



Office of Inspector General

Illinois Department of
Healthcare and
Family Services

2007 Annual Report

Rod R. Blagojevich
Governor

John C. Allen, IV
Inspector General



Office of Inspector General
Illinois Department of Healthcare and Family Services

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Rod R. Blagojevich
Governor

John C. Allen IV
Inspector General

May 14, 2008

To: The Honorable Rod R. Blagojevich, Governor and Members of the General Assembly

As Inspector General for the Illinois Department of Healthcare and Family Services, I am pleased to present you with the Annual Report for the Office of Inspector General (OIG) for Calendar Year 2007. The achievements described within this report are the results of the hard work and dedication of more than two hundred staff members as well as the commitment of Healthcare and Family Services and the Department of Human Services. Due to their efforts, the OIG has shown great progress in the pursuit of our mission.

This report describes a wide array of activities that the Office has undertaken over the past year to enhance the integrity of the programs operated by this Department and the Department of Human Services. As required by Public Act 88-554, this report also provides data on over-payment recoupments, fraud prevention savings, sanctions against providers, and investigation results. It is my hope that the 2007 Annual Report provides you with valuable information.

Sincerely,

John C. Allen, IV
Inspector General
Healthcare and Family Services

Mission

The mission of the Office of Inspector General is to prevent, detect and eliminate fraud, waste, abuse, misconduct and mismanagement in programs administered by Healthcare and Family Services and the Department of Human Services.

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**Office of Inspector General
Illinois Department of Healthcare and Family Services
Annual Report
Calendar Year 2007**

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. DPA became the Department of Healthcare and Family Services (HFS) on July 1, 2005.

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

Prior to 1994, the Division of Program Integrity (DPI) was responsible for many of the duties absorbed by the OIG. The most significant difference between the two entities lies in the OIG's statutory mandate "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct." This directive to first prevent fraud as an independent watchdog has enabled the Illinois Medicaid program integrity functions to greatly increase its

impact on HFS's programs. The OIG investigates possible fraud and abuse in programs administered by HFS and DPA legacy programs in the Department of Human Services (DHS). Acknowledging its mandate, the OIG has developed and enhanced a broad range of tools and techniques to prevent and fight fraud and abuse in Medicaid, All Kids, food stamps, cash assistance and child care. The OIG also enforces the policies of HFS, DHS and the State of Illinois affecting clients, health care providers, vendors and employees.

OIG staff members include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers and information specialists. During 2007, the OIG had an authorized staffing of 210 employees. Staff is 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 2007, with John C. Allen IV serving as Inspector General. Under Inspector General Allen's direction, the OIG continues its current fraud fighting efforts and expands its integrity activities to include new HFS programs as they are implemented.

ENFORCEMENT ACTIVITIES

Audit Initiatives

Recoupment of Overpayments

During 2007, the OIG collected provider overpayments totaling \$19,838,188. The vast majority of these amounts were identified through post-payment audits conducted on providers enrolled in the Medicaid program.

These audits were conducted by the OIG Bureau of Medicaid Integrity (BMI) staff auditors and CPA firms which were contracted by the Department to conduct audits on its behalf. While BMI staff auditors performed audits on all types of providers, CPA firms were only utilized to conduct audits of Long Term Care (LTC) facilities. In 2007, the OIG completed 547 audits of various medical providers participating in the Medicaid Program. This total number of completed audits included desk audits and self audits, as well as traditional field audits where auditors physically visit the providers' facilities.

Desk Audits

During 2007, the OIG completed 301 desk audits. Twenty-one of these desk audits, which were performed during 2007, identified overpayments totaling \$927,465. They were the product of a special computer routine performed by the OIG's Fraud Science Team (FST). These desk audits focused on instances where a transportation provider billed repeatedly for the same service or group of services (duplicate billing), yet did not provide these additional services. Nine additional providers identified through this routine indicated a significant number of duplicate services. Eight of these were selected for field audits during 2007 resulting in identified overpayments of \$11,157,480. The audit of the ninth provider was still in process at the end of the year, so overpayments associated with that audit were not included in the total.

