Department of Healthcare and Family Services

Office of Inspector General

Annual Report

Fiscal Year 2015

BRUCE RAUNER, GOVERNOR

Bradley K. Hart, Inspector General

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Bruce Rauner
Governor

Bradley K. Hart
Inspector General

January 29, 2016

To: The Honorable Bruce Rauner, Governor and Members of the General Assembly

As Inspector General over the Illinois Medicaid system, I am pleased to present you with the Annual Report for the Office of Inspector General (OIG). The OIG is committed to aggressively carrying out its mission of safeguarding the integrity of the Medicaid program throughout Illinois. The OIG's statutory mission is to "prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct…" in Medicaid.

During Fiscal Year 2015, the OIG successfully implemented and continued preventive and enforcement initiatives that resulted in over $204 million dollars in savings, recoupment and avoidance. These savings resulted in a Return On Investment of $8.64 for every dollar expended by OIG.

The achievements detailed in this report are the results of the hard work and dedication of OIG staff members, as well as the commitment of those within the Departments of Healthcare and Family Services, Human Services and Aging. Due to the efforts of these employees, the OIG has made great strides in the pursuit of its program integrity mission and the taxpayers of Illinois can be proud of the work performed by these individuals.

This report describes many of the activities and results of the OIG staff during Fiscal Year 2015, including the continued implementation of the SMART Act (PA 97-689); continued development and implementation of our federal CMS "Best Practice" analytics system called the Dynamic Network Analysis (DNA) system; and our continued enforcement actions over Illinois Medicaid providers and recipients. As required by Public Act 88-554, this report provides information on the composition, recoupment, sanctions and investigatory actions of the OIG. It is with great pride that I provide you with the accomplishments of the Office of Inspector General for Healthcare and Family Services for Fiscal Year 2015.

Sincerely,

Bradley K. Hart
Inspector General

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INTRODUCTION

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). DPA was split into two agencies on July 1, 1998, as much of the Department's field operations were consolidated into the newly created Department of Human Services (DHS). DPA became the Department of Healthcare and Family Services (the Department) on July 1, 2005.

The position of Inspector General is appointed by the Governor; requires confirmation by the Illinois State Senate; and reports to the Office of the Governor through the Executive Inspector General. While the OIG operates within the Department, it does so independently of the agency director. The OIG is fully committed to ensuring that Department programs are administered with the highest degree of integrity.

Prior to 1994, the Division of Program Integrity (DPI) was responsible for many of the duties absorbed by the OIG. The most significant difference between the two entities lies in the OIG's statutory mandate "to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct." The OIG directive, to first prevent fraud as an independent watchdog, has enabled the program integrity component to greatly increase its impact on the Department programs. The OIG investigates possible fraud and abuse in all of the programs administered by the Department and some DPA legacy programs currently administered by DHS. OIG has jurisdiction over the Community Care Program (CCP) within the Department on Aging. The OIG has developed and enhanced a broad range of tools and techniques to prevent and fight fraud and abuse in Medicaid, All Kids, food stamps, cash assistance, and child care. The OIG also enforces the policies of agencies within the State of Illinois affecting clients, health care providers, vendors and employees.

The professionals that make up the OIG staff include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information technology specialists. During Fiscal Year (FY) 2015, the OIG had a staff totaling 160 employees.

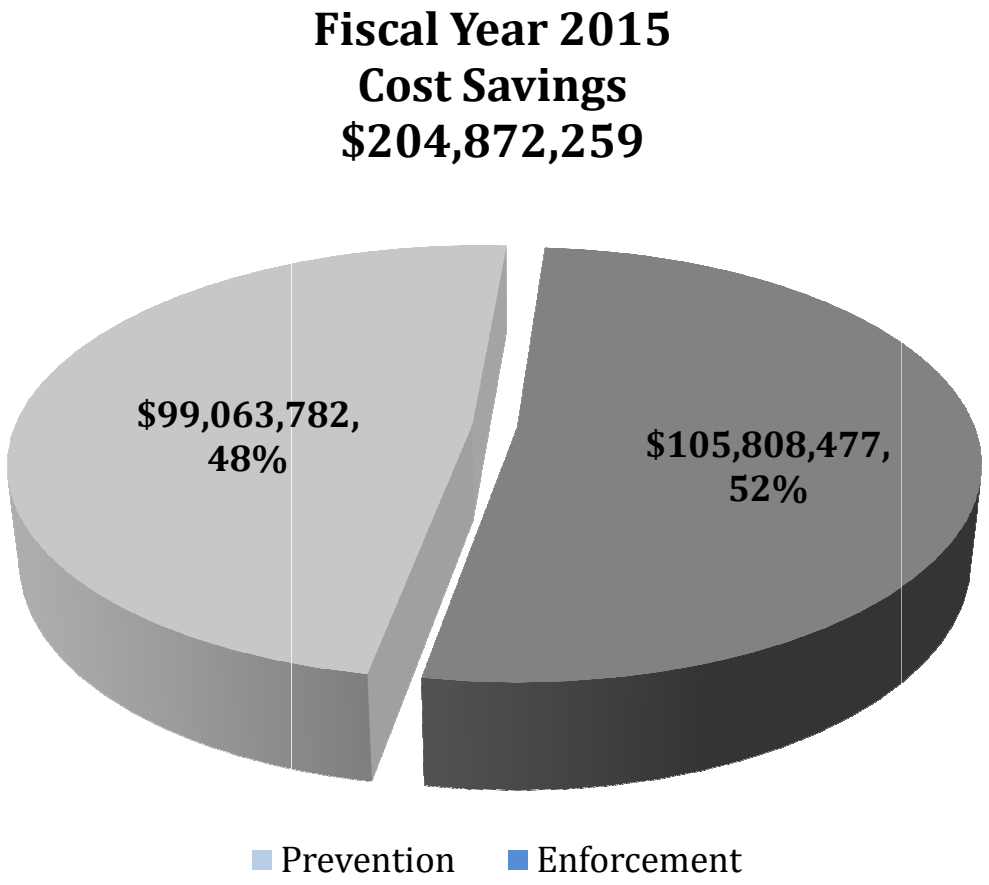
The staff is primarily based in either Springfield or Chicago, and the remainder work out of field offices located throughout the state. The OIG continued fulfilling its mission during FY15, with Bradley K. Hart serving as the Inspector General. The OIG continues working to expand its integrity activities by researching and developing new programs and technologies.

OIG PROGRAM INTEGRITY COST SAVINGS AND AVOIDANCE

During FY15, the OIG moved forward on numerous fronts to expand the depth and breadth of its Program Integrity mission. By relying on the hard work of OIG staff, cooperation with various state and federal government agencies, and the deployment of new technology and scientific methods, the OIG has continued to strive to fulfill its mandate of preventing and detecting fraud, waste, and abuse in the Medicaid program. The dividends have resulted in better prevention methods and more efficient detection tools. The savings realized not only benefit the Department, but several other state agencies as well. Through these efforts, the OIG has succeeded in generating cost savings, as well as in raising awareness of the importance of Program Integrity among clients, providers, and the citizens of Illinois.

OIG FISCAL YEAR SAVINGS

During FY15, the OIG realized a savings of approximately **$204 million** through collections and cost avoidance. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings.



NOTABLE ACCOMPLISHMENTS

$204 MILLION - OIG TOTAL COST SAVINGS AND AVOIDANCE

In FY15, the Office of Inspector General ("OIG") for the Illinois Department of Healthcare and Family Services implemented a comprehensive program integrity work plan, which included focused and expansive fraud, waste, and abuse investigations, audits and reviews. OIG implemented several new initiatives that led to greater prevention and enforcement during FY15. This aggressive work plan resulted in a marked increase in cost savings and avoidance of ***$204 million dollars***. This cost savings and avoidance represents over a ***$110 million dollar*** increase from the $94 million dollars in cost savings and avoidance realized during FY14. This marked increase in cost savings and avoidance was made possible through a multi-faceted OIG work plan strategy to identify and eliminate fraud, waste, and abuse trends, and to prevent new trends from developing.

> ***…$204 million dollars. This cost savings and avoidance represents over a $110 million…***

The OIG consistently recognizes vulnerabilities, creates broad solutions, and realizes tangible results. When the OIG identifies new patterns of improper billing or fraud schemes, the work plan is adjusted to allocate resources to maximize program activities and savings to the State of Illinois. For example, in FY15, the OIG Work Plan included notable initiatives in the area of the Long Term Care-Asset Discovery Investigation (LTC-ADI) unit. As a result of the initiative, the LTC-ADI unit realized gross savings of $152,285,154, with a return on investment of $65.18 to every $1.00 spent. Streamlining evaluation and investigative procedures resulted in 3,544 investigations being completed during the fiscal year.

> ***…savings of $152,285,154, with a return on investment of $65.18 to every $1.00 spent.***

The OIG Work Plan included thousands of investigations, audits and reviews in FY15 aimed at combating fraud, waste and abuse. These activities include: 4,302 Bureau of Medicaid Integrity Audits; 13,481 investigations of fraud allegations received through the Welfare and Recovery Abuse Program; 5,993 investigations conducted by the Bureau of Investigations; over 143 Administrative Sanctions hearings initiated by the Office of Counsel to the Inspector General; and 1,924 recipient restrictions of clients through the Recipient Restriction Program due to overutilization. Details of the prevention and enforcement activities are outlined in the sections below.

Prevention Activities

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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)

OIG COMPOSITION

ADMINISTRATIVE FUNCTIONS

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

ADMINISTRATIVE SUPPORT UNIT

The **Administrative Support Unit** (ASU) is responsible for the **Welfare Abuse Recovery Program** (WARP), which processes fraud and abuse referrals from citizens, local DHS offices, state and federal agencies and law enforcement entities concerning recipients and providers. WARP conducts research on referrals by accessing information from DHS, Secretary of State, Illinois State Police (ISP), DPH vital records, employment and unemployment history.

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

OIG's Personnel and Labor Relations activity is also coordinated through the ASU, which handles necessary paperwork for all personnel transactions, labor relation issues, deferred compensation, direct deposits, and the sick leave bank.

FRAUD AND ABUSE EXECUTIVE

The **Fraud and Abuse Executive** (FAE) was established to coordinate federal and state law enforcement activities related to the Illinois Medicaid program. The FAE identifies key Department and DHS personnel to provide testimony at criminal and civil proceedings and facilitates the disposition of global settlement agreements generated by the National Association of Attorneys General, the Departments of Health and Human Services and the U.S. Department of Justice.

FAE is the liaison with the **Illinois State Police Medicaid Fraud Control Unit** (MFCU). This area evaluates and transmits fraud and abuse referrals to MFCU. In addition, the FAE implements payment withholds pursuant to 42 C.F.R. 455.23 and Illinois State law in the event of Program related felony indictments. The FAE also works in conjunction with OCIG on the implementation of the enhanced payment suspension capabilities authorized by the SMART Act (PA 97-0689).

THE OFFICE OF COUNSEL TO THE INSPECTOR GENERAL

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

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

BUREAU OF FRAUD SCIENCE AND TECHNOLOGY

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

The Bureau's **Provider and Recipient Analysis Section** (PRAS) researches, develops, and implements selection criteria to identify providers with potentially fraudulent behavior. BFST switched from a J-SURS system to a DNA-SURS system to conduct monthly analyses of providers based on their "risk score" and other predictive measurements. This tool provides rich and detailed information with a rapid response mechanism, which is instrumental to the OIG.

DNA-SURS compares a provider's billing patterns against its peers to identify outliers. Together with the Predictive Modeling analytics and other statistical indicators, it has also been supported by other functions in the DNA information system. For example, BFST analysts use profile reports to further study those targeted providers, their services, billing amount, inter-relationships, and prescribing patterns. Utilizing the information provided from the DNA Predictive Analytic model and profile-reporting system, BFST has successfully generated substantial rates of growth in identifying fraudulent providers. Moreover, the DNA system uses a streamlined analysis protocol to increase reporting accuracy and case initiation capacity. BFST conducted new provider monitoring analysis of

transportation and durable medical equipment providers in 2012; in 2013, the analysis expanded to most provider types based on categories and levels of risk defined by the Department.

