

**Department of Healthcare and Family Services**

Office of Inspector General

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# Annual Report

Fiscal Year 2016

**BRUCE RAUNER, GOVERNOR**

Bradley K. Hart, Inspector General





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

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Bruce Rauner  
*Governor*

Bradley K. Hart  
*Inspector General*

November 4, 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 2016, the OIG continued its preventive and enforcement initiatives that resulted in over \$220 million dollars in savings, recoupment, and avoidance. These savings resulted in a Return On Investment (ROI) of \$10.40 for every dollar spent on OIG operations.**

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 continued to make 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 2016, including the continued development and implementation of the Dynamic Network Analysis (DNA) system; new and continued initiatives in the redevelopment of our auditing programs; continued implementation of the SMART Act (PA 97-689); 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 2016.

Sincerely,

A handwritten signature in blue ink that reads "Bradley K. Hart".

Bradley K. Hart  
Inspector General

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**Office of Inspector General  
Illinois Department of Healthcare and Family Services  
Fiscal Year 2016  
Annual Report**

## 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 prevent fraud as an independent watchdog, has enabled the program integrity component to 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 (DoA). The OIG has developed and enhanced a broad range of tools and techniques to prevent and fight fraud and abuse in Medicaid, All Kids, food stamps, cash assistance, and child care. The OIG also enforces the policies of agencies within the State of Illinois affecting clients, health care providers, vendors, and employees.

The professionals that make up the OIG staff include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers, and information technology specialists. During Fiscal Year (FY) 2016, the OIG had a staff totaling 164 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 FY16, with Bradley K. Hart serving as the Inspector General. The OIG continues working to expand its integrity activities by researching and developing new programs and technologies.

# NOTABLE ACCOMPLISHMENTS

## 220 Million - OIG Total Cost Savings and Avoidance

In FY16, the Office of Inspector General (OIG) for the Illinois Department of Healthcare and Family Services (HFS) 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, and enhanced several ongoing initiatives that led to greater prevention and enforcement during FY16. This aggressive work plan resulted in a marked increase in cost savings and avoidance of *\$220 million dollars*. The cost savings and avoidance represented over a *\$16 million dollar* increase from the \$204 million dollars in cost savings and avoidance realized during FY15. The 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.

*...\$220 million dollars. This cost savings and avoidance represents over a \$16 million increase...*

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 FY16, the OIG Work Plan included notable initiatives (page 8) 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 \$167,636,859

*...\$...167,636,859, with a return on investment of \$71.24 to every \$1.00 spent on that initiative...*

The OIG Work Plan included thousands of investigations, audits, and reviews in FY16 aimed at combating fraud, waste, and abuse. These activities include

- 1,813 Bureau of Medicaid Integrity Audits (BMI);
- 17,659 investigations of fraud allegations received through the Welfare Abuse Recovery Program (WARP);
- 4,063 investigations conducted by the Bureau of Investigations (BOI);
- Over 166 Administrative Sanctions hearings initiated by the Office of Counsel to the Inspector General (OCIG); and
- 1,838 recipient restrictions of clients through the Recipient Restriction Program (RRP) due to overutilization of narcotics

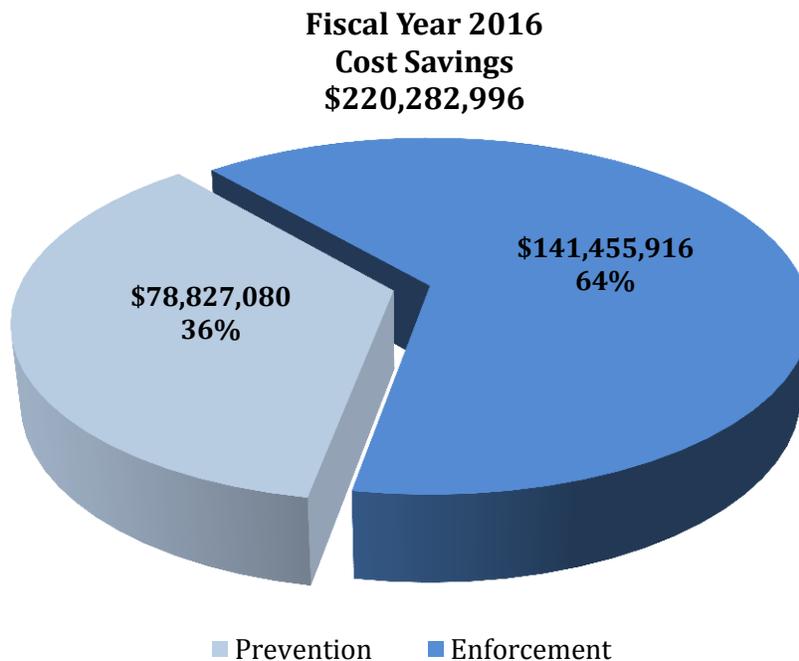
Details of the prevention and enforcement activities are outlined in the sections that follow.

# OIG PROGRAM INTEGRITY COST SAVINGS AND AVOIDANCE

During FY16, OIG has moved forward on numerous fronts to expand the depth and breadth of our Program Integrity Mission. OIG has continued to strive to fulfill its mandate of preventing and detecting fraud, waste, and abuse in the Medicaid program, by relying on the hard work of OIG staff, cooperation with various state and federal government agencies, and the deployment of new technology and scientific methods. 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, OIG has succeeded in generating cost savings, as well as in raising awareness of the importance of Program Integrity among clients, providers, and the citizens of Illinois.

## OIG Fiscal Year Savings

In FY16 OIG realized a savings of approximately \$220 million through collections and cost avoidance. OIG utilized a range of enforcement and prevention strategies outlined in this report to realize those savings.



### **Prevention Activities**

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

### **Enforcement Activities**

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

# OIG FISCAL YEAR 2016 HIGHLIGHTS

## 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. LTC-ADI is charged with ensuring that resource disclosure and transfer policies are appropriately enforced. Execution of this effort is a partnership between the OIG and Department of Human Service Family Community Resource Centers (DHS FCRC). LTC-ADI completes reviews and provides resource directives on LTC applications meeting specified criteria referred by DHS Human Service Caseworkers.

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

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

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

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

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

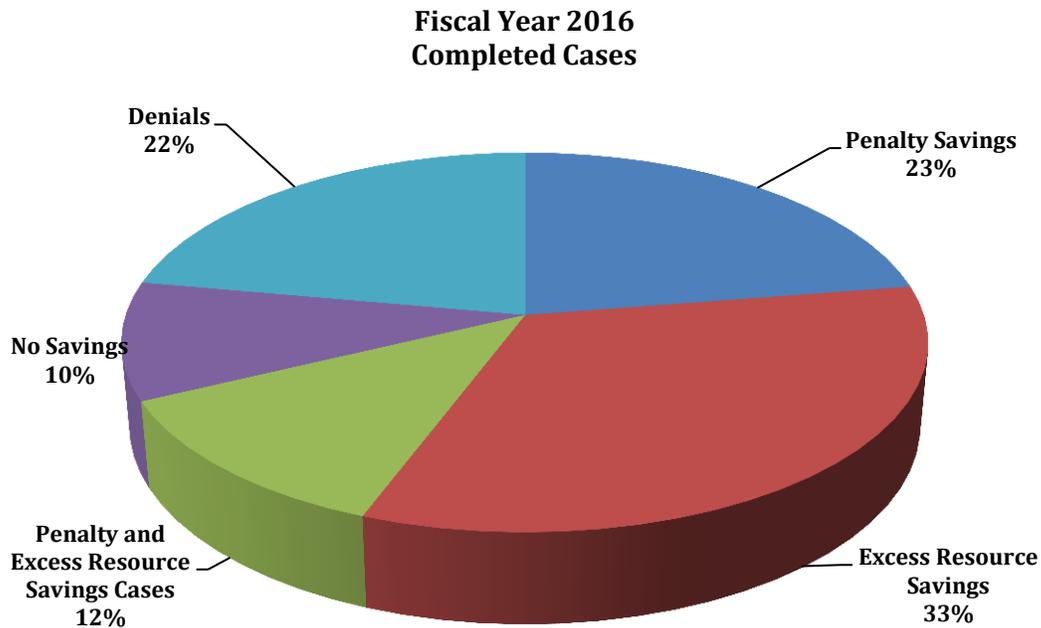
In addition to work on individual eligibility matters, OIG also takes a proactive approach to maximizing administrative efficiency and compliance within state and federal laws. OIG engages in extensive outreach

and education with those entities that specialize in elder and Medicaid eligibility law, LTC facilities, and sister agencies that perform various eligibility tasks.

**NOTABLE RESULTS**

The LTC-ADI unit completed 3,565 cases in FY16. Of the completed cases, 2,751 resulted in a savings to the taxpayer from excess resources or penalties and 898 resulted in a cost avoidance savings<sup>1</sup> as a result of no assistance being authorized. Penalties were applied to 913 cases. A gross savings of \$167,636,859 was realized, with a return on investment of \$71.24 for every \$1.00 spent.