Limited Number of Re-Audits

During 2006, the BMI audit group implemented the "One Re-Audit" policy. Since 2005, the percentage of multiple re-audits has been reduced from 25% to 14% in 2007. This has freed up resources to conduct more post payment audits of more providers.

Prior to the implementation of this policy, multiple re-audits were routine when providers disagreed with the initial audit findings. Under the new policy, it is made clear that to settle disputed findings, only one re-audit providing an opportunity for the provider to submit additional material will be allowed prior to initiating a hearing before an Administrative Law Judge.

DRG Inpatient Audits

The Inpatient Hospital Audit Program (IHAP) will begin a new era of hospital reviews within the Illinois Medicaid program. OIG is in the pilot phase of the program that will consist of an onsite review of hospital billed Diagnosis Related Group (DRG) services. The goal of the program is to identify and recoup erroneous billings and to educate hospitals in proper billing practices. Current OIG hospital reviews are limited to outpatient services and to targeted inpatient self-audits of particular areas of concern. IHAP will ensure the consistent review of hospital claims for added program compliance.

During CY 2008, the OIG plans to fully implement IHAP by contracting with a vendor to perform up to 50 hospital reviews per year. It is anticipated that these full-scale reviews of hospital Medicaid billings will result in significantly increased collection of overpayments. The OIG estimates an average recovery of at least \$5 million per year from this project.

Client Prosecution Cases

The OIG Bureau of Investigations (BOI) referred 28 client fraud investigations to prosecutors during 2007. Several investigations of particular interest are highlighted below.

- *Benefits Investigation*
Household Composition

On September 19, 2007, BOI testified before a Will County Grand Jury regarding this case. The investigation, which was completed in December of 2006, found that the client had received TANF benefits and Food Stamps for over four years for a child who had died in 2002. For the period from March 2002 through June 2006 the client fraudulently received \$5,163 in TANF benefits and \$5,908 in Food Stamps, a total of \$11,071 in state benefits. The grand jury indicted the client on two counts of Vendor Fraud, two counts of Theft, and two counts of Forgery. This case is currently still pending in the Twelfth Circuit Court in Will County.

- *Benefits Investigation*
Household Composition

On February 15, 2006, a local office for the Department of Human Services (DHS) initiated a referral to the OIG. The local office learned that a client who had applied for and received food stamps for household members who were incarcerated in the Illinois Department of Corrections (DOC). The BOI investigation found that the client applied for and received food stamps for three of her adult children, who were incarcerated in DOC, and another adult male who was also incarcerated in DOC. The Bureau referred this case to the State's Attorney's Office due to the nature of the offense and the amount of the overpayment, which totaled \$6870 in Food Stamps. The overpayment covered the period of June 2003 through October 2005. The client was charged on September 27, 2007 with one count of State Benefits Fraud. On October 26, 2007, the client was convicted and sentenced to three years in the Illinois Department of Corrections and was ordered to pay restitution.

- *Benefits Investigation*
Unreported Assets

A BOI Investigator was assigned a joint investigation case with a Special Agent of the Illinois Department of Revenue, who is currently assigned to the Illinois Gaming Board. It was alleged that a client was receiving assistance benefits and not reporting her winnings from gambling. The BOI investigator established a food stamp overpayment on the client in the amount of \$7,909 during the period of May 2005 through September 2006. On November 15, 2007, the investigator and the Special Agent met with a Prosecutor from the Attorney General's Office who agreed to prosecute the multiple charges in McLean County, Illinois. The case is likely to be prosecuted in 2008.

- *Joint Investigation*
Household Composition / Residence

A referral from the Social Security Administration's Office of the Inspector General resulted in a joint investigation involving a client that was receiving social security and claiming to be living in Illinois. In fact, she was living in Missouri with her husband. The client was also receiving food stamps in Illinois. As a result of the joint investigation the client was found to have falsified her living arrangements. The initial overpayment of \$5,379 was reduced after re-calculation by DHS and referred to the Bureau of Collections for recoupment.