PRAS also manages the **Recipient Restriction Program** (RRP). This program identifies clients who inappropriately over utilize Medicaid resources, and then restricts these clients to receive services from a designated Primary Care Provider (PCP) and/or pharmacy in order to control such over utilization. Based on the study of these restriction cases and utilizing domain expert knowledge, BFST has built an intelligent recipient selection system in which recipients' service and billing patterns along with other necessary medical conditions have been considered. This recipient selection system helps BFST proactively identify the recipients rendering inappropriate usage of Medicaid resources even before they were reported through the CASE system.

The Bureau's **Fraud Science Team** (FST) develops fraud detection routines to prevent and detect health care fraud, abuse, overpayments, and billing errors. FST works with the Department to identify vulnerabilities and solutions in the Department's payment system. FST's routines are analytical computer programs written in SAS, Teradata SQL, and DataFlux, utilizing the Department Data Warehouse along with other third-party data sources. FST also identifies program integrity solutions, pre-payment claims processing edits, policy innovations, operational innovations, fraud referrals, desk reviews, field audits, and self-audit reviews. BFST also takes systematic approaches to plan and implement the integration of sampling selection and audit reporting, DNA-CASE integration, statistic validation, executive information summaries, and other analysis that will improve OIG's operational and decision-making processes.

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

BUREAU OF INVESTIGATIONS

The **Bureau of Investigations** (BOI) provides professional investigative services and support to the Department and to the Department of Human Services (DHS) in an effort to prevent, identify, investigate, and eliminate fraud, waste and abuse by providers and recipients in all programs under OIG's jurisdiction. The Bureau attempts to promptly investigate any suspect person or entity and vigorously pursues criminal prosecution and/or recovery of overpayments. The Bureau cultivates and nurtures a professional working relationship with state and federal prosecutors, members of the law enforcement community, and other state and federal agencies. The Bureau is responsible for processing criminal background fingerprint results for all high-risk transportation providers enrolling with the agency.

The goal of the Bureau is to ensure the integrity of the Temporary Assistance to Needy Families (TANF) program, **Supplemental Nutrition Assistance Program** (SNAP),

Medicaid, and other assistance programs. The functions of BOI include client eligibility, provider fraud, prosecution, SNAP/EBT disqualifications/investigations and child care investigations. BOI also manages the **Fraud Prevention Investigations** (FPI) program in Cook County.

BUREAU OF MEDICAID INTEGRITY

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

The Bureau's **Audit Section** performs audits on Medicaid providers to ensure compliance with the Department policies. This Section audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, durable medical equipment suppliers and other types of providers. Contractual CPA firms do additional nursing home audits. Other contractual vendors perform audits of hospital inpatient Drug Related Grouper (DRG) services. 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 establishes a credit against future claims received from the provider. The provider may contest the findings through the Department's administrative hearing process. The Audit Section is also responsible for the oversight of the Recovery Audit Contractor (RAC) program required by the Affordable Care Act (ACA).

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

The Bureau's **Central Analysis Section (CAS)** in conjunction with the **Quality Control (QC) Review Section** operates both the federally mandated Medicaid Eligibility Quality Control (MEQC) program and the eligibility review portion of the Payment Error Rate Measurement (PERM) initiative. The MEQC is conducted annually and PERM is conducted every three years.

CAS plans and designs the sample selection. QC conducts the eligibility reviews for each of the sampled cases to ensure compliance with federal and/or state policies. CAS completes a review of the paid claims related to each eligibility review case and coordinates individual case corrective action with the appropriate local administrating office. CAS analyzes the data, evaluates the findings, makes recommendations, coordinates global corrective action

to address program deficiencies, and ensures compliance with federal and state auditing standards.

LONG TERM CARE-ASSET-DISCOVERY INVESTIGATIONS

The Bureau's **Long Term Care-Asset Discovery Investigations** (LTC-ADI) section conducts reviews of long-term care applications that meet specified criteria related to the transfer and disclosure of assets. These reviews are designed to prevent taxpayer expenditures for individuals that have private funding available for their Long Term Care costs. Reported and discovered assets are reviewed, applying the Deficit Reduction Act (DRA) policies, and verifying transfers are for Fair Market Value (FMV). Undisclosed assets or those transferred for less than fair market value result in penalty periods where the recipient will be ineligible to receive Medicaid payments. During these penalty periods, the recipient is liable for the Long Term Care expenditures at a private pay rate. The LTC-ADI section, including members of the Office of Counsel to the Inspector General, also review trust documents to determine if they meet current policy requirements. This section also manages all decision appeals through the administrative hearing process. Final determinations regarding LTC eligibility are returned to the local Department of Human Services Family Community Resource Center (FCRC) for implementation. This unit applied 762 penalty periods out of 3,544 investigations during FY15; these cases resulted in $68 million in savings and $83.8 million in cost avoidance, resulting in a Return on Investment (ROI) of $65.18 for every dollar spent.

BUREAU OF INTERNAL AFFAIRS

The **Bureau of Internal Affairs** (BIA) investigates misconduct of employees and contractors, and engages in diligent efforts to identify fraudulent staff activity and security weaknesses. The Bureau prepares investigative reports and shares the findings with the agency's division administrators. The Bureau also follows investigations to determine if appropriate actions have been taken, and coordinates investigations of employees and contractors with state or federal authorities. The Bureau has the responsibility for monitoring the safety of employees, and visitors in the Department buildings. The Bureau also obtains criminal history information from the Illinois State Police on new hires and on HFS staff who require access to Secretary of State data. BIA conducts assessments for the Department involving threats from employees, non-custodial parents, clients and civilians and conducts annual fire and storm drills.

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

OIG PROGRAM INTEGRITY INITIATIVES, SAVINGS AND COST AVOIDANCE

LONG TERM CARE-ASSET DISCOVERY INVESTIGATIONS INITIATIVE

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

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

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

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

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

The LTC-ADI team, consisting of clerical support staff, analysts and an attorney, is responsible for comprehensive reviews of an LTC applicant's financial documentation LTC-ADI staff analysts are responsible for reviewing the documentation to discover unreported and transferred resources. LTC-ADI attorneys (through the Office of Counsel to the Inspector General) are responsible for providing legal counsel on the eligibility impact of various financial and property vehicles (including trusts, wills, life insurance, and annuities); novel transfer issues (including personal care contracts); and spousal issues (including divorce, separation, spousal refusal, and spousal transfers). LTC-ADI attorneys also handle the administrative appeals of an LTC-ADI recommendation.

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

Notable Results

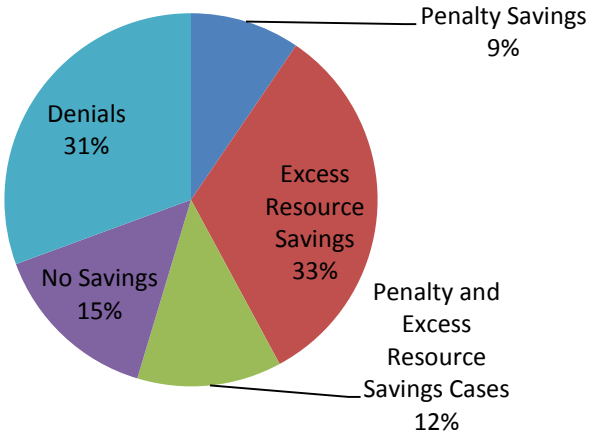
This unit completed 3,544 cases during FY15. Of the completed cases, 1,891 resulted in a savings to the taxpayer from excess resources or penalties and 1,059 resulted in a cost avoidance savings[1] as a result of no assistance being authorized. Penalties were applied to 762 cases. A gross savings of $152,285,154 was realized, with a return on investment of $65.18 for every $1.00 spent.

Enforcement Activities	Total Cases Completed	Total Savings
Total Investigations Completed	3,544	$152,164,959
Cost Savings Cases	1,891	$68,362,477
Cost Avoidance Cases[2]	1,059	$83,802,482

[1] Avoidance savings is a projected savings determination and defines final disposition data as the determination used after the regulated arbitration date and may contain instances of re-application or appeal after the arbitration timeframe.

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

Savings Distribution



The following LTC-ADI results were incorporated into final eligibility determinations during FY15:

- LTC-ADI imposed a transfer penalty in the amount of **$372,886**, based on the client's non-allowable transfer of farmland.
- LTC-ADI imposed a spenddown in the amount of **$297,520**, based on the client's excess resources (cash assets and non-exempt real property).
- LTC-ADI imposed a spenddown in the amount of **$241,481**, based on the client's excess resources (investment accounts).
- LTC-ADI imposed a transfer penalty in the amount of **$197,024**, based on the client's non-allowable transfer of farmland.
- LTC-ADI imposed a spenddown in the amount of **$164,090**, based on the client's excess resources (non-exempt real property).
- LTC-ADI imposed a spenddown in the amount of **$125,893**, based on the client's excess resources (cash assets and non-exempt real property). In addition, LTC-ADI imposed a transfer penalty in the amount of **$4,000**, based on the client's non-allowable transfer of a vehicle.
- LTC-ADI imposed a transfer penalty in the amount of **$127,123**, based on the client's non-allowable transfer of farmland.
- LTC-ADI imposed a transfer penalty in the amount of **$96,323**, based on the client's non-allowable transfers of cash assets and the beneficial interest in life insurance policies.

NEW DEVELOPMENT IN DYNAMIC NETWORK ANALYSIS (DNA) PREDICTIVE MODELING SYSTEM

The Dynamic Network Analysis (DNA) Predictive Modeling System was developed through a federal CMS Medicaid Transformation Grant (MTG). Since its deployment in September 2011, the DNA Predictive Modeling System has been incorporated into OIG's workflow, and now assists in making executive decisions, providing information for referrals and developing audits. The system development and enhancement during 2013 included bringing broader user groups, designing network analysis exploration, and expanding the capacity of statistic model.

The new development of the DNA Predictive Modeling System during FY15 focused on providing early warning and monitoring through analyzing service and payment trends; identifying exception processing through outlier analysis; managing information according to user workflow; customizing reports and functions for different user groups; and improving overall user experience. The newly developed system, DNA Framework, includes the existing functions and programs in the DNA Predictive Modeling System, and adds more functions and analysis areas. In addition to migrating the existing DNA Predictive Modeling programs, the DNA Framework incorporates SURS functions; applies advanced multivariate statistical models; and features dashboard, data visualization and interactivity enhancements.

In the DNA Framework, the routines, reports and inquiry functions are organized into five main areas: Executive Summary, Statistical Analysis, Profile, Report, and Inquiry (see figure 1). The new DNA framework is design to support user workflow and to increase the efficiency. For example, the features of auto-searching, auto-filtering, and roll-over description help users quickly access and find information needed to investigate a provider's data to determine fraud, waste and abuse patterns. These capabilities also allow OIG administrators to better monitor the system usage and analyze how the DNA system is being used by staff, in order to provide support to end users and to improve the overall system. The OIG intends to roll out the DNA Framework in November 2015.