Enforcement Activities	Total Cases Completed	Total Savings
Total Investigations Completed	3,565	\$167,636,859
Cost Savings Cases	2,751	\$96,988,469
Cost Avoidance Cases <sup>2</sup>	898	\$70,648,389



<sup>1</sup> 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.

<sup>2</sup> 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.

## OIG Audit Initiatives

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

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

The OIG consistently recognizes vulnerabilities, creates broad solutions, and realizes tangible results. The 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; including the use of data mining, fraud science routines, and internal and external audits.

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

Additionally, the OIG utilized their partnership with other state and federal resources to insure a greater and immediate impact on high-risk areas. Through FY 2016, Medicaid Integrity Contract auditors (MIC) perform hospice, hospital, pharmacy (specifically high cost drugs), dental, pediatrician, credit balance, and behavior health audits.

The Recovery Audit Contract (RAC) auditors perform audits of provider payments and associated financial records specific to all HFS fee for service payments made to a contractually agreed scope of Medicaid provider(s).

In FY 2017, the OIG intends to expand the use of these specialized internal audit teams, MIC auditors and RAC auditors to aggressively, address program vulnerabilities. Finally, the OIG intends to expand its work with Compliance teams and Special Investigation Units of the managed care organizations to further, enhance program integrity oversight.

The following represents some of the ongoing and proposed FY 2017 OIG Audit Initiatives:

### *POST MORTEM PAYMENT PREVENTION AND RECOVERY*

In FY15, the OIG audit implemented several initiatives focused on areas of identified Program vulnerabilities. This includes audits initiated during FY 15 to identify and recover overpayments made by the Department for deceased Medicaid recipients. This audit initiative is commonly called the Post-Mortem audits. Further, as part of ongoing audit activities, the OIG conducted aggressive outreach to Medicaid providers and provided education on healthcare fraud laws and Department regulations pertaining to the improper billing for payments for deceased recipients.

Importantly, the OIG conducted extensive and comprehensive fraud evaluation of cases involving payments for deceased recipients to determine instances where the evidence of suspected fraud resulted in credible allegations of fraud. In instances of credible allegation of fraud, the cases were referred to law enforcement partners for prosecution. The OIG continues to monitor and audit deceased payments made by MCO providers to ensure overpayments are identified and recovered by the Department.

The OIG intends to continue to monitor for 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 payments made for deceased clients still enrolled in Medicaid. Further, when appropriate, and when the audit provides evidence of improper conduct by a provider, the OIG has invoked its authority to Sanction providers through payment suspensions and terminations from participation in the Medicaid Program.

### *DENTAL SERVICE INTEGRITY COMPLIANCE*

OIG - BFST data reviews established a marked increase in dental payments for orthodontic services. After the SMART Act, dental services were generally excluded from Medicaid coverage, with exceptions for minors. HFS-OIG has performed a comprehensive review to determine the cause of the marked increase in orthodontia payments. HFS-OIG examined compliance with the Departments policies and the quality of orthodontic care rendered to Medicaid Recipients. The OIG intends on expanding both internal and external audits of general dental services to determine whether such payments are in accordance with Illinois Medicaid requirements. HFS-OIG will examine State laws, HFS-policy, procedures, and handbooks to evaluate dental expenditures.

### *HOME HEALTH SERVICES PROGRAM FRAUD PREVENTION AND RECOVERY*

Home health agencies (HHAs) have been identified as potential provider(s) who perform questionable billing practices. Due to identified fraud, waste, and abuse in the area of Home Health Services, CMS imposed a state-wide moratorium on newly enrolling.

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; medical social work; and home health aide services. The OIG developed specialized internal Home Health audit teams and intends to conduct hundreds of audits in FY17. The OIG also intends to review the appropriateness of home health payments and certifications for Home Health eligibility. OIG will review the documentation required in support of the Home Health claims paid by Medicaid. OIG audits will review whether home health claims were paid in accordance with State laws and regulations.

OIG will also work in collaboration with CMS Center for Program Integrity when appropriate to conduct joint audits. The OIG will work in collaboration with other law enforcement partners and CMS to provide education to Home Health Providers and to providers who refer and certify Home Health Services.

### *HOSPICE SERVICES FRAUD PREVENTION AND RECOVERY*

The OIG has identified vulnerabilities in the provision of hospice services that have led to over-utilization and excess payments for hospice services. 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 developed a special internal unit to conduct hospice audits and works with external contractors to ensure greater impact on this identified area of risk for the Department. In FY 15, 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 medical necessity of hospice claims. In FY17, the OIG will expand its use of external audits and capitalize on the ongoing efforts of the internal OIG audit team.

### *AMBULANCE & TRANSPORTATION SERVICES FRAUD PREVENTION AND RECOVERY*

OIG identified Program vulnerabilities involving providers of non-emergency ambulance and transportation services. The identified vulnerabilities included improper duplicate billing, billing for loaded mileage, billing for services paid during an inpatient stay, 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 services. In FY 15 and into FY 16, BMI conducted several different desk and field audits of transportation providers. 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 these 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.

The OIG also evaluated whether there was proper completion and submission of a Medical Certification for Non-Emergency Ambulance (MCA) form for patients discharged who require medically supervised ground ambulance services. As part of these audits, the OIG includes extensive education to ensure ongoing compliance with transportation services. This OIG 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 FY17, the OIG will continue with these audit initiatives to ensure that transportation services are appropriate for the recipient's medical condition at the time of transport.

### *LONG TERM CARE FRAUD PREVENTION AND RECOVERY*

OIG identified Program vulnerabilities associated with Long Term Care payments. The use of both internal and external contract auditors ensures greater impact on this identified area of risk for the Department. OIG has implemented audit initiatives aimed at broadening the scope of oversight over long-term care payments. The OIG has a separate internal audit team that conducts financial audits of long-term care providers and oversees audits performed by external contractors. Long Term Care Audits include financial audits of a long-term care facility's non-medical records and cost reports. In FY17, the OIG intends to expand further the scope of the Long Term Care audits. This includes audits aimed at comprehensive evaluation of potential for fraud, waste, and abuse. Toward this end, the OIG is adding subject matter experts such as nurses and other audit professionals to examine medical necessity of long-term care services.

### *EXTERNAL CONTRACT VENDOR AUDITOR INITIATIVE*

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

- Diagnosis Related Group (DRG) - Inpatient Audits involved the conducting 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.
- Medicaid Integrity Contractor (MIC) - 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 FY 17, the MIC is being replaced by the Universal Program Integrity Contractor. The UPIC is the expansion of the Medicare focused Zone Program Integrity Contractor program that allows the UPIC to perform program integrity functions over both Medicare and Medicaid. The UPIC contractor is expected to be announced and start operations early in state FY 2017;
- Recovery Audit Contractors (RAC) - 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 types and all audit types, with the exception of inpatient DRG, Pharmacy and CPA-LTC audits. Payment to the RAC vendor is a statutorily mandated contingency fee based on the overpayments collected. In FY 2015, the OIG implemented its RAC contract with its external vendor. During FY17, RAC audits will be expanded to focus on other areas of the Medicaid program, such as DRG Hospital, DME, Hospice, and Ambulance services, evaluation, and up-coding among other areas.

### *ENHANCED SELF-AUDIT AND SELF-DISCLOSURE REVIEWS*

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

Self-Disclosure Reviews involve the identification of irregularity in the billing practices of a provider. In appropriate circumstances, the OIG requires a provider to conduct its own investigation and overpayment self-disclosure. The OIG will verify the overpayment amounts through data analytics and professional review. As a result of the Self-Disclosure Protocol and initiatives, the Department has received over 90 new disclosure cases.

In 2013, as a result of the SMART Act, the Department established a protocol to enable health care providers and vendors to disclose an actual or potential violation of Medical Assistance (Medicaid)

program requirements. The OIG established a voluntary disclosure process that providers may utilize upon detection and receipt of an overpayment from the Department. This process is called the “Provider Self-Disclosure Protocol.” This protocol will assist providers to comply with overpayment detection and repayment obligations under the federal Patient Protection and Affordable Care Act. The notice to all providers can be found at <http://www.hfs.illinois.gov/all/2013>.

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

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

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

#### *HOSPITAL GLOBAL BILLING INITIATIVE*

The Hospital Global Billing Initiative was implemented as a pilot project with two hospitals in FY’16. The HFS policy (Topic L-210.12 of the Handbook for Providers of Laboratory Services effective August of 2002) states the following:

“Hospitals may bill fee-for-service for lab tests performed in the Outpatient Department or the Emergency Room. For the Outpatient Department, if the tests are interpreted by a salaried physician, Place Code 3 or 11 (Office) is to be used and the Global fee will be paid. If interpreted by a non-salaried physician, Place Code 2 or 22 (Outpatient) is to be used and the Technical fee paid. For the Emergency Room, Place Code E with Modifier P must be used for the Global and Place Code E with Modifier T for the Technical only fee. Hospitals should not bill fee-for-service for the Professional Component only.” A Hospital may only bill the Department the global rate if the lab and x-ray services were provided within the Emergency Room setting and/or if the pathologist or radiologist was a Hospital salaried physician and the services were provided in an Outpatient setting.”