- *Benefits Investigation*
Household Composition

A hotline referral from an anonymous caller resulted in an investigation of a client who had been receiving food stamps for almost three years. It was found that the client had been living in Macon County with her employed husband, and she had failed to report household composition changes to the local office for three years during which they had filed joint State Income Tax. The food stamp overpayment totaled \$11,925.

- *Joint Investigation*
Unreported Marriage and Income

The OIG received a referral on a client who was inappropriately receiving food stamp benefits. This case was investigated jointly by BOI with the Social Security Administration (SSA)-OIG, the U.S. Department of Veterans Affairs (VA)-OIG, and the U.S. Railroad Retirement Board (RRB)-OIG. The client, a former resident of St. Clair County, allegedly resided with her husband. He had income from employment, VA benefits and RRB disability income while she received food stamps in St. Clair County. The client received a total food stamp overpayment of \$22,188 from September 2001 through February 2006. She also received an overpayment of \$33,252 in SSI benefits. The investigation report was presented to the U.S. Attorney for the Southern District of Illinois (SDI) on January 10, 2007.

The client was charged with seven felony counts under a sealed indictment by the federal grand jury on June 19, 2007. The indictment was unsealed after the subject was arrested in Arkansas, and she was arraigned at the U.S. District Court-SDI in East St. Louis on July 12, 2007. She pled guilty on October 23, 2007.

- *Joint Investigation*
Unreported Income

The U.S. Drug Enforcement Administration (DEA) and the U.S. Department of Agriculture (USDA)-OIG referred an unreported income case to BOI. A resident of Madison County allegedly received food stamps in his own case and his girlfriend's case in Madison County and he did not report all of his income to DHS. This subject also received assistance in a second subject's case in Johnson County while not reporting all of his income. These subjects received an overpayment totaling \$6,036 in food stamps in

those two counties from July 2003 through August 2006. This information was presented to the U.S. Attorney-SDI on March 29, 2007.

Both subjects were indicted in U.S. District Court-SDI on April 19, 2007 and both were charged with three felony counts to commit SSI and food stamp fraud. Both pled guilty on June 20, 2007. The first subject was sentenced on October 19, 2007 to five months in the U.S. Bureau of Prisons and he was ordered to make restitution to SSA and DHS totaling \$35,183. The second subject was sentenced on November 15, 2007 to six months home confinement and three years of probation; she was ordered to pay restitution to SSA and DHS of \$29,969.

- *Joint Investigation*
False Identity

An investigation previously referred to the US Attorney's Office resulted in the client's guilty plea on May 2, 2007 to one felony count of Theft Fraud by Wire, Radio or Television. The client failed to report that she fraudulently applied for and received public aid benefits and Social Security benefits under a different name and Social Security Number. The case was worked with the Office of Inspector General – Social Security Administration. The prosecution overpayment referred by BOI was used in sentencing the client. Final disposition of the sentencing is pending and includes \$55,161 in restitution to HFS.

- *Joint Investigation*
False Identity

An investigation previously referred to the US Attorney's Office resulted in the January 10, 2007 indictment and the client's subsequent guilty plea on August 14, 2007. The client and his wife improperly received duplicate assistance case by utilizing two social security numbers. The overpayment referred totaled \$83,896.07. Sentencing is still pending.

- *HMO Investigation*
Marketing Irregularities

An HMO Marketing investigation was completed involving allegations of marketing irregularities and misrepresentation when two marketers contacted a client without her permission. One marketer engaged in door-to-door marketing and was an accomplice in the attempt to enroll the client into the plan without her knowledge or consent while the other impersonated the client in a telephone call to enroll her and her family into the plan. Both marketers were terminated as a result of the investigation.