The new development of DNA Predictive Modeling Framework System is highlighted below:

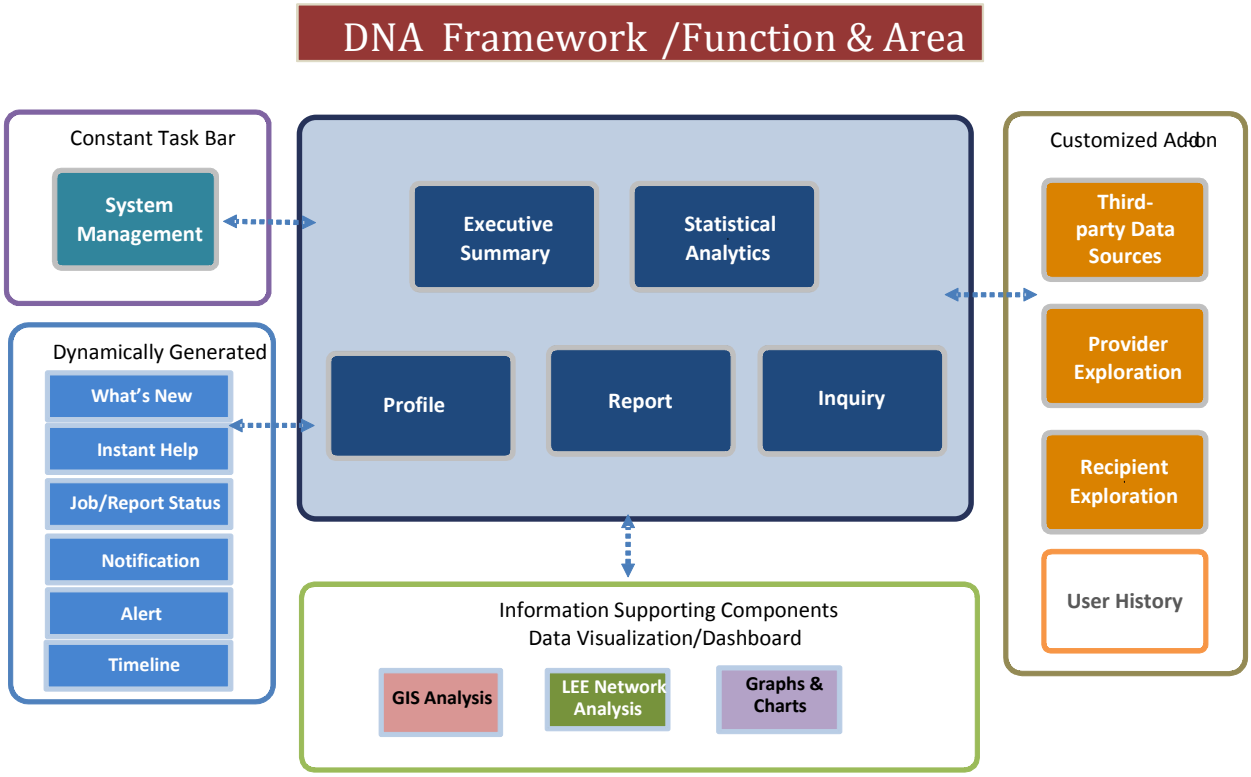


Figure 1 DNA Framework Function & Areas

System Management

DNA Framework enhances the user-experience by providing: (a) information management tools that help users learn about the systems, share knowledge and improve efficiency; and, (b) a customized user workspace to support OIG's daily information processing tasks. The system monitors user activities and analyzes the frequency of programs and functions accessed for future enhancement of the system.

Executive Summary

The newly developed executive summary section in the DNA Framework provides statewide trends to help support administrative decision-making. The dashboard presents annual trend information and has drilldown capacity to view detailed data. Three types of executive summary are available: Statewide Executive Summary, Transportation Executive Summary and Post-Mortem Executive Summary.

The Statewide Executive Summary provides an overview for the OIG administrators that focus on total yearly payments (services, recipients) in each county, or by provider type, or at a procedure and/or diagnostic code level. The Transportation Executive Summary provides at-a-glance information for general payment summary, and any over payment established through the applicable data algorithms. Post-Mortem Executive Summary is also a very useful tool as the post-mortem payment or data quality in HFS becomes a prominent issue and requires special studies. IDPH (Department of Public Health) has been the primary external data source to verify recipient death information. Other external data sources include MDS (long term care), Medicare Eligibility, and hospital reported data.

After checking problematic cases by recipient level information, the associated provider level and claim level information will be extracted from EDW to produce analysis reports.

Statistical Analytics

OIG continues the effort of utilizing various statistical models to calculate risk scores to help investigators select targeted providers. Various programs in the DNA Integration System have been developed to perform exception processing. These programs include: Outlier Analysis by Provider Type and Upstate/Downstate, Outlier Analysis by Provider Type and Region, Outlier Analysis by Provider Type and Cluster, Procedure Code Analysis, and the Mahalanobis Analysis.

The newly enhanced outlier analysis programs in DNA Framework provide the capability to study group practices as well as individuals within the group practice. These programs produce summaries with indicators of whether providers exceed the normal payment within their peer group (by the same provider type, geographic location, procedure codes, or other pre-defined clusters that share the same characteristics). Taking a multivariate approach, the Procedure Code Analysis and Mahalanobis Analysis allow the investigators to detect providers who behave or perform outside the norm in a more sophisticated and meaningful way.

Profile

The Provider Profile Reports and Recipient Profile Reports are the "one-stop shop" for OIG staff for case review, audit and many other purposes. The Provider Profile Reports and Recipient Profile Reports have combined information from various data sources and applied statistical approaches to offer a comprehensive view to examine a targeted provider or a targeted recipient in various categories of services of the Medicaid program. OIG continues to update the information provided in Provider Profiles to improve the usefulness and accuracy of the reports. For example, a new National Provider Identification information table was added for those providers having problematic NPI.

The Recipient Profile Report provides analysts an overview of the recipient's history and patterns, and helps them determine whether further investigation is necessary. Provider and Recipient Profile Reports have been utilized in the analysis of referral cases, and the response to monthly Federal requests and many other ad hoc requests from various agencies. The recipient restriction selection report, recipient profile, recipient claim details, detox study by recipient and many other programs in the DNA Framework serve for the purpose of investigating and revealing over-utilization of the State's Medicaid program by individual participants. These programs not only analyze the patterns of fraud or abuse of the Medicaid system, they also assess any data quality or billing error issues for future system enhancement or policy changes.

Report

Two categories have been added into the Report section in the DNA Framework: ASU reports and Peer Review reports. ASU reports are designed specifically for the Administrative Services Unit to address financial accounts receivable issues. The purpose of Peer Review is for OIG staff to review the services and claim details of Medicaid utilization when comparing providers to other similar providers (e.g., by provider type,

procedure code, diagnosis code, payment trends, and service patterns). The following Peer Review reports have been recently added to the DNA Framework:

- Prescribing Practitioner Recipients
- Recipients Prescribed by Provider
- Prescribing Patterns
- Prescribing Practitioner Script Analysis
- Provider Controlled Substance Prescribing
- Rejected Claims (Institutional and Non-Institutional Claims)
- Procedure Code by Recipient
- Provider Summary Initial Visits Procedure Codes
- Primary Diagnosis Code
- Interrelated Recipients with Providers (Driven by Provider ID)
- Interrelated Recipients Prescribed Medications by Providers (Driven by Provider NPI)

Inquiry

The provider and recipient inquiries have been enhanced with more information. The new development for the Inquiry Section in DNA Framework includes First Transit Inquiry and Death Date Inquiry. The First Transit inquiry allows users a quick look up for recipient prior approval trip information. The Death Date Inquiry allows users to search by partial or complete name and/or SSN, and then pull data from HFS and IDPH to examine whether the individual has post-mortem claims.

Sanction Data Processing Enhancement Plan

The current Sanction data processing involves federal as well as state level resources including Department of Health and Human Services' (HHS) List of Excluded Individuals/Entities (LEIE), and the Illinois Department of Financial and Professional Regulation's (IDFPR) sanctions information. OIG obtains a list of providers being terminated, sanctioned or disciplined from IDFPR, and downloads a list of sanctioned providers from HHS and LEIE regularly. While the data from IDFPR can be appended into OIG's data warehouse, the list of providers from HHS and LEIE requires a process of matching the individual providers with the existing provider demographic data in EDW. The sanction data is valuable to OIG because this information helps OIG identify the providers who should not be billing the state. OIG plans to utilize sanction data and develop an early warning system in DNA Framework, so OIG can proactively stop payments to these sanctioned providers. Furthermore, encompassing sanction data into the DNA Framework will increase efficiency during the investigation and inquiry phases.

DNA (Dynamic Network Analysis) - SURS (Surveillance and Utilization Review) System Integration

According to State Medicaid Manual Part 11, section 11335, this surveillance and utilization review system must be able to develop provider or recipient level statistical profiles, conduct investigation toward potential defects in quality of care, identify exception processing, reveal over or under-utilization and produce comprehensive reports. During 2014–2015, OIG made significant progress implementing the DNA (Dynamic Network

Analysis) - SURS (Surveillance and Utilization Review) System Integration. OIG is in the process of implementing DNA Framework, which is an in-house business intelligent system that emphasizes the capacity of identifying exceptions to the norm for utilization and quality of care standards by applying customized statistical models. These programs specifically address the needs of developing provider or recipient level reports to identify quality of care and exception processing issues mentioned above. Many of the programs were developed from fraud detection and data mining efforts, which are listed in the following section.

Fraud Detection Data Mining and Program Preparation

The Bureau's **Fraud Science Team** (FST) develops fraud detection routines to prevent and detect health care fraud, abuse, overpayments and billing errors. FST works with HFS to identify vulnerabilities and solutions in HFS's payment system. FST utilizes the HFS Data Warehouse (EDW) along with other third-party data sources such as IDPH (Public health), MDS (long term care), Medicare, and hospital data to check death information. OIG will be adding APPRISS (incarceration information) and SOS (driver's and business services information) into the existing data sources. OIG will also be adding sanction information into the DNA inquiry module, so auditors and investigators can verify information during pre-audit/investigation data mining and fraud detection analysis. These efforts related to data mining and case review have helped OIG explore new study areas and expand our analytical capacity. The following programs and data preparation are some of the newly expanded analyses. These programs will be incorporated into the DNA Framework after validating and evaluating their demand and effectiveness. The newly expanded and developed fraud detection programs include:

- Home Health and Hospice study and data validation
- DME provider study, data preparation and validation
- Post Mortem study, data preparation and validation
- CPAP masks study, program development and data validation
- Ping-Pong report (common client) data and program preparation
- MCO payment program preparation
- Construct Network Linkage Analysis Routines/Templates
- Study Hospital Global Billing issues (Technical Component)
- G Code study and program development
- Forecast Model program development
- SPR Report data and program preparation
- Recipient Restriction Report data and program preparation

AUDIT INITIATIVES

The OIG performs pre-payment and post-payment audits, in order 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 a number of 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.
- **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.
- **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.

Audit Processes

The OIG audit processes maximize the prevention, detection, and recovery of overpayments, but also ensure the accuracy, transparency, fairness, and timeliness of the audit processes. Audit processes are overseen by the Executive Audit Compliance Committee (Compliance Committee). The Compliance Committee is comprised of subject matter experts from the OIG's diverse professional staff, including members of the OIG executive team; OIG attorneys from OCIG; audit personnel and management from BMI; and data and information analysts from BFST. The Compliance Committee has implemented formal Audit Methodologies and Processes for all internal and external audits (including desk, field, and contractor audits). The Audit Methodologies and Processes established a single, comprehensive audit process for all audit and provider types, eliminating time-consuming re-audits and provider disputes. This has continued to reduce audit completion time by increasing provider communication, establishing sound legal bases for audit findings, simplifying audit work papers, and categorizing audit findings as disputed and non-disputed. The Compliance Committee has also implemented a process for consistent fraud evaluation in each audit case.

OIG Work Plan

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

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

OIG has developed enhanced methods to identify and monitor potential program vulnerabilities. The OIG adjusts its audit plans to maximize the effectiveness of its program integrity activities. When the OIG identifies improper billing patterns or fraud schemes, it adjusts its audit plan to allocate resources between internal and external auditors to maximize its impact on program vulnerabilities. The OIG has specialized internal audit teams to conduct audit reviews in areas of identified program vulnerabilities and high risk. In FY16, this will include additional focus in the areas of dental, home health, deceased recipient payments, hospice and non-emergency ambulance transportation, among others.

External Contract Vendor Auditors

The OIG work plan includes the use of both internal and external auditors to allow for a wide range of fraud, waste and abuse detection activities and to ensure broad oversight within Program operations. The ability to utilize both internal and external auditors with diverse subject matter expertise allows the OIG expansive oversight capability. The OIG utilized their partnership with other state and federal resources to ensure a greater and more immediate impact on high risk areas. For example, the OIG currently works with external Medicaid Integrity Contract auditors (MIC) and Recovery Audit Contactors (RAC. OIG will continue to expand its work with Compliance teams and Special Investigation Units (SIU) of the managed care organizations to further enhance program integrity oversight. In FY16 the OIG intends to expand the use of specialized internal audit teams, and external contractors, the MIC auditors and RAC auditors, to aggressively address program vulnerabilities.

Medicaid Integrity Contractor (MIC) Audits utilize the OIG's partnership with the federal Centers for Medicaid and Medicare Services' Center for Public Integrity (CPI). CPI offers states the use of MIC auditors, in order to perform targeted audits at no cost to the state. In FY16, the OIG intends to expand the use of the MIC audits to the following areas, as resources allow: High Cost Drugs; Hospice; Dental; Credit Balance; and Behavior Health.