The scope of this initiative is the verification of potential improper billing by hospitals for lab and x-ray services whereby they received the global rate (technical and professional component) and the non-salaried pathologist and/or the non-salaried radiologist also billed separately for the professional component of the rate for the same patients on the same day while the patient was receiving services in an outpatient setting.

The results of this initiative allows the hospital provider to review all instances of OIG identified global billing overpayments and to submit payments for all services determined to be accurate global billing instances. This initiative pilot project resulted in a 100% recoupment of all accurately identified overpayments; therefore, this initiative is being pushed out to all 272 hospitals identified as having global billing issues.

# OIG COMPOSITION AND ACCOMPLISHMENTS FOR FY 2016

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

## Administration

Fiscal Management includes the oversight of all fiscal matters, including collections/bad debt, procurement, and budget responsibilities. Collections/Bad Debt tracks overpayments and court-ordered restitution from providers; a process that involves establishing accounts in the accounts receivable system and monitoring those payments. The unit follows up on delinquent accounts and works with OCIG on provider collection cases, bad debt cases, and cases referred to the Office of the Attorney General for collection, establishment of liens or write off.

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

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

## Management Research and Analysis

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

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the high-risk category. A 5 percent or greater owner includes any individual that has any ownership interest (either direct or indirect) in a high-risk provider or supplier. Note that the high level of risk category applies to providers and suppliers who are newly enrolling Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers; Home Health Agencies (HHA); and Non-Emergency Transportation Providers (NEMT). It also applies to providers and suppliers who have been elevated to the high-risk category based upon prior OIG sanctions or for owing a debt to the Department pursuant to provisions of the Affordable Care Act.

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

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

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

The **Fraud and Abuse Executive** (FAE) coordinates 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). The FAE 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 issues. 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 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 various U.S. Attorneys, the Illinois Attorney General, and the FBI to support their criminal investigations.

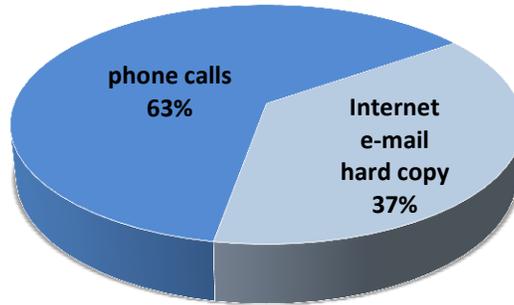
Law Enforcement	
Enforcement Activities	# Cases
Referrals to Law Enforcement	31
Law Enforcement Data Requests	49

FAE is also responsible for tracking referrals sent from OIG to other agencies to address or research on behalf of OIG. These referrals can result from committee reviews, audits, etc., in which provider education or billing concerns need to be addressed.

### **The Welfare Abuse Recovery Program**

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

**FY 2016  
Referrals Received**



Fraud Allegations	
Source	Received
Calls	11,039
Web Referrals(includes HFS employee , DHS hotline and web site)	4,139
Hard Copy(faxes, extra e-mails, USPS and DHS/OEIG)	1,773
Requests from DHS Local Offices	708

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

Client Program Overpayments	
Client Program	Total Overpayments Established
BOC LO Food Stamps	\$948,917
BOC LO Grant	\$80,786
Total	\$1,029,703

**The Office of Counsel to the Inspector General**

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

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

In FY16, OIG terminated, denied, suspended, or excluded over 113 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	74	
Termination/Recoupment	15	
Recoupment	76	
Suspension	0	
Denied Application	10	
Decertification	1	
		<b>Total Medical Provider Sanction Dollars</b>
Final Actions	# Cases	
Termination	104	
Termination/Recoupment	5	Cost Savings: \$1,477,091
Suspension	0	Cost Avoidance: \$2,831,288
Voluntary Withdrawal	2	
Recoupment	72	
Decertification Resolution	0	
Civil Remedy	1	
Barrment*	2	
Reinstatement Actions	# Cases	
Denied Application	9	
Reinstated	11	
Disenrollment	9	
Payment Withhold	22	

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

## Bureau of Fraud Science and Technology

The Bureau of Fraud Science and Technology (BFST) is responsible for the introduction, development, maintenance, and training of staff on new technologies, and maintaining the OIG's website. BFST utilizes sophisticated computer technology to analyze, detect, and prevent fraud, waste, and abuse by providers and recipients. BFST oversees the maintenance and enhancement of the (Dynamic Network Analysis

(DNA) Predictive Modeling System, a Center for Medicare & Medicaid Services (CMS) “Best Practice” put into production in September 2011; and Case Administrative System Enquiry (CASE), a highly sophisticated case tracking, and document management system developed specifically for OIG. BFST responds to referrals from within and outside the Department. The areas within BFST include the Provider and Recipient Analysis Section (PRAS), Recipient Restriction Program (RRP), Fraud Science Team (FST) and the Technology Management Unit (TMU).

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

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

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

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

primary care providers must coordinate and approve most outpatient services and all prescriptions. To date, there are approximately 1900 active recipient restrictions.

The \$1.67 million dollars in cost avoidance in FY 2015 reflects several trends HFS has experienced this past year. RAU staff analyzes approximately 250-350 clients per month for new, ongoing or discontinued restrictions. These include Medicaid recipients in traditional Fee for Service (FFS) plans as well as those who have transitioned into Managed Care Organizations (MCOs). Even though OIG RRP makes recipient restriction recommendations to all MCOs, many MCOs do not have recipient restriction, or “lock in programs” implemented. This severely limits the Departments ability to restrict those clients identified as “over users” of medical benefits. As more MCOs implement these programs, cost avoidance dollars will increase.

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

Client Medical Abuse		
Client Restrictions	# Clients	Total Cost Avoidance
	Client Reviews completed	2,183
	New Restrictions	150
12 Month	Released or Canceled Restrictions	65
	Converted to 24 Month Restrictions	44
		\$1,660,786
24 Month	New Restrictions and Re-restrictions	51
	Released or Canceled Restrictions	56
	Total clients restricted as of 06/30/2016	1,838

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

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

## Bureau of Investigations

The Bureau of Investigations (BOI) provides professional investigative services and support to HFS, DHS, and DoA 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 pursue criminal prosecution and/or recovery of overpayments. The Bureau cultivates and nurtures a professional working relationship with state and federal prosecutors, members of the law enforcement community, and other state and federal agencies. The Bureau is responsible for processing criminal background fingerprint results for all high-risk transportation providers enrolling with the agency.

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 one of the U.S. Attorneys.

Client Eligibility		
Enforcement Activities	# Cases	Total Overpayments Established
Investigations Completed	845	
Founded	590	
Unfounded	255	\$6,262,374
Convictions	13	
Administratively Closed	35	
Type of Investigations	# of Allegations	Percent (%)
Absent Children	524	13
Absent Grantee	72	2
Assets	108	3
Employment	911	22
Family Comp / RR In Home	627	15
Family Composition	401	10
FS Traffic / Link Misuse	286	7
Impersonation	27	1
Ineligible Household Member	29	1
Other Income:	412	10
Prosecution	119	3
Residence Verification	459	11
SSN Misuse/Discrepancy	31	1
Third Party Liability	57	1
Total	4,063	100%

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	12	
Unfounded	2	
Convictions	0	\$1,164,609
Investigations Completed	14	

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	4	
Founded In-Part	0	
Unfounded	5	\$86,880
Investigations Completed	9	

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

Clients who intentionally violate the SNAP are disqualified from the program for a period of 12 months for the first offense; 24 months for the second offense; permanently for the third offense; and 10 years for receiving duplicate assistance and/or trafficking. Cost avoidance in SNAP cases is calculated as the average amount of food stamp issuances made during the overpayment period times the length of the disqualification period.

Supplemental Nutrition Assistance Program		
Enforcement Activities	# Cases	Total Dollars Established
Referred to BAH	1,136	
Reviews Completed	1,776	
Pending ADH decision	54	
FADS	761	Cost Avoidance: \$3,686,617
Waivers	517	SNAP Overpayments: \$6,084,331
Lost	25	
Court Decisions	12	

During the period from July 2015 through June 2016, the Bureau of Investigations (BOI) completed various types of investigations throughout the state. A number of investigations that had been completed during this fiscal year have elements of particular interest that are noted below:

- **Child Care Provider** – This joint investigation with the Social Security Administration of a Chicago Child Care Provider revealed that the child care provider had applied for two Social Security Numbers. The child care provider was employed as a Chicago Police Department Crossing Guard and receiving SSA under one SSN and a DCFS certified Child Care Facility receiving SSI under her second false identity. The potential overpayment for the child care provider for operating under her false identity is \$398,763 for the period January 2001 through June 2016. The investigation was completed in June 2016. The Illinois Department of Human Services' Child Care and Development and Action for Children are currently considering recoupment of the \$398,763 overpayment. The agencies that were notified by this department of the discontinued false identity were the Illinois Department of Revenue (DOR) for unreported income, Illinois Department of Children And Family Services (DCFS), Child Care Provider Licensing Department for false identity, DCFS, Problem Resolution and Collection Unit for false identity receiving foster payments and Illinois Secretary of State Police for false identity that has state ID.
- **Child Care Provider** – A BOI investigation found in November 2015 that a Child Care Provider continued to operate her daycare while she was under a DCFS protection plan, which effectively prohibited her from operating as a licensed child care provider. The results of the investigation was submitted to the Bureau of Child Care Development, which calculated that for the period of November 2014 through April 2015, this child care provider received an overpayment of \$59,446 in ineligible child care provider payments.
- **Client Eligibility / Family Composition / Responsible Relative in Home** – The allegation stated that the client is committing fraud by not reporting that her husband is employed. The investigation found several address verifications showing that they are residing together. Some of those verifications included Illinois Secretary of State, Will County Recorder of Deeds, DOR and school verification. In addition, the husbands' employer reported that the client and her three children are covered under their health insurance policy. The investigation was completed in September 2015, and referred to the DHS Local Office for calculation of an overpayment. The calculation resulted in a SNAP overpayment

of \$28,486 and Medical overpayment of \$5,855. The case is being referred for possible prosecution.