- *Investigation*
False Identity

A client eligibility case was referred to the United States Attorney in August, 2007. The case involved a married client who had failed to report her marriage and their assets and income through the duration of her assistance. The client later admitted to possessing a

large amount of money in her bank, the sale of two properties and purchase of another. The client further admitted to the use of an alias name and social security number to remain eligible for assistance. The overpayment identified on this case was \$27,260.00. This case is has been under Grand Jury seal since September, 2007.

- *Benefits Investigation*
Household Composition

A prosecution case in Cook County resulted in an estimated overpayment of \$76,021.00. A client failed to report a marriage, divorce and another marriage during a ten year period. During this period of time, the client failed to report her income as a nail technician, husband's income and child support payments with the intent to remain eligible for welfare assistance. The case was forwarded to the Attorney General's Office in January 2008 to be included with a Social Security Administration's criminal case.

Food Stamp EBT Referrals and Disqualifications

The Food Stamp Fraud Unit (FSFU) reviews cases referred for suspected food stamp fraud. The cases are reviewed, evidence is compiled and then it is determined if sufficient evidence is available to prove the suspected violation. If so, the client is notified of the charges and is provided the opportunity to return a signed waiver admitting to the charge. If the client does not return the signed waiver, an Administrative Disqualification Hearing (ADH) is scheduled.

Since the inception of the Electronic Benefits Transfer (EBT) Program in 1999, FSFU has received 28,631 referrals from the USDA Food and Nutrition Services (FNS) and 388 referrals from field staff and hotline calls. According to the Chief of Program Operations Section for the USDA, FNS Midwest Region, Illinois is the most active State in the Midwest Region in pursuing clients suspected of EBT fraud.

"Illinois has the longest running and most successful EBT client integrity project in the Midwest Region. FNS MWRO continues to hold Illinois up as a model of a successful EBT client integrity project. We know that in this environment of limited resources tough decisions have to be made on where to expend our efforts, so we commend you and your staff for your commitment and ongoing efforts to improve the integrity of the Food Stamp Program by ensuring that clients are held accountable for the proper use of Food Stamp benefits."

*Tim English, Regional Director, Food Stamp Program
Food & Nutrition Services, Midwest Regional Office*

In 2007, FSFU received a total of 4,824 referrals, completed 3,072 reviews, participated in 1,213 ADHs and received 700 positive hearing decisions. In addition, FSFU processed 330 signed waivers and 19 prosecution cases. FSFU efforts resulted in the disqualification of 1,049 clients during 2007 and a cost savings to the State of Illinois of \$1,950,911.

HFS Employee Investigations

The OIG Bureau of Internal Affairs (BIA) completed 178 employee and vendor investigations during 2007. Several of these cases are described below.

- During their monthly Internet email review, BIA discovered evidence that an employee was engaged in an excessive amount of personal use of GroupWise email. The investigation determined that he used the state email system for personal use by sending personal email messages during regular work hours to a network of other individuals outside of the Agency. Between January 5 and January 26, 2007, the employee generated over 700 email messages, nearly all were personal and non-work related. He was issued a seven-day suspension.
- An employee allegedly made several inappropriate remarks about a past workplace violence incident that occurred in Chicago. The incident involved an employee physically attacking (choking) a co-worker in the break room.

The remarks were made during an HFS training program: *Dealing with Difficult People*. The victim of the attack was an attendee at the training course and took offense at several of the comments made by the employee. There were also allegations that BIA's investigation may have been compromised.

The employee admitted that she discussed the altercation in class. The employee violated several HFS policies and the comments made in the class were unacceptable and not consistent with HFS' mission to reduce incidents of workplace violence by offering alternatives to the use of physical force to resolve conflict. The use of actual HFS incidents that provide such a high level of detail (based upon hearsay) can be counterproductive to the goal of the training class and can result in the dissemination of false and misleading information. The employee was issued a counseling.