Recovery Audit Contractors 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 During FY16, RAC audits will be expanded to continue to focus on areas, such as DME, Hospice, and other high risk areas. The following represents some of the ongoing OIG Audit initiatives planned for FY16.

Diagnosis Related Group (DRG) Inpatient Audits involve the conduct of a statewide audit program of inpatient hospital services reimbursed under the Diagnosis Related Grouping Prospective Payment System (DRG PPS). A member of the OIG internal audit team provides oversight of the external vendors and their findings, ensuring accuracy, transparency, and fairness.

Prevent Payment for Deceased Recipients

In FY15 the OIG implemented several initiatives focused on areas of identified Program vulnerabilities. This includes preventing payments and recovering overpayments made for deceased recipients. In FY15 the OIG performed 2,825 audits to identify and recover overpayments made by the Department for deceased Medicaid recipients. Further, the OIG conducts 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, OIG identifies instances of credible allegations of fraud and appropriately refers the cases to law enforcement partners for further criminal investigation.

The OIG intends to continue to monitor improper payments made for deceased recipients and to conduct audits to recoup any additional improper payments. OIG has implemented monthly monitoring using a newly implemented Dynamic Network Analysis (DNA) system that allows for identification of improper payments made by the Department on behalf of deceased clients.

Ensure Integrity in Medicaid Payments for Dental Services

OIG identified marked increases in payments for orthodontic services. After the SMART Act, dental services were generally excluded from Medicaid coverage, with exceptions for minors. HFS-OIG will examine State laws, HFS-policy, procedures, and handbooks to evaluate dental expenditures. HFS-OIG plans to conduct audits to examine provider compliance with Department policies and to review the quality of orthodontic care rendered to Medicaid recipients. In addition, the OIG will expand internal and external audits of general dental services to determine whether such payments are in accordance with Illinois Medicaid requirements.

Prevent Fraud in the Home Health Services & Waiver Programs

Home health agencies (HHAs) raise concern for questionable billing. Due to fraud, waste and abuse identified in the area of Home Health Services, CMS imposed a moratorium on newly enrolling HHAs in certain counties within the State of Illinois. Home Health services include part-time or intermittent skilled nursing care, as well as other skilled care services,

such as physical, occupational, and speech therapy. The OIG will continue to evaluate the appropriateness of home health payments in FY16. OIG intends to conduct onsite and in house field audits of Home Health Agencies and physicians who refer and certify recipients for Home Health Care services to determine compliance with Department regulations and State and federal laws. The OIG intends to work in collaboration with CMS to provide education to Home Health Providers and to providers referring and certifying physicians for Home Health Services.

Ensure Appropriate Billing for Hospice Services

The OIG has identified vulnerabilities in the provision of hospice service. Hospice care is palliative, rather than curative. When a recipient elects hospice care, the hospice agency assumes responsibility for medical care related to the Medicaid recipient's terminal illness and related conditions. The OIG internal unit conducts hospice audits and works with external contractors to ensure greater impact on this identified area of risk for the Department. In FY15, the OIG strategy included use of both internal and external auditors to address the overutilization of hospice. These comprehensive audits include a review of medical records to verify the eligibility and medically necessity of hospice claims. In FY16, the OIG will expand its use of external audits and capitalize on the ongoing efforts of the internal OIG audit team.

Ensure Appropriate Billing of Ambulance & Transportation Services

OIG identified Program vulnerabilities involving payments for nonemergency ambulance and transportation services. The identified vulnerabilities included improper duplicate billing, billing for loaded mileage, improper inpatient stays, up-coding, billing for services not rendered and other improper billing practices. In response, OIG developed comprehensive transportation audit strategies that ensure regular monitoring of ambulance and other transportation payments. Specialized BFST data routines are performed routinely to identify improper payments associated with duplicate billing, improper billing for inpatient stays, and improper billings for loaded mileage. Desk audits are performed to recover improper payments. The OIG also conducts scheduled and unscheduled onsite field audits to evaluate medical necessity, to verify services billed were rendered, and to ensure general compliance with Department regulations.

In FY15, the OIG continued to monitor proper compliance with the Department's requirement for Medical Certification for Non-Emergency Ambulance (MCA) form in patients who are discharged and require medically supervised ground ambulance services. As part of these audits, the OIG includes extensive education to ensure ongoing compliance with transportation services. This OIG audit initiative includes both medical necessity audits, encompassing a full review of a recipient's relevant medical records; and, documentation compliance audits, which focus on a provider's compliance with Department documentation requirements and the proper completion of a MCA service form. In FY16, the OIG will continue audit initiatives aimed at ensuring provider compliance with Department transportation requirements.

Ensure Appropriateness of Long-Term Care Payments

OIG identified Program vulnerabilities associated with long-term care payments. OIG has implemented audit initiative aimed at broadening the scope of oversight over long-term

care payments. The OIG has an internal audit team that conducts financial audits of long-term care providers and oversees audits performed by external contractors. Due to the audit reforms, during FY15, there were 257 LTC cases assigned, LTC audits completed 281 audits and re-audits. In FY16, the OIG intends to expand further the scope and of the Long-Term Care audits and associate providers.

Self-Disclosure Protocol and Self-Audit Reviews

Self-Disclosure Reviews involve the identification of irregularity in the billing practices of a provider. In appropriate circumstances, the OIG requires a provider to conduct its own investigation and overpayment self-disclosure. The OIG will verify the overpayment amounts through data analytics and professional review. As a result of the Self-Disclosure Protocol and initiatives, the Department received 28 new disclosures. The total collected for FY15 was $1,008,617.

The Office of the Inspector General (OIG) established a voluntary disclosure process that providers may utilize upon detection and receipt of an overpayment from the Department. This process is called the "Provider Self-Disclosure Protocol." This protocol assists providers to comply with overpayment detection and repayment obligations.

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

The Self-Disclosure Protocol Notice can be found at the following link: http://www.illinois.gov/hfs/MedicalProviders/notices.

ENSURE EFFECTIVE MANAGED CARE PROGRAM INTEGRITY INITIATIVES TO COMBAT FRAUD, WASTE, AND ABUSE

In order to address the transition to Managed Care Program Integrity Oversight, the Department implemented several initiatives to ensure an effective program integrity plan. HFS-OIG developed its Managed Care program integrity strategy by researching best practices from States with long standing Managed Care experience. HFS-OIG also worked with federal and State partners at the Medicaid Integrity Institute (MII) to review oversight obligations for Managed Care expenditures.

As part of the HFS-OIG work plan strategy, HFS-OIG conducted a review of current program integrity activities within Illinois Managed Care Organizations. The purpose of the review was to obtain a more detailed understanding of the structure, staffing, and program integrity capabilities of the Illinois MCOs. HFS-OIG established effective lines of communication for the reporting of fraud referrals and pending investigations. During monthly meetings, HFS-OIG provides comprehensive guidance pertaining to HFS-OIG's administrative program integrity oversight functions, healthcare laws and compliance regulations. Monthly meetings between staff from the HFS-OIG, MCOs/SIUs, and Illinois

State Police allow for ongoing evaluation of fraud investigations, audits and potential fraud referrals. In order to allow for efficient reporting and effective tracking of all MCO fraud referrals, HFS-OIG established electronic transfer of referrals through a web portal dedicated to MCOs. HFS-OIG also worked with MCO entities to ensure the development of a single uniform reporting tool aimed at elimination of duplicate reports. The reporting tool ensures comprehensive review of all MCO program integrity activities.

HFS-OIG coordinates investigations with other State agencies such as the Illinois Department of Professional and Financial Regulation (IDFPR). Likewise, HFS-OIG reports and reviews all administrative sanctions with the MCOs, such as HFS-OIG provider terminations, HFS-OIG payment suspension, and ensures that the MCO has taken appropriate action pertaining to the Sanctioned Providers. HFS-OIG also reviews and approves MCO lock in policies for the Department and recommends approval or revision to ensure an MCO's implementation of an effective lock in program. HFS-OIG performs provider enrollment screening, background checks, on-site inspections of providers and brings administrative actions on behalf of the Department to deny, terminate, exclude, or suspend providers from the program.

COOPERATIVE EFFORTS AND INITIATIVES

OVERSIGHT OF WAIVER PROGRAMS

Collaborative Efforts with the Department of Human Services

The OIG continues its ongoing efforts to strengthen oversight of the Medicaid waiver programs. OIG works closely in collaboration with DHS and other sister agencies to ensure early detection of fraud committed by Individual Providers (IPs) or Personal Assistants (PA's) working in the Home Services Program (HSP). Medicaid Waiver programs enable states to use both federal and state Medicaid funds to pay for services related to medical care that would not ordinarily be covered under Medicaid. The Department of Human Services (DHS) Division of Rehabilitation Services (DRS), HSP provides services to individuals with disabilities so they can remain in their homes and be as independent as possible. Services are provided by Individual Providers (formerly referred to as Personal Assistants) or by a Homemaker Agency. In order to preserve the integrity of the HSP waiver program, the Department-OIG identifies and evaluates referrals of suspected fraud and abuse of the HSP program.

Personal assistants within the HSP who commit fraud are subject to administrative, civil and criminal actions. There are two types of fraud that commonly occur in this program, Individual Provider and Customer. IP fraud may involve billing for services not provided, agreeing to split checks with the Customer, providing services when the Customer and is not in the home and forgery. Customer fraud may consist of approving hours not worked by IPs, forgery of signature(s) and "splitting" checks with IPs.

In FY 2015, one example of IP fraud included an IP who claimed to have provided personal assistant services for the same days and times that the Customer was residing in the state of Minnesota. The IP pled guilty to a class 1 felony of vendor fraud and was sentenced to six months in the county jail and ordered to pay $38,787 in restitution to the State of Illinois. In another case, the IP claimed to have provided personal assistant services and continued billing for services after the Customer died. The IP pled guilty to a class 1 felony of vendor fraud and was placed on probation and ordered to pay $12,823 in restitution to the State of Illinois.

OIG's evaluation process included review of 573 cases involving suspected fraud and abuse of the personal assistant program. As a result of the OIG evaluations, over 39 cases of potential fraud have been referred to the Illinois State Police Medicaid Fraud Control Unit (ISP-MFCU).

Criminal Actions

Several of the cases referred by the OIG to the ISP-MFCU have resulted in further investigations and recent prosecutions by the U.S. Attorneys in the Southern and Central Districts of Illinois. Investigations of these cases are performed by the Illinois Health Care Fraud Task Force. This task force is composed of the ISP-MFCU; HFS-OIG; U.S. Department of Health and Human Services-OIG; the FBI, Internal Revenue Service; and the Illinois Attorney General's Office; among others. In addition, several referrals are also currently

being prosecuted in the state courts by the Illinois Attorney General's office or local State's Attorneys. During the current fiscal year, there have been six cases successfully prosecuted, with many others still being investigated or working their way through the court system. These convictions resulted in more than nine and ½ years of incarceration and 21 years of probation, along with restitution ordered in the amount of $115,961.

OIG Administrative Actions and Penalties

Every IP is required to enroll in the Medical Assistance Program and is subject to OIG oversight. Therefore, OIG has the authority to pursue administrative actions to terminate an IP from the program if he/she is convicted of fraud or if the IP has a disqualifying conviction. Further, IPs who commits fraud is subject to recovery of improper billings, termination, and the imposition of civil monetary penalties or fines. Finally if an IP is terminated from the HSP, such action also results in the IP becoming barred and prohibited from employment in any state or federal healthcare program. This sanction provides important protections for the State of Illinois and prevents further loss of revenue from the Medicaid Waiver Programs.

DHS Fraud Unit and Collections

In a collaborative effort to identify fraud, waste and abuse of the HSP Program, DHS maintains a Fraud Unit consisting of a manager, three researchers and one support staff who conduct initial investigations related to allegations of fraud within the HSP program. HSP Investigations focus on Customer & Individual Provider (IP) eligibility issues, benefits and services. The DHS Fraud Unit coordinates investigations with collaborative partners such as HSP field offices, Health & Family Services (the Department) Office of the Inspector General (OIG), ISP MFCU, along with Federal law enforcement agencies as applicable. Investigations may take anywhere from a few days up to a year or more depending on the allegations.