- Client Eligibility / Family Composition / Employment – The allegation stated that the client does not live in Illinois and her husband is employed in Indiana. The investigation found that the client had been residing in Indiana since August of 2008. The Porter County Recorder of Deeds confirmed that on July of 2007, the client and her husband purchased a property in Portage, Indiana. They also confirmed that on February of 2014, the client's husband purchased a second property in Portage, Indiana. The United States Postal Services verified that the client receives mail at both Indiana properties. Portage Township School District reported that the client's children have been enrolled at Portage Township School District since August of 2008. The investigation also found that since at least March 2, 2011, most of the purchases made with the client's Illinois LINK card were made in Portage, Indiana. The investigation was completed on October of 2015 and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of \$44,694. The case is being referred for possible prosecution.
- Client Eligibility / Family Composition / Responsible Relative in Home – The allegation stated that the client is married and her husband is employed. The investigation found that the client has been married since February of 2009. The Cook County Recorder of Deeds confirmed that on September of 2009, they signed a mortgage together for a property in Chicago, Illinois. They also confirmed that on September of 2014, they signed a mortgage together for a property in Alsip, Illinois. Stone Creek School verified that both parents are listed as the responsible guardians for their children. DOR reported that the client and her husband filed their taxes as jointly married and his reported income. The employer reported that the client is covered under his health insurance policy. The investigation was completed on November of 2015, and referred to the DHS Local Office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of \$30,953 and Medical overpayment of \$3,387. The case is being referred for possible prosecution.
- Client Eligibility / Family Composition / Responsible Relative in Home / Employment / Income – The client, a resident of Effingham County, deliberately failed to report her living with the father of her children and his employment income to the DHS in order to prevent the reduction and/or cancellation of her public assistance. The client received an excess of \$23,297 in SNAP assistance, from the DHS from September of 2012 through September of 2015. The investigation was completed in November of 2015, and referred to the local DHS Local Office, which calculated the overpayment.
- Employment / Family Composition / Other Income – An anonymous referral was received alleging the DHS client is married and the client's spouse is receiving income from employment. Furthermore, the client was receiving unreported income. The investigation revealed the client, as well as the client's spouse, received unreported employment and unemployment income. The period under investigation covered October 2010 through November 2015. The investigation was completed in November 2015, and referred to the

DHS Local Office for calculation of an overpayment. The calculation resulted in an overpayment of \$19,211.

- Employment / Family Composition / Responsible Relative in Home / Residence Verification / Other Income – A referral was received alleging the DHS client’s spouse was residing in the assistance unit and the spouse received income from employment. The investigation revealed the client’s spouse was receiving employment income. The period under investigation covered January 2011 through September 2015. The investigation was completed in October 2015, and referred to the local office for calculation of an overpayment. The calculation resulted in an overpayment of \$26,919.
- Employment / Prosecution – A BOI prosecution investigation revealed that a client was receiving assistance benefits while she was employed with a second social security number. The client also received benefits from the Chicago Housing Authority and failed to report her earnings/second social security number to them. The client admitted knowing her benefits from all agencies would be affected and that she was aware of her responsibility to report all income from employment to all the agencies. The client was also aware that she could be referred for prosecution for fraud as the result of her hiding or reporting false information. The client neglected to report to DHS that she was employed while also receiving public assistance during the period of January 2000 through July 2015.

The concealment of the client’s employment income allowed her to receive \$29,324.00 in SNAP/food stamp assistance during the period of January 2000 through July 2015. The client would not have been eligible to receive SNAP/food stamp assistance during that period if she had reported her employment earnings. Therefore, the client received \$29,324.00 in excess SNAP/food stamp assistance.

The investigation was completed by BOI in September 2015, and submitted to the Cook County State’s Attorney Office for prosecution with the Chicago Housing Authority’s loss and is currently on going.

- Family Composition / Other Income – A referral was received alleging the DHS client was married, the client’s spouse resided in the assistance unit, and the client was receiving unreported income. The investigation revealed the client was married and her spouse was receiving income. The period under investigation covered December 2009 through August 2015. The investigation was completed in August 2015, and referred to the local office for calculation of an overpayment. The calculation resulted in a SNAP overpayment of \$24,205.
- Family Composition / Responsible Relative in Home – A BOI investigation found in December 2015, that a SNAP recipient failed to report to DHS that her husband had been living in the assistance unit since February 2012, during which time he had income from employment. The results of the investigation were submitted to the local DHS office, which calculated an overpayment to the recipient for \$19,090 in SNAP benefits.

- Family Composition / Responsible Relative in the Home – A BOI investigation found in April 2016, that a SNAP recipient failed to report to DHS that her husband had been living with the assistance unit since November 2011, during which time he had income from employment and unemployment insurance benefits. The results of the investigation were submitted to the local DHS office, which has calculated that the recipient received an overpayment of \$23,266 in SNAP benefits.
- Family Composition / Responsible Relative in Home – A BOI investigation found in June 2016, that a SNAP recipient failed to report to DHS that her husband had been living in her assistance unit since December 2010, during which time her husband had income from employment. The results of the investigation were submitted to the local DHS office, which calculated the recipient had received an overpayment of \$63,840 in SNAP benefits.
- Family Composition / Responsible Relative in the Home – A BOI investigation found in August 2014, that a SNAP recipient failed to report that her boyfriend, who is also the father of her two children, had been living in the assistance unit since March 2010, and had employment income from that time to March 2016. The DHS Local Office calculated that because this recipient had failed to report that the father of her children was residing in the assistance unit with income. The recipient received an overpayment of \$31,754 in SNAP benefits.
- Family Composition / Responsible Relative in Home / Absent Child – A BOI investigation found in August 2015, that a SNAP recipient failed to report to DHS that his wife had been living in his assistance unit since September 2009, during which time she had income from employment and unemployment insurance benefits. This investigation also found that the recipient’s children lived outside of his assistance unit from August 2009 through July 2013 and September 2013 through July 2014. The investigation further found that the recipient’s niece, who had been included as an assistance unit member, never lived with the assistance unit. The results of the investigation were submitted to the local DHS, BOC office, who calculated the SNAP recipient received an overpayment of \$38,589 in SNAP benefits. This case is currently being reviewed for prosecution.
- Family Composition / Responsible Relative in Home / Employment / Residence Verification – The investigation reveals the client received excess SNAP assistance because they failed to report to DHS, their spouse resided in the assistance unit and had employment income.

The investigation was completed in November 2015. The client received a total of \$33,421 in excess assistance because of their failure to report the correct household composition.

- Family Composition / Responsible Relative in Home / Employment / Residence Verification – The investigation revealed the client received excess SNAP assistance because they failed to report to DHS, their spouse resided in the assistance unit.

The investigation was completed in June 2016. The client received a total of \$46,751 in excess assistance because her spouse had income from employment the client failed to report his income from January 2008 through May 2016.

- Family Composition / Responsible Relative in Home – A BOI investigation found in March 2016, that a SNAP recipient failed to report that her husband had resided in the assistance unit since 2008, during which time the husband had income from employment. The results of the investigation were submitted to the DHS Local Office, which calculated the SNAP recipient received an overpayment of \$23,734 in SNAP benefits.
- Family Composition / Responsible Relative in Home / Other Income – A BOI client eligibility investigation found that the client failed to report her true employment income and that the parent of their children had been living in the client’s assistance unit the entire time. The client failed to cooperate with said investigation, allowing BOI to sweep the overpayment calculation for failing to cooperate for the period of January 2008 through July 2015, totaling \$49,579. The investigation was completed in December 2015, and was accepted for prosecution by the Cook County State’s Attorney Office.
- Family Composition / Responsible Relative in Home / Other Income – A BOI client eligibility investigation found that the client failed to report that her spouse, the parent of their children, had been living in the client’s assistance unit the entire time and they had income from businesses and rental properties. The client failed to cooperate with said investigation, hired an attorney for representation, which led to the local office immediately canceling her case. The results of the investigation were submitted to DHS/BOC, which calculated four overpayments totaling \$52,045.

The investigation was completed in January 2016, and was accepted for prosecution by the Cook County State’s Attorney Office.