- Staff from the Department of Human Services reported that an HFS employee allegedly provided false information on DHS childcare benefit forms about either being unemployed or having only low-income jobs. The employee allegedly provided proof of his income by forging payment receipts from a previous employer in order to receive childcare subsidy benefits without disclosing his actual employment with HFS. This matter was referred to the Office of Executive Inspector General and subsequently referred to the Illinois State Police, Division of Internal Investigation.

Prosecution by the Office of the Attorney General was declined. BIA's administrative investigation determined the employee violated multiple HFS policies. The investigation concluded he repeatedly submitted false and misleading information to the Illinois Department of Human Services in an effort to acquire childcare benefits for which he was not entitled. He also knowingly and intentionally withheld his true state of Illinois employment earnings by falsifying official childcare records and creating false and misleading earning records in an effort to mask his fraudulent activities. These acts made him eligible for a higher level of childcare subsidy. The employee misappropriated \$1,253.47 in state of Illinois childcare benefits. The employee tendered his resignation in lieu of the Agency proceeding with discharge for cause.

- A division manager reported that a custodial parent (CP) may have altered DCSE documents by increasing set child support obligation amounts on two Orders/Notices to Withhold Income for Child Support - DPA 3683. Further, it is suspected she mailed the

altered documents to the non-custodial parent's (NCP) employer. The employer believed the order to be authentic and honored it; thus, causing the NCP to pay more to the CP than she was entitled by court order.

As a result of the forgery the CP received over \$3,000 in excess child support withholding income. The CP knowingly altered official documents that set child support order amounts with the intent to defraud the NCP and mailed the documents via the United States Postal Services and within the state of Illinois, intending the altered documents to be delivered to further her unlawful scheme to obtain additional child support money from the NCP. As a result she received \$3,849 to which she was not entitled. The case was referred to the Morgan County States Attorney's office and theft charges were filed. The CP was convicted in criminal court.

- While conducting another investigation, BIA received information that a supervisor within the unit allowed subordinate staff to abuse time, was allegedly engaged in inappropriate behavior with a male subordinate, was discourteous towards her manager and subordinate employees, abused her own Available Benefit Time, falsified records, failed/refused to follow instructions, was negligent in the performance of her duties and failed to maintain confidentiality on an on-going internal investigation. The investigation determined she violated multiple HFS policies.

The employee admitted participating in conversations with subordinate staff about inappropriate subjects. She was personally aware of multiple occasions where staff took extended breaks, was away from their work stations/areas, took extra breaks, read magazines after returning from breaks, or handled personal business during work hours. There was no evidence to suggest or support she intervened or took any corrective action against subordinate staff. The employee was issued a seven-day suspension.

- Labor Relations reported that an employee allegedly approached a co-worker, gave him an obscene gesture and then verbally threatened him. The subordinate allegedly approached the supervisor and called him derogatory names. The employee had previously been directed not to have contact with this co-worker.

The investigation was substantiated. The employee knowingly violated policy when he disregarded a supervisory directive to stay away from a co-worker. The employee provided false information to the investigators. A witness refuted a key portion of the employee's statement. The employee was issued a 20-day suspension.

- The Office of Labor Relations contacted BIA and requested that they interview an employee regarding a release of confidential client information to a non-custodial parent. The employee had recently returned from a leave and was soon due for certification of his position. There was a question that he may not have been given a refresher course since returning from his leave. BIA interviewed the employee and confirmed he had recently returned from a leave and had not received any training regarding his duties and responsibilities. However, he acknowledged the circumstances surrounding the purported release of confidential client information to the non-custodial parent. He was issued a 7-day suspension.

Security / Employee Safety

The OIG is responsible for HFS physical security and employee safety. The following discusses OIG's activities during the past year pertaining to these issues.

- *Building Security*

During 2007, the OIG successfully updated the communications link at all HFS facilities that are outfitted with the Hirsch Keyless Entry System. This system utilizes keypads at building entrances for employees to enter pass codes. It also permits some employees to utilize proximity cards for frequent access to controlled areas within buildings. The system tracks and reports employee building access and movement within buildings to controlled areas. This most recent modernization to the Hirsch system allows us to electronically update all of the control and communications pieces and eliminates the need to do manual changes of hardware. The agency also replaced all of the existing proximity card readers with HID compatible card readers. These updates were done as part of a move to centralize the Hirsch system for agencies under the Governor.