The DHS Fraud Unit receives notification of alleged fraudulent activity in a number of ways. Allegations may be received from a DRS Field Office, phone calls from the public reporting possible fraud or by data mining reports. Before an investigation commences, an Unusual Incident Report (UIR) typically is completed in the WEB CM (a case management system). The report is then forwarded to the Fraud Unit manager for review and assignment. Each report is given a unique number for tracking purposes. The Unit has begun "data mining" as electronic files become available. This allows the Unit to sort applicable data in an effort to identify fraudulent trends that may be developing. As potential fraudulent activity is identified, referrals will be made to the HFS-OIG for further investigations.

The Customer or IP may or may not know an investigation is being conducted. Once an investigation has been completed and the alleged fraud is substantiated, the case is either forwarded for prosecution or returned to HSP for the establishment of an overpayment. The Customer and/or IP are notified an overpayment has been identified and that misspent funds will be recovered. Overpayment claims are forwarded to the DHS Bureau of Collections, who has the authority to establish repayment agreements and enforce collection activity.

Overall, there have been 231 claims worth $369,376 established for the HSP and forwarded to the DHS Bureau of Collections during FY15.

COOPERATIVE INITIATIVES WITH THE ILLINOIS STATE POLICE'S MEDICAID FRAUD CONTROL UNIT

The OIG and the MFCU unit have created a well-functioning and committed partnership. As part of this relationship, OIG follows consistent standards for the evaluation of fraud referrals to the MFCU. The State of Illinois in collaboration with MFCU developed a standard referral form that ensures that cases having reliable evidence that overpayments discovered during an audit are the product, in whole or in part, of fraud committed by the provider, or that are based on data analysis that reveals aberrant billing practices that appear unjustifiable based upon normal business practices, are referred to the MFCU.

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

On an ongoing basis, OIG offers education to MFCU. In order to allow MFCU investigators to more efficiently pursue their cases Illinois has offered education and training to MFCU units, both informally and formally pertaining to the Medicaid program, which has improved that unit's efficiency and overall ability to investigate and prosecute Medicaid fraud cases.

Illinois holds regular meetings between the two entities in order to promote the high level of communication that is integral to the success of both. The meetings have achieved an increased number of quality fraud referrals. The meetings include agendas that allow close coordination between MFCU and the OIG that facilitates the identification of new fraud trends, increases accountability, and generally improves the productivity of the two agencies. The OIG meets monthly with the entire group and a smaller established group meets on the Narrative Review committee to discuss specific fraud referrals. The leadership for the OIG and MFCU is present at the meetings. As part of this ongoing initiative, the appointed Fraud and Abuse Executive from OIG serves as the representative responsible for selecting meeting dates and times to ensure that appointments for future meetings occurred on a regular basis as planned.

THE DEPARTMENT'S THIRD PARTY LIABILITY PROGRAM

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

The Department requires individuals to report TPL coverage when applying for Medical Assistance as a condition of eligibility. Although one of the primary sources of TPL identification is through client interviews during the intake and redetermination processes, the Department also identifies potential third party resources through a variety of methods, including contacting employers and relatives, through data exchanges with health insurance carriers, review of court dockets and data exchanges with the Illinois Workers' Compensation Commission. The Department also requires medical providers to bill third parties prior to billing the Department for most services (cost avoidance), and assists enrollees in coordinating benefits between their private health insurance coverage and Medicare.

The TPL program saved taxpayers approximately $85,810,148 in Medicaid federal cost avoidance and recovered $432,242,641. During FY15, these savings and recoveries resulted from identification of third party resources, avoidance of payments on claims with a known responsible third party, benefit recovery efforts through subrogation of paid claims, as well as estate and tort action collections. The Department works to maximize TPL utilization and to integrate TPL recovery with the managed care program.

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

FEDERALLY MANDATED PAYMENT ERROR RATE MEASUREMENT (PERM) INITIATIVE

For the review periods of FFY14–FFY16, in lieu of allowing states to target specific areas within the Medicaid program for MEQC, CMS provided states guidance for a three year review of cases affected by the implementation of the Affordable Care Act. The pilots are intended to evaluate the performance of both automated processes and caseworker actions as well as to correct eligibility errors and to identify discrepancies.

These reviews consist of two components; reviews of eligibility determinations (pulling a sample of eligibility determinations made by the state and perform an end to end review from initial application/point of transfer to the final eligibility determination) and testing cases (running test cases provided by CMS through the UAT section of the state's eligibility determination system.) For the eligibility portion, the states have been mandated to conduct a minimum of 200 reviews for each of the six month sample periods within the FFY, or 400 annually. The OIG tested 21 cases through the UAT testing system and is in the process of testing another 20 more.

In FY15, findings were submitted to CMS for the first and second six months of the eligibility reviews (FFY14) and for the first six months of the test cases. Currently the OIG is

reviewing the first six months of eligibility reviews for FFY15 and the second six months of test cases for FFY14.

Prior to FFY14, to fulfill the MEQC requirement, states were allowed (with approval) to target specific areas within the Medicaid program as long as they met the number of hours equivalent to conducting 1750 (875 each six month sample period) Medicaid reviews, or 13,650 hours annually.

OIG PROGRAM INTEGRITY SAVINGS AND COST AVOIDANCE TABLES

LEGAL ACTIVITIES AND SANCTIONS

Termination, Suspension, Exclusions and Denials from Program Participation

The OCIG acts as the Department's prosecutor in administrative hearings in matters pertain to program violations. In certain instances when adequate evidence of violations exists, OIG considers whether to invoke the termination, denial, exclusion or suspension authority on the basis of the provider's actions. OIG may terminate, suspend, deny or exclude individuals and entities from participation in Medicaid health care program for many reasons, some of which include program-related convictions, patient abuse or neglect convictions, licensing board disciplinary actions, or other actions that pose a risk to recipients of the Program. Certain exclusions and terminations may be based on referrals from other Federal and State agencies. OIG works with these agencies to ensure timely and efficient administrative action.

Corporate Integrity Agreements

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

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

In FY15, OIG terminated, denied, suspended or excluded over 143 providers, individuals and entities from participation in the Illinois Medical Assistance Program. Searchable exclusion lists are available on OIG's Web site at: http://www.illinois.gov/hfs/oig/Pages/SanctionsList.aspx. Providers who are terminated or debarred from the program are restricted from participation in the Program and may not be employed by any entity receiving payment by a federal or State health care program.

Sanctions			
Hearings Initiated	# Cases		
Termination	128		
Termination/Recoupment	16		
Recoupment	152		
Suspension	0		
Denied Application	6		
Decertification	8		
Final Actions	# Cases	Total Medical Provider Sanction Dollars	
Termination	123		
Termination/Recoupment	7	Cost Savings:	$2,195,998
Suspension	0	Cost Avoidance:	$2,225,165
Voluntary Withdrawal	2		
Recoupment	74		
Decertification Resolution	7		
Civil Remedy	12		
Barrment*	3		
Civil Remedy	0		
Reinstatement Actions	# Cases		
Denied Application	9		
Reinstated	10		
Disenrollment	29		
Payment Withhold	11		

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

MEDICAL PROVIDER AUDITS

The OIG initiates provider audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Audits generally cover a 24-month audit period and are conducted on both institutional and non-institutional providers. The OIG conducts field audits, desk audits and self-audits of providers. When a provider is selected for a field audit, the provider is contacted, and records are reviewed onsite by the audit staff. When the OIG performs desk audits of providers, claim information is reviewed without having an auditor physically visit the providers' facilities. Self-audits allow an opportunity for providers to review their own records and report billing irregularities.

Providers with identified overpayments are asked to either repay the liability, present documentation to dispute the findings or request an administrative hearing. Audits are considered completed upon receipt of the provider's payment, a negotiated settlement or the HFS Director's final decision. The provider may repay the Department by check or by a credit against future billings, in either monthly installments or a single payment. Because providers are allowed to make payments in installments, collections vary, and the amount reported will often cover audits closed in previous periods. As a consequence, collections generally result from audits completed in prior periods.

Collections by Audit Type	
	Dollars
Desk Audit	$329,273
Field Audit-	$14,987,062
FST Projects*	$2,807,744
Self Disclosure	$1,008,617
Other	$11,399
Total	**$19,144,095**
Restitution	$37,349
Global Settlements	$3,350,398
Total	**$22,531,842**

* Audits established through system routines

Audits Initiated	
	# Cases
Initiated	3,899
Completed	403

PROVIDER PEER REVIEWS

OIG's Peer Review Section monitors the quality of care and the utilization of services rendered by practitioners to Medicaid recipients. Treatment patterns of selected practitioners are reviewed to determine if medical care provided is grossly inferior, potentially harmful or in excess of need. Provider types selected for Peer Reviews include physicians, dentists, audiologists, podiatrists, optometrists, and chiropractors. Peer review also reviews providers seeking to be reinstated into the Medicaid program.

OIG staff nurses schedule onsite reviews with providers or request that the provider mail medical records to review. Applicants seeking reinstatement submit medical records for review. A written report documenting findings and recommendations is subsequently completed. Possible recommendations may include: case closure with no concerns; case closure with minor deficiencies identified; or a referral to a department physician consultant for further review of potentially serious deficiencies. Additionally, a recommendation may be made to evaluate the reinstatement applicant's medical records. Based upon the seriousness of the concerns, the physician consultant's recommendations may include: case closure with no concerns identified; case closure with minor concerns

addressed in a letter to the provider; Continuing Medical Education; intra-agency or inter-agency referrals; onsite review by the consultant; and/or an appearance before the Medical Quality Review Committee (MQRC). In addition to the above recommendations, the provider may be referred to OCIG for suspension or termination from the Medical Assistance Program.

Peer Review Outcomes	
	# Cases
Letter to Provider with Concerns	22
Letter to Provider without Concerns	2
Referral for Sanction	5
Referral for Audit	3
Voluntary Withdrawal	4
Withdrew Reinstatement Request	3
Recommend Reinstatement	2

LAW ENFORCEMENT

The OIG is mandated to report all cases of potential Medicaid fraud to the ISP-MFCU. Along with reporting the occurrence of fraud, the OIG also provides data and data analysis support to MFCU, and other law enforcement entities such as HHS OIG, the U.S. Attorney, the Illinois Attorney General, and the FBI to support their criminal investigations.

Law Enforcement	
Enforcement Activities	# Cases
Referrals to Law Enforcement	87
Law Enforcement Data Requests	63

CLIENT ELIGIBILITY

Eligibility for public assistance depends on factors such as earnings, other income, household composition, residence, and duplicate benefits. When clients are suspected of misrepresenting their eligibility, the OIG will conduct an investigation. Results from an investigation are then provided to DHS caseworkers to calculate the recoupment of any overpayments. In cases with large overpayments or aggravated circumstances, the OIG prepares the case for criminal prosecution and presents it to a state's attorney or a U.S. Attorney.

Client Eligibility		
Enforcement Activities	# Cases	Total Overpayments Established
Investigations Completed	906	
Founded	639	
Unfounded	267	$8,092,142
Convictions	7	
Administratively Closed	121	
Type of Investigations	# of Allegations	Percent (%)
Absent Children	731	12.0
Absent Grantee	117	2.0
Assets	218	4.0
Employment	1,098	18.0
Family Comp / RR In Home	652	11.0
Family Composition	699	12.0
Impersonation	31	1.0
Ineligible Household Member	70	1.0
FS Traffic / LINK Misuse	489	8.0
Interstate Dup. Assistance	47	1.0
Other Income	687	11.0
Prosecution	324	5.0
Residence Verification	719	12.0
TPL	111	2.0
Total	**5,993**	**100.0**

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

Clients who intentionally violate the Supplemental Nutrition Assistance Program (SNAP) are disqualified from the program for a period of 12 months for the first offense; 24 months for the second offense; permanently for the third offense; and ten years for receiving duplicate assistance and/or trafficking. Cost avoidance in SNAP cases is calculated as the average amount of food stamp issuances made during the overpayment period times the length of the disqualification period.