- Family Composition / Responsible Relative in Home / Other Income / Residence Verification – A BOI client eligibility investigation revealed the client’s spouse and son were employed and residing in the home with the client, while the client was receiving SNAP benefits from June 2009 through October 2015. The spouse was employed at Aldi Inc., and the son was employed at Wal-Mart during the period that the client received SNAP benefits. The client failed to report the spouse and son’s income to the local office during the above period. The client did not qualify for SNAP benefits because her household exceeded over the gross maximum amount for her household size.

The investigation was completed in October 2015, and referred to the DHS Local Office for the calculation of an overpayment. The BOI investigation estimated a SNAP overpayment of \$59,690.

- Interstate Duplicate Assistance / Residence Verification – The investigation revealed that the client had been living in Indiana since as early as August of 2006, and had been receiving TANF, SNAP, and medical benefits in Indiana at the same time that she was

receiving SNAP and medical benefits in Illinois. The investigation was completed in July 2015.

The investigation revealed that the client had been employed at multiple places while living in Indiana all of which she provided an Indiana address as her current home address. She also provided one of her employers with an Indiana ID and a City of Gary Health Department Food Handlers Health Card.

The overpayment concerning the SNAP benefits was \$45,821 for the period September 2006 through March 2012, due to interstate duplicate assistance, an intentional program violation in which the client received medical and SNAP benefits in both Indiana and Illinois. The overpayment concerning the medical benefits that the client received was \$1,031.

- Prosecution – The allegation indicated the client deliberately failed to report the self-employment income of the other responsible relative living in the household. 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 \$31,056 in excess assistance from July 2010 through May 2015, based on the client’s failure to report self-employment income of the other responsible relative living in the household.

The investigation was completed in November 2015, and referred to the Wayne County State’s Attorney. The defendant was charged with three felony offenses: Theft (Class 3 Felony), State Benefits Fraud (Class 3 Felony), and Public Assistance Recipient Fraud (Class 4 Felony) on February 29, 2016. The Defendant is currently awaiting trial.

- Prosecution / Family Composition / Responsible Relative in Home – In 2012, an OIG investigation was opened on a DHS client at the request of the DHS - BOC. It was discovered that the client deliberately failed to report the presence and employment income of her child’s father in the assistance unit for the period of February 2012 through March 2014.

BOI completed an investigation into the matter on February 25, 2015. This client was subsequently charged with State Benefits Fraud (Class 3 Felony) and Theft (Class A Misdemeanor). Through a negotiated plea agreement, on August 26, 2015, the charge of State Benefits Fraud was dismissed and the client pled guilty to Theft (Class A Misdemeanor). The client was sentenced to 24-month probation, 30 days periodic imprisonment and ordered to pay DHS \$7,548.00 in restitution. Restitution has since been paid in full.

- Prosecution / Employment / Family Composition / Responsible Relative in Home – The client, a resident of Coles County, deliberately failed to report her living with the father of her children and his employment income to DHS in order to prevent the reduction and/or

cancellation of her public assistance. The client received an excess of \$22,126 in SNAP assistance from DHS, from September of 2011 through February of 2015.

The investigation was completed in September of 2015, and referred to the Coles County State's Attorney for criminal prosecution. In February 2016, the client was convicted of misdemeanor theft and sentenced to 2-year probation, court costs, restitution of \$22,126.00, 100 hours of public service, and 180 days jail pending successful probation completion.

- Prosecution / Employment / Family Composition / Responsible Relative in Home – The client, a resident of Douglas County, deliberately failed to report her living with the father of her children and his employment income to DHS in order to prevent the reduction and/or cancellation of her public assistance. The client received an excess of \$21,811 in SNAP assistance from DHS, from January of 2009 through August of 2014. The investigation was completed in December of 2014, and referred to the Douglas County State's Attorney for criminal prosecution. In February of 2016, the client was convicted of Recipient Fraud and sentenced to 3-year probation, court costs, restitution of \$21,811.00, and 60 days incarceration.
- Residence Verification – A BOI investigation revealed that a client failed to report that he was no longer residing in the state of Illinois. The client relocated to Wisconsin in November 2008, and continued to receive public assistance from Illinois until May 2013. The investigation was concluded in October 2015, and the findings resulted with an estimated overpayment of \$19,929 in SNAP benefits.

The **Fraud Prevention Investigation (FPI)** program was 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 was supported by funding from the Office of Inspector General (OIG). The FPI program was utilized in Cook County, DHS local offices.

Throughout the program's history, the OIG utilized a contractor to conduct the pre-eligibility investigations. At the end of fiscal year 2015, the OIG determined that it was no longer cost effective to support this program. No cases were assigned during fiscal year 2016, and the contractor was notified that the program was officially cancelled in April 2016.

**New Provider Verification** Previous monitoring of non-emergency transportation 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 High Risk 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	19
Withdrew Application	0
Applications Returned	12
Applications Referred for Denial	1
On-Site Verifications Completed	35
Provider Monitoring	33
Reviews Completed	90

Provider Revalidations	
Enforcement Activities	# Cases
On-Site Verification with Concerns	18
On-Site Verification with No Concerns	0

### Bureau of Medicaid Integrity

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

The **Audit Section** performs audits on Medicaid providers to ensure compliance with the Department policies. This section audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, durable medical equipment suppliers, and other types of providers. This Section reviews various records and documentation, including patient records, billing documentation and financial records. Deficiencies noted because of these audits may result in the recoupment of any identified overpayments. 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).

OIG initiates provider audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. The audit generally covers a 24-month period and is conducted on both institutional and non-institutional providers. 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 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	
Audit Type	Dollars
Desk Audit	\$384,019
Field Audit	\$15,694,063
Self Audit	\$532,938
FST Projects*	\$2,030,794
Self Disclosure	\$2,893,607
RAC	\$499,881
Other	\$49,150
Total	\$22,034,452
Restitution	\$274,013
Global Settlements	\$6,003,994
Total	\$28,312,459

\* Audits established through system routines

Audits Initiated	
	# Cases
Initiated	1,813
Completed	670

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

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

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

seriousness of the concerns, the physician consultant’s recommendations may include: case closure with no concerns identified; case closure with minor concerns addressed in a letter to the provider; Continuing Medical Education; intra-agency or inter-agency referrals; onsite review by the consultant; and/or an appearance before the MQRC. In addition to the above recommendations, the provider may be referred to OCIG for suspension or termination from the Medical Assistance Program.

Peer Review Outcomes	
	# Cases
Letter to Provider with Concerns	18
Letter to Provider without Concerns	5
Referral for Sanction	2
Referral for Audit	3
Voluntary Withdrawal	3
Withdrew Reinstatement Request	4
Recommend Reinstatement	4

**Central Analysis Section (CAS)** in conjunction with the **Quality Control (QC) Review Section** operates both the federally mandated Medicaid Eligibility Quality Control (MEQC) program and the Payment Error Rate Measurement (PERM) initiative (both the eligibility and the claim component).<sup>3</sup> The MEQC is conducted annually and PERM is conducted every three years.

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

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

CAS also manages the PERM Claim Reviews (data processing - DP and medical record - MR) for the Department.<sup>4</sup>

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

<sup>3</sup> The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.

<sup>4</sup> The DP review consists of ensuring the claim has been paid correctly according to the rates set at the time of the service. The medical record review consists of ensuring the provider has all the supporting medical documentation required for that claim type.

For FFY15, 1785 claims were selected for review by CMS. The FFY15 PERM initiative is scheduled to conclude as of August 31, 2016 with final reporting in November 2016.

In addition to conducting eligibility reviews, these sections also conduct verifications of services received. CAS designed and implemented this project in November 2015 in order to meet the requirements of 42 CFR 455.20 and 433.116. The QC reviewers conduct the verifications (500 per month) via phone to confirm with recipients whether services billed by providers were received. Negative responses are analyzed by CAS and if appropriate, referred for the review of probable fraud and abuse.

**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 913 penalty periods out of 3,565 investigations during FY16; these cases resulted in \$96.9 million in savings and \$70.6 million in cost avoidance, resulting in a Return on Investment (ROI) of \$71.24 for every dollar spent.

The 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 - FCRC throughout the state participate in the effort. The goal is to prevent ineligible persons from receiving long-term care benefits due to diverting or not disclosing assets, thereby saving tax dollars and making funds available to qualified applicants who meet the eligibility requirement based upon Medicaid standards.

Long-Term Care-Asset-Discovery Investigations		
Enforcement Activities	# Cases	Total Cost Avoidance
Cost Savings Cases <sup>5</sup>	2,751	\$96,988,469
Cost Avoidance Cases <sup>6</sup>	898	\$70,648,389
Total Investigations Completed	3,565	\$167,636,859

The following LTC-ADI results were incorporated into final eligibility determinations during FY16:

- An application was referred to the OIG for the fact the daughter had closed all financial accounts and the caseworker was unable to track the funds. Upon review of the application, it was

<sup>5</sup> 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.