- *Emergency Planning*

The OIG's security coordinator has been involved in the relocation planning for offices at 1001 N. Walnut and 607 E. Adams in Springfield as it relates to the implementation of emergency plans and creating a facility safety team. This planning also included the installation of access control systems when it was warranted.

In an ongoing effort to address staff safety during fire and severe weather crises, the OIG insured that emergency training programs and evacuation exercises were completed at all properties where HFS staff is located. Safety teams and emergency procedures have been reviewed and revised as needed.

- *Threat Assessments*

In calendar year 2007, OIG's security coordinator completed sixty-three threat assessments. The threat assessments were based upon reported incidents of physical threats by employees, clients, non-custodial parents and other civilians against agency employees and clients.

Conflicts of Interest: Secondary Employment

During calendar year 2007, Internal Affairs received 16 allegations regarding conflict of interest complaints. A number of these allegations involved employees conducting secondary employment on state time. Employees often hold other employment outside of state government with the department's permission; however, HFS policy does not allow an employee to conduct outside business on state time. Furthermore, the use of state facilities, staff, commodities, computers, pagers or phones to support outside activities is strictly prohibited. Seven of these investigations were substantiated. Of these, four investigations involved secondary employment and are described below:

- A division manager reported that an employee was suspected of using her state issued computer to engage in secondary employment activities. A preliminary Internet review of her usage supported the allegation.

The investigation determined that the employee used the HFS Internet computer system for personal use. She admitted that the subject content of the personal Internet activity was not appropriate for the workplace. The employee utilized regular work hours to access the Agency's computer system for personal use to include notify staff within her office of planned jewelry parties.

The employee was discharged for cause; however, as a result of an appeal, the discharge was reversed and she was issued a 30-day suspension. According to the Office of Labor Relations, this suspension is tantamount to a last chance agreement for the employee.

- BIA received a complaint from a Weatherization Program contractor that an employee was using his position with the state to push sales of a specific brand of windows to Weatherization contractors. The complaint also alleged that while the employee previously worked for a Local Administering Agency (LAA) he engaged in a similar practice. At about the same time the complaint was received, the employee submitted an Ethics Guidance Request Form to the Department's Ethics Officer. The form claimed the employee had operated a small personal business (as a jobber/installer of vinyl windows) for 28 years and that the employee had no knowledge of selling his product to any LAA's or their contractors.

We secured the employee's bank records and obtained sales invoices from the window vendor documenting the business transactions from the vendor to the employee's business. The invoices contained the names of both the contractor and the energy assistance client. The contractors were the same contractors that were performing work for the LAA for whom the employee had previously worked before his employment with the state. We also determined that the client's names on the vendor invoices matched names contained in the weatherization program.

We obtained documents from the employee's previous employer that showed the LAA's Executive Director presented the employee with a letter stating the agency's knowledge of his personal contracting business practice of selling replacement windows to existing Weatherization contractors could be a possible conflict of interest. The employee resigned from the LAA several weeks after being presented the letter and shortly thereafter, assumed his duties with the state.

We determined the employee provided false and misleading information to the Department's Ethics Officer on his Ethics Guidance Request Form. He failed to disclose his actual business relationship with the contractors doing weatherization projects for the agencies administering the program. When we interviewed the employee and confronted him with the evidence, he elected to resign his position with the Agency.

- In an anonymous complaint it was alleged that an employee was selling copies of DVD movies to co-workers on state time and maintained a list of DVDs he has sold to co-

workers on his agency computer. During the Internal Affairs interview, the employee resigned his position with HFS.

- While conducting routine monitoring of employees' email activity, BIA discovered that an employee had 248 outgoing or incoming cross-gateway E-mail. Upon further analysis of the email the investigator determined that she might be conducting secondary employment on state time.