Supplemental Nutrition Assistance Program		
Enforcement Activities	# Cases	Total Dollars Established
Referred to BAH	1,431	Cost Avoidance: $4,264,832 SNAP Overpayments: $3,750,667
Reviews Completed	1,456	
Pending ADH decision	688	
FADS	1,202	
Waivers	417	
Lost	75	
Court Decisions	3	

CHILD CARE

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care provided at inappropriate rates. The results of these OIG investigations are provided to DHS's Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. Attorney, or to the DHS Bureau of Collections for possible civil litigation.

Child Care		
Enforcement Activities	# Cases	Total Dollars Established
Founded	7	$154,980
Unfounded	0	
Convictions	0	
Investigations Completed	**7**	

CLIENT MEDICAL CARD MISUSE

The OIG conducts investigations when clients or vendors are suspected of misuse or misrepresentations concerning the medical programs. Client fraud occurs when clients are suspected of misusing their medical cards or when their cards are used improperly without their knowledge. Typical examples include loaning a medical card to ineligible persons; visiting multiple doctors during a short time period for the same condition; obtaining fraudulent prescriptions; selling prescription drugs or supplies; or using emergency room services inappropriately.

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

Client Medical Card Misuse		
Enforcement Activities	# Cases	Total Dollars Established
Founded	8	$34,475
Founded In-Part	3	
Unfounded	10	
Investigations Completed	**21**	

FRAUD PREVENTION INVESTIGATIONS

The Fraud Prevention Investigation (FPI) program was originally implemented in FY1996. The FPI program was designed to target error-prone assistance applications containing suspicious information or meeting criteria for pre-eligibility investigation. The program is administered through Cook County Illinois Department of Human Services (DHS) local offices. The program's goal is to prevent ineligible persons from receiving welfare benefits, thereby saving tax dollars.

Since the program's implementation, the annual cost savings has been calculated using cases that resulted in "negative action" – cases in which benefits were denied, canceled or reduced. Assistance program expenditure information is obtained from DHS and an average monthly amount of expenditures by each program for each person for a fiscal year is calculated; the average monthly amount identified is then applied to the number of people in each type of assistance program which identifies a monthly savings; this number is then multiplied by 12-months (since this was considered the amount of time that a person would be without assistance); an estimated gross savings is identified through this process for the FPI program. The savings of 12-months has been used since FY06 through FY14.

Originally, the FPI monthly savings was calculated at 6-months from FY96 through FY05. In FY06, the multiplier was changed to 12-months in order to increase the savings amount

for that fiscal year. The 12-month multiplier has been used thereafter in order to calculate cost savings.

Upon reviewing the program's savings for the last three fiscal years, the multiplier of 3-months would be more accurate since this is considered the amount of time that a person would be without assistance. This multiplier would more accurately reflect the number of months a person is off the assistance rolls before reapplying and being approved for assistance. This multiplier was identified as a result of reviewing each "negative action" cases for fiscal years 2013, 2014 and 2015.

For fiscal years 2013, 2014 and 2015, using the 12-month multiplier, the program averaged a cost savings of $11.54: $1.00 for each dollar spent on the program; for fiscal years 2013, 2014 and 2015, using the 3-month multiplier, the program averaged a cost savings of $2.88:$1.00 for each dollar spent on the program. As a result of using the 3-month multiplier in the calculation of cost savings, this significantly reduced the amount of savings that was identified in previous fiscal years. The Office of Inspector General (OIG) is reviewing this data to determine if the FPI program remains a viable cost savings program for the Department of Healthcare & Family services and the OIG.

Fraud Prevention Investigation		
Enforcement Activities	# Cases	Total Cost Avoidance
Denied Eligibility	202	
Reduced Benefits	742	
Cases Canceled	166	$1,856,32
Approved	1,790	
Investigations Completed	**2,900**	

LONG TERM CARE-ASSET DISCOVERY INVESTIGATIONS

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

Long-Term Care-Asset-Discovery Investigations		
Enforcement Activities	# Cases	Total Cost Avoidance
Cost Savings Cases[3]	1,891	$68,632,477
Cost Avoidance Cases[4]	1,059	$83,802,482
Total Investigations Completed	**3,544**	**$152,164,959**

CLIENT MEDICAL ABUSE

The OIG investigates allegations of medical abuse by clients enrolled in Medical Assistance Programs. Abusive clients may be placed in the Recipient Restriction Program (RRP). While in previous years the OIG was limited to recipients over-utilizing narcotic prescriptions, the SMART Act expanded OIG's authority to restrict recipients to *any* type of over-utilization. During such an investigation, both staff and medical consultants will participate. Clients whose medical services indicate abuse are restricted to a primary care physician, pharmacy, or other provider type for 12 months on the first offense and 24 months for a second offense. Except in emergencies, program services will not be reimbursed unless authorized by the primary care provider.

[3] Avoidance savings is a projected savings determination and defines final disposition data as the determination used after the regulated arbitration date and may contain instances of re-application or appeal after the arbitration timeframe.

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

A significant advance took place in 2013: total cost avoidance increased more than four times compared with the previous year. This was due to OIG utilizing the DNA Predictive Modeling System during the investigative process. OIG staff saved significant time and resources on data preparation and validation, were able to focus on Recipient Restriction analysis, and handled more cases.

Client Medical Abuse			
Client Restrictions		# Clients	Total Cost Avoidance
12 Month	Client Reviews completed	1,296	
	New Restrictions	85	
	Released or Canceled Restrictions	166	
	Converted to 24 Month Restrictions	139	$6,914,471
24 Month	New Restrictions and Re-restrictions	155	
	Released or Canceled Restrictions	153	
Total clients restricted as of 06/30/2015		**1,924**	

INTERNAL INVESTIGATIONS

The OIG investigates allegations of employee and contractor misconduct and conducts threat assessments as part of its security oversight. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses, and contract violations.

Internal Investigations	
Enforcement Activities	# Cases
Investigations Completed	**318**
Substantiated	34
Unsubstantiated	282
Administratively Closed	2
Types of Allegations Investigated	Percent (%)
Non-Criminal (Work Rules)	93.8
Discourteous and Inappropriate Behavior	2.7
Failing to Follow Instructions	1.7
Negligence in Performing Duties	1.8
Conflict of Interest	1.2
Falsification of Records	34.9
Sexual Harassment	0.3
Release of Confidential Agency Records	0.9
Misuse of Computer	1.4
Work Place Violence	0
Time Abuse and Excessive Tardiness	1.4
Conduct Unbecoming State Employee	47.5
Criminal (Work Rules)	2.6
Theft or Misuse of State Property	0.5
Commission of or Conviction of a Crime	0.9
Criminal Code 720 ILCS 5	1.2
Misappropriation of State Funds	0
Security Issue, Contract Violation	2.6
Special Project, Assist other Agencies	1

Internal investigations often reveal violations of work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension, or reprimand. Misconduct Outcomes identified during FY15 are listed below:

Internal Investigations	
Misconduct Outcomes	# Actions
Misconduct Identified in 2015	15
Employee	15
Vendor/Contractor	0
Misconduct Resolutions Reported 2015	37
Discharge	0
Resignation	3
Suspension	9
Other, such as reprimands	5
Referred to Other Sources for Resolution	1
Administrative Action Pending at Year End	16
No Action Taken by Agency	3

NEW PROVIDER VERIFICATION

Previous monitoring of non-emergency transportation and durable medical equipment providers began in June 2001. This was done by performing pre-enrollment on-site visits to verify their business legitimacy and by performing an analysis of their billing patterns to detect aberrant behaviors during a 180-day probationary period. This process has been expanded under the SMART Act to include comprehensive monitoring of all providers for a one year probationary period. During on-site visits, the business' location and existence is confirmed; information provided on the enrollment application, including ownership information, is verified; and the business' ability to service Medicaid clients is assessed.

After applications are returned, enrollment may be denied for various reasons: an incomplete enrollment package; a non-operational business; the inability to contact the applicant; a requested withdrawal by the applicant; applying for the wrong type of services; and the applicant's non-compliance with fingerprinting requirements. Once the applicant has addressed the issue(s) and re-submitted the application, the New Provider Verification process is re-started. Applicants can also be denied enrollment into the

program for other reasons such as the failure to establish ownership of vehicles; fraud detected from another site affiliated with the applicant; an applicant's participation in the Medicaid Program using another provider's number; and providing false information to the Department.

New Provider Verification	
Enforcement Activities	# Cases
Enrolled	40
Withdrew Application	2
Applications Returned	25
Applications Referred for Denial	2
On-Site Verifications Completed	68
Provider Monitoring	1
Reviews Completed	**64**

CLIENT PROGRAM OVERPAYMENTS

WARP receives fraud referrals from internal and external entities and gathers the supporting documentation. Based on the documentation that is gathered, WARP makes a decision to do one of the following: send the information to BOI for additional investigation, close the case for lack of merit, forward the case onto a DHS office for additional follow up or sends all the findings to DHS Bureau of Collections, BOC, to have a dollar amount and timeframe established.

If the information is sent to BOC, they will then respond via e-mail to WARP with the dollar amount and timeframe of the overpayment that is then entered into case as BOC LO Food Stamp and/or BOC LO TANF.

Client Program Overpayments	
Client Program	
BOC LO Food Stamps	$656,821
BOC LO Grant	$29,076
Total	**$685,896**

Fraud Allegations	
Allegations	Received
Calls	7,205
Web Referrals(includes HFS employee , DHS hotline and web site)	3,873
Hard Copy(faxes, extra e-mails, USPS and DHS/OEIG)	1,985
Requests from DHS Local Offices	418

ENFORCEMENT ACTIVITIES

INVESTIGATIONS

During the period from July 2014 through June 2015, the Bureau of Investigations (BOI) completed various types of investigations throughout the state. A number of investigations had been completed during this fiscal year have elements of particular interest, which are noted below:

- *Absent Children/Other Income* - The investigation reveals the client received excess assistance because they failed to report to the Illinois Department of Human Services, that the child did not reside with the client and because the client failed to report their spouse resided in the assistance unit.

  The investigation was completed in June 2014. The client received a total of $27,393 in excess assistance because of their failure to report the correct household composition. The case is being considered for prosecution and is pending assignment to an investigator.

- *Family Composition/Responsible Relative in Home* - The evidence in this case shows the client was aware of their responsibility to report all household members, household income and assets to the Illinois Department of Human Services, yet the client deliberately failed to do so in order to avoid the reduction or cancellation of their food stamp benefits. The client received a total of $16,031 in excess assistance from December 2007 through April 2012 based on their failure to report all of her husband's income to the Illinois Department of Human Services.

  The investigation was completed in March 2014 and referred to the Randolph County State's Attorney's office in April 2014. The defendant waived their preliminary hearing on June 19, 2014. The defendant pled on September 30, 2014 to theft under $500 and a Class A misdemeanor. The defendant was ordered to pay $500 in court costs/fines and full restitution of $16,031.

- *Medicaid/HMO* - During the course of a recipient medical investigation in September 2014, it was discovered that the recipient, who had an active medical benefits only case, had been deceased since November 2013. The Reporting Investigator (R/I) followed up on this information in order to determine if another person may have fraudulently been using the recipient's Medical Card after their death. For the previous four months (June 2014 – September 2014), payments of $918.87 had been made to Health Alliance Medical ICP.

  The BOI medical investigation verified that the recipient had been deceased since November 16, 2013, and that there were no indications that another individual had used or attempted to use the recipient's Medical Card. The investigation also

verified that the recipient's medical benefits only case had remained active, and that monthly payments of $918.87 were made to Health Alliance Medical ICP for the period from June 2014 through September 2014.

The investigator obtained a copy of the recipient's death certificate, and after the proof of death was provided to the Department of Human Services, the medical benefits only case was cancelled. Information concerning the recipient's death was also provided to the Department of Healthcare & Family Services Bureau of Claims Processing and Health Alliance HMO. As a result of the investigation, it was recommended that recoupment of any and all monies paid to Health Alliance Medical ICP be initiated.

- *Family Composition/Responsible Relative in Home/Prosecution* - The investigation revealed the client was aware of their responsibility to report all household members, income and assets to the DHS, yet she deliberately failed to do so in order to avoid the reduction or cancellation of her food stamp benefits. The client received a total of $42,684 in excess assistance from April 2007 through December 2012 based on her failure to report the client's spouse was living in the assistance unit and receiving employment income.