<sup>6</sup> 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.

discovered that the daughter transferred the funds to another account with another financial institution in the name of the applicant. Upon further review, the analyst traced some interest income to another account. The applicant had an excess of \$180,000.00 that was not disclosed.

- An application was referred to the OIG for transfers of over \$5000.00. Upon review of the application, approximately \$70,000.00 of the applicant's money was used to pay her son's credit card bills; another \$30,000.00 was withdrawn by family members at the ATM after the applicant was admitted to the facility. A penalty of \$101,725.51 was assessed for this case.
- An application was referred to the OIG for transfers of over \$5000.00. Upon review of the application, the applicant's son made several purchases for his own personal benefit. He made cash and ATM withdrawals, and made loans to himself and his girlfriend. Some of the items purchased by the son were vacation trips, jewelry, sporting event tickets, as well as payments on his own credit card bill. A penalty was assessed resulting in a savings of \$56,398.25.
- An application was referred to the OIG for transfers of over \$5000.00. Upon review of the application, the applicant had two tracts of farm ground. One tract was 80.79 acres and the second was 75.79 acres with a combined value of \$955,073.79. The farm ground was held in a trust, which was deemed to be revocable and therefore was available to the applicant.
- An application was referred to OIG due to a trust. Upon review of the case, multiple CD's, investment accounts and \$37,793.85 of Gold bars were discovered. The LTC-ADI analyst asked for deposits that lead to the multiple accounts and CD's owned by the applicant as well as a safe deposit box. The applicant had excess resources of \$172,187.95
- An application was referred to the OIG for transfers over \$5000.00. Upon review of the application, the LTC-ADI analyst discovered that a property existed with a value of \$221,679.04. Once the property sells, the applicant should have enough funds to pay for their own nursing home services.
- An application was referred to the OIG for an annuity and transfers over \$5000.00. Upon review of the application, the analyst found \$63,443.84 in an undisclosed money market account and \$121,538.06 in an undisclosed CD. The applicant was put in a spend down and will have to pay privately, as they have \$192,003.73 available to pay for their nursing home care.
- An application was referred to the OIG for transferring a property and transfers of over \$5000.00. Upon review of the application, the applicant owned a business that she gave to her son during the 5 year look back. Her son within months sold the business to another party for \$700,000.00. The applicant did not receive any proceeds from the sale of the business and a penalty was imposed. The case went to hearing and a final administrative decision was issued affirming the Departments penalty of \$700,000.00.

- An application was referred to OIG for transfers over \$5000.00, a trust, caregiver contract, and promissory note. Upon review of the application, the applicant was using her credit card to pay for the daughters bills, multiple funds were gifted to the daughter as well as the applicant's home. No caregiver contract, logs, or creditable documentation was provided as per policy for the POA providing care giving services and therefore found to be gifts of love and affection. A penalty was assessed for all gifting and resulting in a savings of \$313,371.63.
- An application was referred to the OIG for a trust and an annuity. Upon review of the application, the LTC-ADI analyst discovered that the applicant had three undisclosed Certificates of Deposits at the bank with a value of \$200,804.90. The applicant is able to pay for his or her own nursing home services.
- An application was referred to OIG by the local office for consulting with an attorney. Upon review of the application, the LTC-ADI analyst discovered a sawmill business that was owned by the applicant. The business is no longer in operation, but the applicant still owned the buildings, vehicles, equipment, and tools. The value of all the business resources totaled \$579,525.00. Therefore, the applicant had excess resources that can be liquidated and used to pay for his care. This case was appealed and the Bureau of Administrative Hearings upheld the department's decision.
- An application was referred to OIG by the local office for trust and consulting an attorney. Upon review of the application, the LTC-ADI analyst found that the applicant and the community spouse had accounts that were not disclosed. LTC-ADI discovered that the community spouse had a IRA worth \$63,000.00 and the applicant had an two IRAs, one with a value of \$93,269.73 and another that had a balance of \$74,929.43. This new information combined with the reported information was more that the community spouse impoverishment level. Therefore, the applicant is able to pay for his or her own nursing home services and saving the tax payers money.
- An application was referred to the OIG by Medical Fields Operations for an annuity and transfers over \$5000.00. Upon review of the application, the analyst found \$63,443.84 in an undisclosed money market account and \$121,538.06 in an undisclosed CD. The applicant was put in a spend down and will have to pay privately, as they have \$192,003.73 available to pay for their nursing home care.
- An application was referred to OIG by the Macon County hub for transfers totaling over \$5000.00. Upon review of the application, the LTC-ADI analyst discovered that 188 acres of farm ground was sold during the 5 year review. The farm ground was sold to family members and fair market value was not received. In addition, a life insurance policy was transferred to the same family member during the review period. A penalty was assessed resulting in a savings to the taxpayers of \$812,247.35.
- OIG issued a \$635,518 penalty based on the sale of the applicant's property that was given to the children. At administrative hearing, the applicant's attorney argued that the sale of

the property was payback for a promissory note owed to the applicant’s children. OIG was unable to verify that the children actually loaned the money to the applicant. The Bureau of Administrative Hearings (BAH) affirmed the OIG decision.

- OIG issued a \$61,047 penalty based on the applicant’s failure to name the State as the remainder beneficiary on her annuity and instead listed the State of Arkansas. OIG decision affirmed stating that because the applicant chose to avail herself of Illinois benefits, the State of Illinois needed to be listed as the remainder beneficiary.
- OIG issued a penalty for \$65,623 that was based on reimbursement to the power of attorney. There was no agreement between the applicant and the power of attorney (who was the applicant’s sister). In addition, the evidence showed that substantial amounts of withdrawals were made by the power of attorney from an ATM at a racetrack in Florida.
- OIG issued a penalty for \$55,417.43. This penalty was based on an irrevocable trust with the proceeds of the sale of her home and life insurance policies. The trust permitted distribution of the proceeds to the applicant’s children but prohibited distribution to the applicant. On February 26, 2013, the applicant died. Applicant’s attorney argued that they tried to return the money but could not because of the death and the Department delayed in processing the application.

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

Internal Investigations	
Enforcement Activities	# Cases
Substantiated	48
Unsubstantiated	264
Administratively Closed	2
Investigations Completed	314

Types of Allegations Investigated	Percent (%)
Non-Criminal (Work Rules)	92.5
Discourteous and Inappropriate Behavior	4.5
Failing to Follow Instructions	2.2
Negligence in Performing Duties	0.8
Conflict of Interest	1.5
Falsification of Records	40.6
Sexual Harassment	0.0
Release of Confidential Agency Records	0.5
Misuse of Computer	1.0
Work Place Violence	0.0
Time Abuse and Excessive Tardiness	1.8
Conduct Unbecoming State Employee	39.6
Criminal (Work Rules)	2.6
Theft or Misuse of State Property	.03
Commission of or Conviction of a Crime	0.8
Criminal Code 720 ILCS 5	1.3
Misappropriation of State Funds	0.2
Security Issue, Contract Violation	1.7
Special Project, Assist other Agencies	3.2

Internal investigations often reveal violations of work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension, or reprimand. Misconduct Outcomes identified during FY16 are listed below:

Internal Investigations	
Misconduct Outcomes	# Actions
Misconduct Identified in 2016	38
Employee	37
Vendor/Contractor	1
Misconduct Resolutions Reported 2016	51
Discharge	0
Resignation	6
Suspension	18
Other, such as reprimands	5
Referred to Other Sources for Resolution	2
Administrative Action Pending at Year End	6
No Action Taken by Agency	14

HFS Employee Investigations - The OIG Bureau of Internal Affairs (BIA) completed 314 employee and contractor investigations during FY2016.

- Misuse of Computer System/Secondary Employment - A Public Service Administrator (PSA) resigned her position with HFS at the conclusion of an Internal Affairs interview related to her misconduct at work. This PSA was confronted with evidence that she was performing activity related to secondary employment, during work hours. The employee is an independent distributor for a dietary supplement company. This activity was being performed on her State of Illinois owned computer. In addition, the employee was shown evidence that she was performing other personal activity on her State owned computer related to her church and an upcoming family reunion among other things. The employee admitted to investigators that she had in fact performed the activity and acknowledged that her activity was a violation of HFS work rules and policy.

The activity described above deprived the State of Illinois of the work product that this employee was responsible for as well as the loss of computer resources.

At the conclusion of the interview, the investigators discussed the results of the employee's interview with the HFS Bureau of Personnel and Labor Relations. Based on that discussion she was advised that because of the secondary employment activity being performed on State time and State equipment that the Agency would be pursuing a discharge against her. The employee was offered the opportunity to resign and she opted to do so effective May 2016.

- Administrative Malfeasance\Time Abuse - The Bureau of Internal Affairs received a complaint from the Governor's Office of Citizen Action on September 17, 2015, alleging that an HFS employee was abusing time spent on official state business. The complaint alleged that a Public Service Administrator (PSA) frequently would leave the Bloom Building in running attire for extended periods during the business day.

The investigation determined that the Public Service Administrator repeatedly falsified agency timekeeping records and wrongfully and unlawfully received wages of \$3,427.84 to which he was not entitled, in violation of the State of Illinois Employees Ethics Act.

