms

AABD	Aid to Aged Blind or Disabled	DVA	Department of Veteran’s Affairs
ACA	Affordable Care Act	EH	Eligible Hospital
AFDC	Aid to Families with Dependent Children	EP	Eligible Professional
AG	Illinois Attorney General	ERP	Enterprise Resource Planning
AIU	Adoption, implementation, or upgrade	FAD	Final Administrative Decision
BAH	Bureau of Administrative Hearings	FAE	Fraud Abuse Executive
BCCD	Bureau of Child Care and Development	FBI	Federal Bureau of Investigation
BFST	Bureau of Fraud Science and Technology	FCRC	Family Community Resource Centers
BIA	Bureau of Internal Affairs	FFP	Federal Financial Participation
BMC	Bureau of Managed Care	FFS	Fee For Service
BMI	Bureau of Medicaid Integrity	FOIA	Freedom of Information Act
BOC	Bureau of Collections	FQHC	Federal Qualified Health Center
BOI	Bureau of Investigation	FST	Fraud Science Team
CAP	Corrective Action Plan	FWA	Fraud, Waste, and Abuse
CASE	Case Administrative System Enquiry	FY	Fiscal Year
CFR	Code of Federal Regulations	EDW	Enterprise Data Warehouse
CHA	Chicago Housing Authority	EH	Eligible Hospitals
CHIP	Children’s Health Insurance Program	EHR	Electronic Health Records
CMS	Centers for Medicare and Medicaid Services	EP	Eligible Professionals
CMS-CPI	Centers for Medicaid and Medicare Services’ Center for Public Integrity	ERP	Enterprise Resource Program
CPA	Certified Public Accountant	GUI KIDS	Graphical User Interface Key Information Delivery System
CPI	Center for Public Integrity	HFPP	Healthcare Fraud Prevention Partnership
CPIP	Certified Program Integrity Professional	HFS	Healthcare and Family Services
DCSS	Division of Child Support Services	HHA	Home Health Agencies
DHS	Department of Human Services	HHS	Department of Health and Human Services
DHS-BAH	Department of Human Services – Bureau of Hearings	HHS-OIG	Department of Health and Human Services Office of Inspector General
DHS-BOC	Department of Human Services – Bureau of Collections	HITECH	Health Information Technology for Economic and Clinical Health
DHS-DRS	Department of Human Services- Division of Rehabilitation Services	HSP	Home Services Program
DHS-FCRC	Department of Human Services – Family Community Resources Centers	IDES	Illinois Department of Employment Security
DI	Data Integrity	IDFPR	Illinois Department of Financial and Professional Regulation
DME	Durable Medical Equipment	IDPH	Illinois Department of Public Health
DNA	Dynamic Network Analysis Predictive Modeling System	IES	Integrated Eligibility System
DoIT	Department of Innovation & Technology	IGA	Interagency Agreement
DOJ	United States Department of Justice	ILCS	Illinois Compiled Statutes
DPA	Department of Public Aid	IOC	Illinois Office of the Comptroller
DUI	Driving Under the Influence of Alcohol	ISP	Illinois State Police
		ISP-MFCU	Illinois State Police-Medicaid Fraud Control Unit
		LTC	Long Term Care

Acronyms

LTC-ADI	Long Term Care- Asset Discovery Investigations	PE	Provisional Eligibility
MCO	Managed Care Organization	PERM	Payment Error Rate Measurement
MEQC	Medicaid Eligibility Quality Control	PES	Provider Enrollment Services
MFCU	Medicaid Fraud Control Unit	PI	Program Integrity
MME	Average Daily Morphine Milligram Equivalent dose	PRAS	Provider and Recipient Analysis Section
MMIS	Medicaid Management Information Systems	PSA	Public Service Administrator
MPIS	Medicaid Program Integrity Spotlight	QC	Quality Control
MQRC	Medical Quality Review Committee	RAC	Recovery Audit Contractor
MRA	Management, Research, and Analysis	RAU	Recipient Analysis Unit
MU	Meaningful Use	ROI	Return On Investment
NAC-MII	National Advocacy Centers - Medicaid Integrity Institute	RRP	Recipient Restriction Program
NAMFCU	National Association of Medicaid Fraud Control Units	RTS	Refill Too Soon
NAMPI	National Association for Medicaid Program Integrity	RVP	Recipient Verification Procedure
NEMT	Non-Emergency Medical Transportation	RY	Review Year
NHCAA	National Healthcare Anti-Fraud Association	SAS	Statistical Analysis System
NPI	National Provider Identifier	SIU	Special Investigative Unit
NPV	New Provider Verification	SMART	Save Medicaid Access & Resources Together (Act)
NRC	Narrative Review Committee	SNAP	Supplemental Nutritional Assistance Program
OCIG	Office of Counsel to the Inspector General	SPSA	Senior Public Service Administrator
OIG	Office of Inspector General	SURS	Surveillance Utilization Review Subsystem
PA	Personal Assistant	TANF	Temporary Assistance to Needy Families
PAAS	Public Aid Accounting System	TDB	Time Dependent Billing
PAU	Provider Analysis Unit	TMU	Technology Management Unit
PBMS	Pharmacy Benefit Management System	UCOWF	United Council on Welfare Fraud Conference
PCCM	Primary Care Case Management	UPIC	Universal Program Integrity Contractor
PCS	Personal Care Services	USDA	United States Department of Agriculture
		USDOJ	United States Department of Justice
		WARP	Welfare Abuse Recovery Program



OIG Statutory Mandate

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

- Audits of enrolled Medical Assistance Providers
- Monitoring of quality assurance programs
- Quality control measurements of any program administered by 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)

Financial Results Explained

An investigation, audit or review that is performed, managed or coordinated by the OIG can result in:

Dollars recovered: Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection, or review.

Questionable costs (formerly listed as overpayments): Questioned costs include overpayments identified for recovery during an OIG investigation, audit or review due to an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds or for their intended purpose or were unnecessary, unreasonably spent, or wasteful.

Funds put to better use (formerly listed as dollars identified as cost avoidance): Putting funds to better use results in avoidance of unnecessary expenditure of funds for operational, medical, contract, or grant costs. These measures align with those used by the federal Government Accountability Office.

Refill Too Soon

A new Pharmacy Benefit Management System (PBMS) went live in April 2017. In this system, only payable claims are priced; therefore, OIG is unable to calculate the dollars associated with any claims that would be subject to a Refill Too Soon (RTS) edit. With the advent of HealthChoice Illinois and the expansion of managed care in the Illinois Medicaid system, the Managed Care Organizations (MCO) maintain their own billing policies regarding pharmaceuticals. The OIG suggests that this statutory requirement needs to be addressed and modified or eliminated for these reasons.

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 2019 Annual Report OIG's Website. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably.



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