  The investigation was completed in October 2013 and referred to the Madison County State's Attorney. The client was charged with a Class A misdemeanor of theft in relation to State Benefits Fraud, on October 28, 2013. The client's case had a number of continuances. However, on June 1, 2015 the client was sentenced to two years probation and ordered to pay full restitution of $42,684.

- *Family Composition/FS Traffic/LINK Misuse/Prosecution* - An anonymous referral was received alleging the DHS client was married, the client's spouse resided in the assistance unit and the client was selling her LINK card. The investigation revealed the client was married and her spouse was receiving income from employment. However, there was insufficient evidence to prove the client was selling her LINK card. The period under investigation covered June 2009 through October 2014. The investigation was completed in October 2014 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $27,257. The case is being referred for possible prosecution.

- *Family Composition/Other Income/Prosecution* - A BOI investigation found in November 2014 that a Child Care recipient failed to report to the Child Care Connection that for the period of June 2011 through May 2012 the client's child care provider was incarcerated in the Kankakee County Detention Center and the Illinois Department of Corrections. During this time period, the client continued to report to the Child Care Connection that this incarcerated provider was providing care to her children, which resulted in a child care overpayment of $11,465.73 for the period of June 2011 through May 2012.

The results of this investigation were submitted to the Kankakee County State's Attorney's Office and on March 6, 2015 this recipient was indicted for State Benefits Fraud (Class 3 felony).

- *Prosecution* - A BOI investigation found that from May 2012 through April 2014 a SNAP client was employed with a local hospital, during which time they had income from the hospital totaling $101,309.66. Despite being aware of her responsibility to report this income to DHS, the client admitted she deliberately failed to report this income to DHS to avoid having her SNAP benefits reduced or cancelled. As a result of this client's intentional failure to accurately report her income, it was determined that, for the period of May 2012 through April 2014, the client was overpaid $12,327 in SNAP benefits.

  On April 28, 2105 an investigative report detailing the facts of this case was submitted to the Tazewell County State's Attorney's Office. The Tazewell County State's Attorney's Office subsequently charged this client with one count of State Benefit's Fraud (Class 3 Felony) and on July 2, 2015, this client was indicted on that charge.

- *Family Composition/Responsible Relative in Home* - An internet referral was received indicating the parent of the DHS client's children was living in the assistance unit. The investigation revealed the parent of the client's children lived in the assistance unit with the client and their children from January 2008 through April 2015. During this time, the parent had income from employment. The investigation was completed in May 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $7,407.

- *Family Composition/Prosecution* - A BOI Client Eligibility investigation found that a client falsified her spouse's residence and household composition by not reporting the client's spouse (and parent of their children) who resided with client. The investigation determined that the client's spouse resided with the client at a residence not reported, and the client's spouse had earned significant unreported income. Forms the client submitted to the DHS local office were found to be fraudulent, and the fraud was determined to originate as far back as January of 2011. Additionally, statements given by neighbors were useful in determining the extent of the fraud, despite inconsistent information given by the client, the client's employer, and relatives of the client.

  The client eligibility investigation was completed in January 2015 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $30,907.00. That information was also referred to the local State's Attorney Office for prosecution.

- *Employment/Prosecution* - A BOI prosecution investigation revealed that a client was aware of his responsibility to report all income from employment to the Illinois

Department of Human Services (DHS). The client was also aware that he could be referred for prosecution for fraud as the result of him hiding or reporting false information. The client neglected to report to DHS that he was employed and received income from the State of Illinois, while also receiving public assistance during the period of December 2013 through March 2014.

The concealment of the client's employment income allowed him to receive $1,388 in SNAP/food stamp assistance during the period of December 2013 through March 2014. The client would not have been eligible to receive SNAP/food stamp assistance during that period if he had reported his employment earnings. Therefore, the client received $1,388 in excess SNAP/food stamp assistance.

Wage verifications, State of IL employment earnings, 2013 W-2's & IL Taxes, confirmed the client's employment. The client admitted to using the LINK card while employed.

The investigation was completed by BOI in December 2014 submitted to the Sangamon County Attorney's Office. On July 8, 2015, the client plead guilty to theft, a Class A misdemeanor. A Judgment was entered on the plea and the client was sentenced to 24 months' probation. The client was also ordered to pay restitution to the Department in the amount of $1388.

- *Interstate Duplicate Assistance/Residence Verification* - The Bureau completed an investigation into Interstate Duplicate Assistance. It was reported by a Walgreen's pharmacist that the recipient was using an Illinois Medical Card to have pain medication prescriptions filled in Illinois and an Indiana Medical Card to simultaneously have pain medication prescriptions filled in Indiana.

  The BOI client eligibility investigation found sufficient evidence that the recipient was receiving and using Medicaid benefits simultaneously in Illinois and Indiana. The investigation found that the recipient was eligible to receive Medicaid benefits in Indian during the period from June 1, 2013 through July 31, 2014, and that during the same period the recipient was eligible to receive Medicaid benefits in Illinois. Records showed that during the period from June 2013 through July 2014, $51,995.36 in Medicaid claims were paid on the recipient's behalf in Illinois. The investigation also determined that the recipient received SNAP benefits in both states during the month of April 2014. Indiana FSSA/DFR pursued an overpayment for the duplicate SNAP benefits, while Illinois DHFS pursued an overpayment for the duplicate Medicaid benefits.

- *Absent Children/Employment/Interstate Duplicate* Assistance - It was reported by an individual via the Internet that the client was claiming that their child was living with the client in Illinois in order to receive welfare benefits for the client and the child. It was further reported that the child had been living with the other parent in Iowa during the period the client was receiving welfare benefits for the child.

The BOI client eligibility investigation found that the client committed welfare benefits fraud by claiming that child was residing with the client in Illinois in order to receive welfare benefits for the client and the child. The investigation found the client had repeatedly reported to the Department of Human Services (DHS) that the child was living with the client in Urbana, IL, and that the client had received welfare benefits for this child during the period from January 2012 through August 2014, when the case was cancelled. The investigation found evidence that the child was living with the other parent in Iowa during this period, and confirmed that the child had been continuously enrolled in school in the Davenport, IA school system during the period that the client had reported they were living in Urbana, IL. The failure of the client to accurately and truthfully report information to DHS resulted in the client receiving an estimated overpayment of SNAP/food stamp benefits totaling $8,855.00 for the period from January 2012 through August 2014, and an estimated overpayment of cash assistance benefits totaling $1,260.00 for the period from February 2013 through June 2013.

- *Absent Children/Absent Grantee/Impersonation* - A BOI investigation found in September 2014 that the spouse of a former DHS client was issued SNAP benefits in the client's name. The former client, the person whose identity was fraudulently used, was actually living in the country of Serbia at the time the benefits were issued. The results of the investigation were submitted to the local DHS office, which calculated that the spouse had fraudulently received $13,758.00 in SNAP benefits.

- *Employment* - A BOI investigation was completed in October 2014 which found that a SNAP client reported to DHS in June 2011 that her income from employment had ended. The investigation found that despite what the client had reported to DHS, the client continued to work for the same employer. The results of the investigation were submitted to the local DHS office, which calculated she received a SNAP overpayment of $18,012.

- *Third Party Liability* - A BOI investigation found in October 2014 that on three occasions (August 14, 2012, November 9, 2012, and February 7, 2013) a nurse fraudulently prescribed three prescriptions, with a total of four refills, for Hydrocodone-Acetaminophen in the name of a Medicaid recipient. In October 2014, the investigation found the nurse acted alone and without the knowledge of the recipient in whose name the prescriptions were listed. These prescriptions resulted in $198.75 in misspent Medicaid monies.

- *Child Care Recipient* - A BOI investigation found in November 2014 that a SNAP and Child Care client failed to report to DHS, or the Child Care Connection, that the client's spouse, the parent of her two children, had been living in the client's assistance unit since May 2010. During this time period, the spouse/parent of the children had income from employment. The results of the investigation were

submitted to the local DHS office as well as the Bureau of Child Care Development. As a result of this investigation, DHS determined the client had received an overpayment of $20,688.00 in SNAP benefits. The overpayment calculation from the Bureau of Child Care Development is pending, but has been estimated by BOI to be approximately $9,470.

- *Family Composition/Responsible Relative in Home/Other Income* - A BOI investigation found in December 2014 that a SNAP client failed to report to DHS that the client's spouse, and parent of their children, had been living in the client's assistance unit since January 2009, during which time the spouse had income from employment. The results of the investigation were submitted to the local DHS office, which calculated that due to the client failing to accurately report his household composition and income, the client received an overpayment of $33,222 in SNAP benefits.

- *Child Care Recipient/Employment/Family Composition/Responsible Relative in Home/Residence Verification* - A BOI Child Care investigation found that a client falsified her residence and household composition by not reporting her fiancé (and the parent of her child) who resided with the client, and their actual residence. The investigation determined that the client's fiancé resided with them at a residence not reported, and the fiancé had earned significant unreported income. Forms the client submitted to the DHS local office were also found to be fraudulent. Additionally, social media postings by the client on Facebook were useful in determining the extent of the fraud.

  The child care investigation also led to a client eligibility investigation as SNAP benefits was paid. The BOI child care investigation estimated a $28,820.85 child care overpayment and that information was referred to Bureau of Child Care Development for collection activity.

  The client eligibility investigation was completed in January 2015 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $9,224.

- *Family Composition* - A BOI client eligibility investigation found that the client was residing with her spouse and they were employed during the entire time of residing together. The client reported she was separated from her spouse. However, all information led to the conclusion that the client's spouse was in the home. A family friend also verified that the client was indeed residing with her employed husband.

  The investigation was completed in December 2014 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $28,742.

- *Family Composition/Responsible Relative in Home* - A BOI investigation found in January 2015 that for the period of October 2010 through May 2011 a SNAP client received unreported child support for her daughter, who was in DCFS care at the time. The completed investigation has been submitted to DHS for SNAP overpayment calculations. BOI has estimated the SNAP overpayment to for this case is $3,678.

- *Employment/Family Composition* - A BOI investigation found in February 2015 that for the period of August 2012 through July 2014 a SNAP client failed to report to DHS that the parent of the client's three children had been living in the client's assistance unit, during which time the spouse had income from employment. The completed investigation has been submitted to DHS for SNAP overpayment calculations. BOI has estimated the SNAP overpayment to be $16,537.

- *Family Composition/Responsible Relative in Home/Other Income/Employment/Third Party Liability/Prosecution* - A hotline referral was received indicating the spouse of the DHS client was living in the assistance unit. The investigation revealed the client's spouse, and parent of the client's children, lived in the assistance unit with the client and their children from March 2008 through February 2015. During this time, the spouse had income from employment. The investigation was completed in March 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $22,911. The case is being referred for prosecution.

- *Family Composition/Other Income/Employment/Prosecution* - A BOI investigation found in March 2015 that a SNAP client failed to report to DHS that the client's spouse had been living in the client's assistance unit since April 2010, during which time the spouse had income from employment. The results of the investigation were submitted to the local DHS office, which calculated that due to the client failing to accurately report her household composition and income, the client had received an overpayment of $30,352 in SNAP benefits.

- *Prosecution* - The allegation indicated the client deliberately failed to report the spouse's income from employment. The investigation revealed the client was aware of her responsibility to report all household income to DHS yet she deliberately failed to do so in order to avoid the reduction or cancellation of their food stamp benefits. The client received a total of $12,103 in excess assistance from November 2010 through May 2012 based on the client's failure to report her spouse's employment income.

  The investigation was completed in August 2013 and referred to the Marion County State's Attorney. The client was charged with a Class 3 Felony of theft in relation to State Benefits Fraud, on March 12, 2015. The Defendant was ordered to pay $12,103 in restitution and fines/fees of $757.

- *Family Composition/Responsible Relative in Home* - A BOI investigation found in March 2015 that a SNAP client failed to report to DHS the client's spouse and parent of the child had been living in the client's assistance unit since April 2011, during which time the spouse had income from employment. The results of the investigation were submitted to the local DHS office, which calculated the client had received an overpayment of $17,040 in SNAP benefits.

- *Employment* - A BOI client eligibility investigation found that a client was employed and failed to report this information to the local office. The client had reported she was only working for a few months at the time of the investigation when the client was indeed working for nearly one year.

  The investigation was completed in April 2015 and referred to the local office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $11,689.