The employee received a 30-day suspension in May 2016.

- Conduct Unbecoming a State Employee - The Bureau of Internal Affairs received a complaint on September 23, 2014, alleging that an Office Coordinator had been engaging in telephone harassment against a civilian. It was alleged that the employee was using both her own cellular telephone and her CMS State of Illinois assigned work telephone.

The investigation determined that the Office Coordinator had been engaging in telephone harassment against the civilian using her state telephone and had accessed the state computer to retrieve the civilian's personal information. The employee admitted calling the civilian for at least a year and a half from the CMS State of Illinois phone to harass her for having an affair with the employee's husband. The employee also admitted to using another co-worker's AID# to obtain KIDS information on the civilian, without the other employee's permission or knowledge.

The employee received a 29-day suspension in October 2015.

- Failing or Refusing to Follow Department Policy or Supervisory Instructions - The Bureau of Internal Affairs received a complaint on January 16, 2015, alleging that an Office Coordinator (OC) was taking longer lunch breaks and arriving to work late. It was also alleged that she was not doing her work as indicated by her production.

The investigation determined that this Office Coordinator had not processed the mail in over three years; therefore, neglecting clients' request to obtain child support services. It was also determined that she regularly had her children in the office during the workday which was disruptive for other staff.

She violated HFS Employee Handbook (EH-605.1) #4 Failing or refusing to follow Department policy or supervisory instructions, and violated HFS Employee Handbook (EH-605.1) #5 Unsatisfactory work performance or neglect in the performance of duties, when she neglected clients' requests to obtain child support services.

She received a 30-day suspension in October 2015.

- Background Check - The Bureau of Internal Affairs completed a criminal record check on an Account Tech 1. Criminal record inquiries into files and systems available to criminal justice agencies (based upon name search only) developed conviction information in the State of Illinois and State of Florida. This employee failed to report that he had been convicted of criminal offenses.

He resigned in March 2016.

- Conflict of Interest/Misuse of State Property - The Bureau of Internal Affairs received a complaint on December 7, 2015 alleging that a Child Support Specialist 2/Spanish Speaking (CSS/SS 2) Division of Child Support Services (DCSS) was conducting secondary employment business while on official State of Illinois time and utilizing State of Illinois resources.

CSS/SS 2 admitted that she had conducted business for her husband's trucking company while on official state business. She voluntarily resigned in March 2016 and agreed not to seek future employment with the Department.

# PROGRAM INTEGRITY EFFORTS AND COOPERTIVE INITIATIVES

## **New Development in Dynamic Network Analysis Predictive Modeling System**

The Dynamic Network Analysis (DNA) Framework was developed through a federal CMS Medicaid Transformation Grant (MTG). Since its deployment in September 2011, the DNA Framework was incorporated into OIG's workflow to support executive level decisions by providing information for referrals and audit development.

Based on auditor/investigator needs, user feedback, system audit logs, and OIG management, the Bureau of Fraud Science & Technology (BFST) development team redesigned the back-end database and framework structure in FY 2016. This redesign allows for a streamlined user workflow that improves both user experience and efficiency.

In addition, development provided opportunities for improved system integrity, data security, consideration for future expansion within the redesigned database, project reconceptualization to provide a better foundation for application performance and team collaboration, and incorporation of new web application technologies in preparation for future enhancements. The development team revised some of the existing programs and reports, and added functions and analyses to enhance statistical models, executive summary dashboard, data visualization, and interactivity. The updated framework was released in November 2015, which included major enhancements as noted in the following subcategories.

### *ANALYSIS OF MANAGED CARE ORGANIZATION (MCO) CLAIMS*

Managed Care Organization (MCO) claims increased significantly in Medicaid services beginning in 2014. The BFST development team incorporated this trend into the DNA system. Weekly updates are provided for generation of multiple executive summaries on annual statewide Medicaid services, provider profiles, recipient profiles, and recipient claim detail reports.

Comparable to the previous DNA release, both Fee-for-Service (FFS) and MCO claims are analyzed and summarized as part of the reports. In addition, FFS in transportation services decreased in the past few years as more and more recipients enrolled in MCO. The transportation spike analysis report was updated to reflect all services (FFS and MCO) in overpayment, including the duplicate services routine, inpatient services routine, and load mileage routine. The graphical overpayment distributions of each provider directly show the change in overpayment distribution for the corresponding years. Additionally, OIG monitor abuse and fraud by the managed care providers more effectively through the inclusion of MCO information in the DNA system.

### *PROFILES AND REPORTS ENHANCEMENT*

The Provider Profile Report and Recipient Profile Report are the "one-stop shop" for OIG staff for many purposes, including case review and audit. The Provider Profile Report combines information from various data sources and applied statistical approaches for a comprehensive view for a targeted provider in various categories of services of the Medicaid program under review. The Recipient Profile Report provides analysts an overview of the recipient's history and potential patterns to support analysts' with decisions on whether further investigation is necessary. The Provider and Recipient Profile Reports are widely used in

the analysis of referral cases, responses to Federal requests, and other ad hoc requests from various agencies.

Enhancements and updates to the existing profiles and routines occurred throughout the past year. More detailed, aggregated information was added to the reports, along with the introduction of a broader range of data sources to address policy changes, with continuous modifications based on need. Profiles and Reports became the most used features in the DNA system with more than 6,800 reports generated during the last fiscal year, which drew the development team towards ongoing improvements to the features of these modules to meet various types of users' expectations and needs.

As the U.S. health care system transitioned the coding of patient visits from ICD-9 to ICD-10, impacted profiles and reports in the DNA system were modified to adapt this change. The ICD-10 diagnosis codes were applied in EDW after October 2015. In the DNA system, the new reports use the diagnosis codes to automatically, display the corresponding descriptions.

The Ping-Pong report (common client) was developed to indicate when multiple providers serve the same recipient on the same day. The users have the option to show, or not show, the services rendered by providers with their NPI (national provider identification) number in addition to the provider ID. Moreover, users have the option to show providers with common client scenarios with respect to all lab providers, home health providers, or dental providers after the primary provider information is submitted. The interrelated report (multiple providers serve the same recipient during the queried time range) is another option for users to choose.

In order to correctly combine the services rendered by provider ID and corresponding NPI, the NPI Provider Crosswalk table in the EDW is adjusted and maintained weekly to remove duplicate NPI records, blank NPI numbers, and scenarios where one provider has multiple NPI or multiple providers share one NPI.

An important revision related to recipient in the DNA system is the recipient restriction routine, which identifies abusive Medicaid recipients and places them into a 12 or 24 month Physician/Clinic, Pharmacy, or dual restriction. The selection criteria for restriction were modified to comply with policy changes. For example, greater weight is applied to recipients on the restriction list for narcotics and controlled substances. Also taken into consideration are other important factors such as the number of office visits, days of ER visits, and number of prescribing physicians. The revised restriction routine helps RAU identify abusive Medicaid recipients and potentially lead to improved cost avoidance in the end, which in turn, will save tax payers money.

Since the previous DNA system release, new requests from OIG units, through corresponding reports, were implemented. Some examples are the Peer Review Report, CVU All Services Report, and CVU PA Lookup Report. In addition, the Marriage & Divorce verification reports were built into the DNA system, which were created to help users query recipient marriage and divorce information.

### *FRAUD DETECTION DATA MINING AND PROGRAM PREPARATION*

The Bureau of Fraud Science & Technology (BFST) develops fraud detection routines to prevent and detect health care fraud, abuse, overpayments, and billing errors. BFST's routines are analytical programs written in SAS, Teradata SQL to implement the integration of sampling selection and audit reporting, executive information summaries, and other analyses. After the developed programs and algorithms are fully evaluated and validated, some are implemented in the DNA system for iterative use. Efforts related to data

mining and case review help OIG explore new area of study and expand analytic capacity. The below are some examples of these efforts.

BFST revised the sampling method for home health provider services. Unlike using RINDOS (recipient and date of services) as a sampling unit to generate the hundreds level sample for transportation providers, or only using service level as a sampling unit to generate the samples for physicians, a new method to generate samples for home health providers is to use the proportional sampling method based on different procedure codes, since only a few procedure codes are used by the home health providers. Furthermore, another analysis of home health providers was performed in order to study the relationship between the referring physicians and the home health providers. According to Medicaid policy, the recipients must receive specific certification services from the referring physicians before receiving service from home health providers. This routine identifies the service types for those recipients prior to home health services so that the investigator can evaluate whether the home health services are necessary.

BFST continued the post mortem study and revised its logic based on investigation feedback. In the past, BFST used the DHFS Enterprise Data Warehouse (EDW) along with other third-party data sources, including IDPH, MDS (long term care), Medicare, and hospital data, to check death information. However, the audit outcome has proven that the IDPH data source is more reliable and accurate, which should be used as the primary source to verify recipient death information. BFST established automated processes to identify if there are new claims for deceased recipients billed by any providers. Since multiple audits were performed on some providers, the carve-out process must be carefully put into place to avoid overlapping of audited services. The Post Mortem study is evidence that OIG uses trust-worthy external data sources to monitor and combat abusive and fraudulent activities.

BFST developed hospital global billing algorithm to study if both hospital and physician bill the department for the same recipient on the same service date and for the same procedures. If so, then OIG recoups the professional component of the global rate from the hospital.

BFST also collaborated with DHS to identify if the recipient received services from the same providers on the same dates for both the Developmental Disabilities (DD) and the Division of Rehabilitation Services (DRS). The result was returned to DHS for further actions.

#### *NETWORK LINKAGE TEMPLATE DEVELOPMENT*

In order to more, effectively and efficiently investigate network and relationship patterns among abusive and fraudulent providers, OIG used a commercial link analysis and visualization tool (Link Explorer/Designer). This tool allows users to investigate information by establishing connections to data sources, setting up relationships among objects, dragging and linking icons, and viewing the results through charts and reports. It provides various types of graphical representation to help users uncover patterns and networks. This tool is fully integrated into the current DNA Framework.

After integration with Link Explorer, the BFST development team designed a customized template to use various data sources to create a more comprehensive and visually meaningful investigative and explorative process. Through visualization charts, the DNA system provides the capacity to answer questions such as whether a transportation provider share vehicles with other providers, whether different providers are located in the same place, and how the providers are linked with each other.

Recently Illinois replaced the legacy MMIS system to IMPACT (Illinois Medicaid Program Advanced Cloud Technology) system, of which the provider enrollment system contains more information than the current

Enterprise Data Warehouse (EDW) can offer. Corresponding changes were incorporated into the Link Explorer (for instance, the provider's enrollment and owner information) template to better monitor the service patterns of sole proprietor, FAOs (Facility, Agency, and Organization), and groups.

Moreover, the provider sanction and discipline information was added to the template so that auditors and investigators can verify information during pre-audit data mining and fraud detection analysis. The sanction data is valuable to OIG to help identify the providers who should not bill the state and help OIG in proactively stopping payments to these sanctioned providers. The current sanction data processing involves federal as well as state level resources, including HHS OIG List of Excluded Individuals/Entities (LEIE), and IDFPFR sanction information. OIG obtains a list of providers being terminated, sanctioned, or disciplined from IDFPFR and downloads a list of sanctioned providers from HHS regularly. The automated process of matching these individually sanctioned providers against existing providers in EDW occurs weekly. The Link Explorer chart displays sanction effective date and reason.

### *FUTURE ENHANCEMENT*

Due to the constant, changing nature of abuse and fraud in the Medicaid program, the DNA system must evolve to accommodate. This is accomplished not only through continuous modification of programs and reports to embrace policy changes, but also through adoption of the latest advancements in technology for improvement in system performance and efficiency.

The next release of DNA is anticipated in winter 2016/2017. Part of the next release addresses the idea of data intelligence. Data intelligence focuses on enhancements that allow pre-summarized data to be more informative throughout the workflow process in the DNA system based on users' input. Service and payment information can be presented through traditional tables or interactive graphs, both of which allow mouse hover-over interaction and drill-down capacity. For example, entering a provider ID on the profile page, results in the display of key indicators for the provider and a summary chart with payment, services, and recipient information for the past five years. As another example, on the common client routine page, before the user submits the form, a Link Explorer chart is displayed to provide a quick preview of the relationship between providers. Such data integration will help users' data analysis through different displays and relationships, and will further assist the users' decision-making. Greater connectivity will exist between screens in the next release of the DNA. For example, the user has the option to run a statistical analysis on risk score for a provider ID with a high risk score without going to a separate screen.

In addition, text fields will use data intelligence in the next release. The current release includes the auto complete feature in some of the text fields, which received positive feedbacks. For the next release, the feature will be expanded into most text fields and allows "fuzzy" matching and multiple selection capacities. This allows users to more quickly and easily select a wanted value from a list of related records from the database.

In terms of functionality, the BFST development team will continue to enhance the Dynamic Network Analysis (DNA) Framework System by streamlining further the profiling process, OIG CASE referencing, advance fraud routines integration, and social networking inter-relationship among targeted entities. Also, the BFST development team will work to enhance and incorporate more customized statistical models for Service Utilization Review System (SURS) into the DNA Framework system to improve the accuracy and efficiency of OIG's capacity to identify exceptions to the norm for use and quality of care standards, use SAS and other visualization tools to better assist OIG in monitoring providers and recipients' service and payment trends, and proactively make decisions.

## Prescription Drug and Opiate Abuse Initiative

Additionally, HFS OIG is committed in joining local, regional, and national agencies in combating the prescription drug and opiate abuse epidemic. Prescription diversion, or selling prescription drugs for monetary gain, has become very lucrative for physicians as well as for Medicaid recipients. Combinations of opioid narcotics, benzodiazepines and other controlled substances commonly known as “Cocktails” or “The Holy Trinity” are taken together to heighten euphoria. These medications are highly addictive by themselves, but when mixed with other drugs or alcohol they can be deadly.

By using the same DNA Predictive Analytic model and profile-reporting system, OIG recently identified over 10,000 recipients obtaining unusually high dosages and quantities of these medications from multiple pharmacies and/or multiple providers.

In FY '16, OIG will analyze these identified recipients to determine if there are appropriate diagnoses to support the initial and continued use of each drug. When supporting documentation is missing, recipients will be restricted to receive medical and prescription services from one medical provider and/or one pharmacy. Provider’s prescribing patterns will be analyzed in the same fashion. After identifying recipients receiving the Holy Trinity combination, we will determine which providers are prescribing these medications and if they are compliant with Standards of Care when prescribing them. If standard protocols are not followed, disciplinary action may be recommended, up to and including suspension and/or termination of Medicaid Provider privileges.

## Home Health Agency Enrollment Reviews

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

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

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

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

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

## **Combined Managed Care Organization/OIG Peer Review On-Site Visit**

The OIG Inspector General received an email from Centene, Inc. -Managed Care Organization (MCO) requesting that the Peer Review team accompany their team of investigators in conducting an on-site visit for an IlliniCare provider. The provider being investigated was flagged in Centene's pre-payment software system in 2014 for performing autonomic nervous system function testing which was out of the scope of his practice. The provider stopped billing codes for the special testing and Centene closed the case.

The provider was flagged again in early 2016 for up coding, which data displayed a high number of 99214s billed for the majority of his patient population. The data also exhibited that the provider was performing the autonomic nervous system special testing again. The provider was also billing for EKG, auditory evoked hearing tests, diagnostic ultrasound tests for a large number of Medicaid patients without a medical reason for the tests.

Two Health Facility Surveillance Nurses accompanied four investigators from Centene, Inc. to the provider's office on April 29, 2016. The nurses along with the investigators discovered that equipment was missing that was needed to perform some of the special testing that the provider is submitting bills for. There were also several quality of care concerns assessed for this provider including lack of referrals for outside specialty services including physical therapy, psychiatric services, pain management and orthopedic services; questionable prescriptions for weight loss medications, anti-anxiety medications, narcotic medications and medications for altered autonomic nervous system disorders. The provider is also practicing, excessive up coding of numerous codes, which will lead to an extensive OIG audit being completed.

The results of this combined investigation proved to be very successful. The MCOs investigators discovered things that the OIG Peer Review Nurses did not detect and vice versa. Working collaboratively with the MCOs will be a good practice in the future in order to share information and widen OIG's partnerships with other sectors that are less advanced in their approach to fighting fraud. The providers do not work in silos when it comes to committing fraud and neither should OIG. Working together will end in delivering significant results and success in fighting fraud.

## **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 \$529,224,528 in Medicaid federal cost avoidance and recovered \$90,924,669. During FY16, these savings and recoveries resulted from identification of third party resources, avoidance of payments on claims with a known responsible third party, benefit recovery efforts through subrogation of paid claims, as well as estate and tort action collections. The Department works to maximize TPL utilization and to integrate TPL recovery with the managed care program.

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

### **Federally Mandated Payment Error Rate Measurement 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.

## STATE STATUTORY MANDATES

The Inspector General reports to the Governor by statute 305 ILCS 5/12-13.1(a). OIG statutory mandate authorized by 305 ILCS 5/12-13.1 are “to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct.” 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

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

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

## APPENDIX A - REFILL TOO SOON

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

Refill Too Soon	
Total Number of Scripts	10,213,467
Amount Payable	\$703,068,796
Scripts Not Subject to RTS	24,077
Amount Payable	\$4,412,294
Scripts Subject to RTS	10,189,390
Amount Payable	\$698,656,502
Rejected Number of Scripts	654,327
Estimated Savings	\$66,457,577

## APPENDIX B – AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

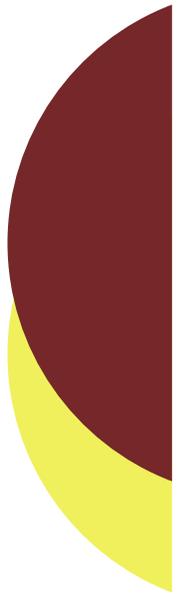
Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of 2015 Annual Report on the OIG website, <http://www.illinois.gov/hfs/oig/Pages/AnnualReports.aspx>. The information, required by Public Act 88-54, is by provider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