- *Absent Children* - A BOI investigation found in April 2015 that a SNAP client had received SNAP benefits for the client's two children since April 2010. The investigation found the two children had not lived or stayed with the client since November 2007. The results of the investigation were submitted to the local DHS office, which found that due to this client not accurately reporting their household composition, the client received an overpayment of $16,421 in SNAP benefits.

- *Absent Grantee/Family Composition/Responsible Relative in Home* - A BOI investigation found in April 2015 that a SNAP client had not resided within the United States since May 10, 2013. This information was verified by Immigration and Customs Enforcement. The results of the investigation were submitted to the local DHS office, who calculated a SNAP overpayment of $11,674.00.

- *Employment/Family Composition/Responsible Relative in Home/Other Income* - A BOI investigation found in May 2015 that a SNAP client failed to report to DHS that she was married and living with the client's spouse. The client also failed to report the spouse's income. The results of the investigation were submitted to the local DHS office, which calculated that due to the client failing to accurately report their household composition and income, the client received an overpayment of $24,319.00 in SNAP benefits.

- *Family Composition/Responsible Relative in Home/Employment* - A BOI client eligibility investigation revealed that the client's spouse was employed and residing with the spouse in Normal, IL, while the client received SNAP benefits during the period of November 2011 through March 2015. The spouse was employed at State Farm Insurance and CBRE during the period of November 2011 through March 2015. The client failed to report the spouse's income to the Department of Human Services (DHS) during the above period.

Illinois Secretary of State information, 2012 & 2013 W-2's & IL Taxes, employment verification information, children's school verifications and U.S. Postal information confirmed the spouse was in the client's household.

The investigation was completed in March 2015 and referred to the local office for calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of $24,266.00.

- *Other Income/Assets* - A local office referral was received alleging the DHS client was self employed and was not reporting his income. The investigation included pursuing several financial institution subpoenas before revealing one of the client's bank accounts which demonstrated deposits from his business. The client was asked to provide documentation to explain the source of the deposits, but failed to do so, resulting in an estimated SNAP overpayment. During the investigation, the Social Security Administration (SSA) OIG was notified of the potential benefit fraud as the client was also receiving social security benefits.

  The period under investigation covered August 2009 through November 2014. The investigation was completed in March 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $12,173. Subsequent to the closure of this case, the SSA investigator interviewed the client and obtained a written statement wherein the client admitted to not reporting employment income. The case is currently under review by the Assistant US Attorney's office.

- *Employment/Family Composition/Responsible Relative in Home/Prosecution* - A local office referral was received alleging the DHS client's spouse was living in the assistance unit of the client and had income from employment. The period under investigation covered January 2009 through April 2015. The investigation was completed in March 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $30,744. The case is being referred for possible prosecution.

- *Employment/Family Composition/Responsible Relative in Home/Other Income/Residence Verification/Prosecution* - A local office referral was received alleging the DHS client's spouse was living in the assistance unit of the client and had income from employment. The period under investigation covered June 2010 through April 2015. The investigation was completed in March 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $16,602. The case is being referred for possible prosecution.

- *Employment/Prosecution* - A local office referral was received alleging the DHS client's spouse was self-employed and their adult children were working and none of their income was being reported. The client failed to produce verification of such income resulting in an overpayment. The period under investigation covered January 2009 through May 2014. The investigation was completed in March 2015

and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $24,279. The case is being referred for possible prosecution.

- *Family Composition/Responsible Relative in Home/Employment* - This BOI investigation showed the recipient failed to report to the DHS that her husband and father of her children, was living with the assistance unit and receiving employment income.

  The local office reported, during a Supplemental Nutrition Assistance Program (SNAP) redetermination, the caseworker questioned the financial management of the household. The recipient claimed her estranged spouse pays the mortgage and all utilities along with $75 per week, and claimed her estranged spouse also provided everything for the children except food. The recipient also told the local office her estranged spouse was living in a room at a local hotel.

  The investigation was completed in April 2013 and referred to the local office for calculation of an overpayment which was determined to be $8,078. The client was subsequently disqualified from the SNAP program for 12-months in March 2015.

- *Family Composition/Responsible Relative in Home* - A phone referral was received alleging the recipient was receiving child care assistance while the parent of the child was living in the home of the assistance unit. Although the investigation revealed an adult was living in the home of the assistance unit while the recipient was receiving child care assistance, the investigation did not prove the adult to be the parent of the child, therefore there was no overpayment of SNAP benefits. Subsequent to the closure of this investigation, the U.S. Probation and Pretrial Services Office became interested in the allegations made against the client. BOI staff, working with the U.S. Probation and Pretrial Services Office and the Children's Home & Aid Society of Illinois (CHASI), proved the client falsified application documents when applying for child care assistance with CHASI. The BOI investigation was completed in February 2014. During the period of investigation by the three agencies, December 2012 through May 2013, the client admitted to willfully and knowingly stealing government funds. The client knowingly falsified 2 child care application forms, receiving $2,379 in benefits. The client pled guilty on April 16, 2015 to the charge of Theft of Government Funds in violation of Title 18, United States Code, Section 641. The client faces the following penalties: ten years imprisonment; three years of supervised release; a $250,000 fine; restitution to the child care program; and a special assessment of $100.

- *Employment/Family Composition/Responsible Relative in Home/FS Traffic/LINK Misuse* - A phone referral was received indicating the father of the DHS client's children was living in the assistance unit with the client. The investigation revealed the father of the client's children lived in the assistance unit from January 2008 through April 2014. During this time, the father had income from employment. The

investigation was completed in June 2015 with an estimated SNAP overpayment of $23,542.

- *Residence Verification/Employment* - An internet referral was received alleging the DHS client moved to Florida in 2013 and was still receiving benefits in Illinois. The investigation revealed the client was receiving duplicate assistance in Florida and Illinois from August 2014 through February 2015, while residing in Florida. The investigation was completed in June 2015, and determined there was an estimated SNAP overpayment of $5,505. The local office concluded the entire amount to be an overpayment.

- *Employment* - A local office referral was received alleging the DHS client's spouse was self-employed and their income was not being reported. Furthermore, the allegation indicated the client and spouse shared a bank account. The client was asked to produce verification of the spouse's self-employment and verification of the joint bank account deposits; however, the client provided no documentation to support of dispute the self-employment income nor provided documentation to explain the continuous deposits into the joint bank account. During the investigation, local law enforcement authorities were interviewed, who conducted a residency verification to confirm the self-employment allegation. Based on the residency verification and the authority's interview, the client's spouse did operate some sort of business. The investigation was closed as a complete overpayment of SNAP benefits for the period of January 2009 through May 2015. The investigation was completed in June 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of $31,056.

APPENDIX A - REFILL TOO SOON

This table summarizes the Refill Too Soon (RTS) program, as required by Public Act 88-554. RTS is a computerized system of prepayment edits for prescription drug claims. The edits are designed to reject attempts to refill prescriptions within the period covered by a previously paid claim. The estimated savings represents the maximum amount the Department could save as a result of RTS edits. Once payment for a prescription is rejected, the prescription is probably resubmitted later, after the first prescription expires. The estimated savings shown in this table represent the value of all rejected prescriptions, but the true savings are probably less.

Refill Too Soon	
Total Number of Scripts	$2,742,002
Amount Payable	$188,758,205
Scripts Not Subject to RTS	$6,337
Amount Payable	$1,136,759
Scripts Subject to RTS	$2,735,665
Amount Payable	$187,621,446
Rejected Number of Scripts	$175,788
Estimated Savings	**$17,032,897**

APPENDIX B – AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

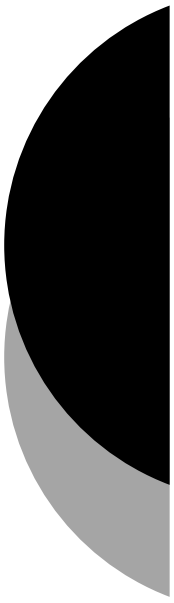
Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of 2015 Annual Report on the OIG website; http://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx. The information, required by Public Act 88-54, is by provider type because the rates of payment vary considerably.

APPENDIX C – ACRONYMS

AABD	Aid to the Aged, Blind or Disabled (AABD) program
ABT	Available Benefit Time
ACA	Affordable Care Act
ADH	Administrative Disqualification Hearing
ALJ	Administrative Law Judge
ASU	Administrative Service Unit
BAH	Bureau of Administrative Hearing
BAK	Bureau of All Kids
BCCD	Bureau of Child Care Development
BFST	Bureau of Fraud Science and Technology
BIA	Bureau of Internal Affairs
BMI	Bureau of Medicaid Integrity
BOI	Bureau of Investigations
CAS	Central Analysis Services
CASE	Case Administration and System Enquiry
CCP	Community Care Program
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHOW	Change of Ownerships
CIA	Corporate Integrity Agreement
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Reconciliation Act
CP	Custodial Parent
CPA	Certified Public Accountant
CPA-LTC	Certified Public Accountant-Long Term Care
CVU	Central Verification Unit
DCSS	Division of Child Support Services
DHS	Department of Human Services
DII	Division of Internal Investigation
DME	Durable Medical Equipment
DNA	Dynamic Network Analysis
DPA	Department of Public Aid
DPH	Department of Public Health
DPI	Department of Program Integrity
DRA	Deficit Reduction Act
DRG	Drug Related Grouper
DRS	Division of Rehabilitation Services
DUI	Driving under the influence
EBT	Electronic Benefit Transaction

EDG	Eligibility Determination Group
EDW	Electronic Data Warehouse
EHR	electronic health record
FAE	Fraud Abuse Executive
FBI	Federal Bureau of Investigations
FCRC	Sangamon County Family & Community Resource Center
FFY	Federal Fiscal Year
FOIA	Freedom of Information Act
FPI	Fraud Prevention Investigations
FRS	Fraud Research Section
GIS	geographic information system
DHFS	Department of Healthcare and Family Services
HHS	Department of Health & Human Services
HMS	Health Management Systems
HSP	Home Services Program
HUD	Housing and Urban Development
IDFPR	Illinois Department of Financial and Professional Regulation
IDOR	Illinois Department of Revenue
IHAP	Inpatient Hospital Audit Program
ILCS	Illinois Compiled Statutes
IPIA	Improper Payments Information Act
IPV	Intentional Program Violation
IRS	Internal Revenue Services
ISP	Illinois State Police
LAN	Local Area Network
LEA	Local Education Agency
LTC-ADI	Long Term Care-Asset Discovery Investigations
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid fraud control unit
MIG	Medicaid Integrity Group
MII	Medicaid Integrity Institute
MMIS	Medicaid Management Information System
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MQRC	Medical Quality Review Committee
MTG	Medicaid Transformation Grant
NCAR	Negative Case Action Reviews
NCCI	National Correct Coding Initiative
NCP	non-custodial parent
NPV	New Provider Verification
OCIG	Office of Counsel to the Inspector General
OEIG	Office of Executive Inspector General

OIG	Office of Inspector General
PA	Personnel Assistant
PACIS	Public Aid Client Inquiry System
PCP	Primary Care Provider
PERM	Payment Error Rate Measurement
PIP	Provider Incentive Payments
PIU	Program Integrity Unit
PRAS	Provider and Recipient Analysis Section
PSA	Public Service Administrator
QC	Quality Control
RAC	Recovery Audit Contractors
ROI	Return of Investment
RRP	Recipient Restriction Program
RTS	Refill too soon
SAS	Social Security Administration
SB	Senate Bill
SCHIP	State Children's Health Insurance Program
SIPV	Suspected Intentional Program Violation
SLF	Supportive Living Facility
SMART Act	Save Medicaid Access and Resources Together Act
SMD	State Medicaid Director
SMDL	State Medicaid Director Letter
SNAP	Supplemental Nutrition Assistance Program
SOS	Secretary of State
SPSA	Senior Public Service Administrator
SQL	Structured Query Language
SSA	Social Security Administration
SSN	Social Security Number
SURS	Surveillance Utilization Review System
TANF	Temporary Assistance to Needy Families
TCN	Document Control Number
TMS	Technology Management Section
TMU	Technology Management Unit
TPL	Third Party Liability
UIB	Unemployment Insurance Benefits
UIR	Unusual Incident Report
US	United States



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