The employee's agency computer hard drive was imaged and BIA conducted a more in-depth analysis of the employee's computer usage. The investigation and computer forensic evidence determined that she had violated HFS policy by conducting secondary employment during regular work hours. This was validated by the recovery of 408 emails discussing the products, meetings, flyers and procedures of the Mary Kay Cosmetic business. The computer forensic examination also revealed that the employee had looked up Mary Kay products, placed the orders and communicated with the cosmetic company during regular work hours.

During her interview with Internal Affairs, the employee resigned her position with HFS, agreed to waive reinstatement rights and not seek or accept future employment with the state.

PREVENTION ACTIVITIES

Fraud Prevention Investigations

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

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

In 2006, the FPI program expanded to include the four DHS local offices in the Metro East counties of Madison and St. Clair. Prior to that, the program was only operational in the nineteen Cook County DHS local offices.

The FPI program has provided a twelve-year estimated average savings of \$13.32 for each \$1.00 spent by the state. FPI has averaged a 66% denial, reduction or cancellation rate of benefits for the 35,945 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings has reached over \$84.8million.

During calendar year 2007, the program generated 4,916 investigations, of which, 3,564 cases led to reduced benefits, denials or cancellation of public assistance. The denial rate for this period was 72.5%. BOI calculated an estimated gross savings for calendar year 2007 of approximately \$19.2 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps. The program's estimated average savings for calendar year 2007, was \$22.14 for each \$1.00 spent on the program.

Long Term Care - Asset Discovery Investigations

The Long Term Care-Asset Discovery Investigations (LTC-ADI) program targets error-prone long term care Medicaid applications. In partnership with the Department of Healthcare & Family Services (HFS), Office of Inspector General (OIG), the Department of Human Services (DHS) local offices throughout the state participate in this effort. LTC-ADI evaluates Medicaid applications containing or meeting special referral criteria for pre-eligibility investigations. The program's goal is to prevent ineligible persons from receiving long-term care benefits, thereby saving tax dollars and making funds available to qualified applicants who meet the eligibility requirement based on Medicaid standards. The investigations attempt to reveal undisclosed assets and unallowable asset transfers.

Bank accounts are a common asset reported on applications, and checking accounts are the predominant source of information that leads to the discovery of unreported assets. Bank account review procedures established by the LTC-ADI staff require identification and documentation of specific transactions for a defined period of time.

Acquisition of the required volume of documentation from banking institutions proves to be a challenge. In 2007, LTC-ADI began taking steps to educate financial institutions at the corporate level about the need for verifications. Passage of the Deficit Reduction Act by the Federal Government in 2006, and roll-out of the proposed changes at the state level, further exacerbate the challenge with the look back period being extended to 5 years instead of the current 3-year period. LTC-ADI has initiated dialogue with several banking institutions to inform them of the importance of obtaining the necessary documentation from them. Additionally, the communication includes a reminder of the benefits programs like LTC-ADI bring to the taxpayer and of the financial institutions' mission to provide customer service to their patrons.

During an investigation in 2007, the bank account review procedures established by the LTC-ADI staff confirmed their relevance. The assets reported on a particular application included a checking account, savings account and redeemed government bonds valued at approximately \$4,000. Questionable transactions found in the bank records led to a query with the Bureau of Public Debt resulting in the discovery of 155 unreported U.S. Government Bonds valued at \$77,326. The applicant had enough funds to pay for a minimum of 12 months of long-term care expenses and the State realized a savings of approximately \$38,000.

While bank account review and verification plays a significant role in the discovery of undisclosed assets, the basic premise of the LTC-ADI program identifies all assets currently or previously owned by the applicant. Changes in asset ownership discovered during investigations can lead to substantial savings for the State and ultimately the taxpayer.

Investigation results for the 2007 calendar year revealed many such changes in the way applicants' assets were held that resulted in ineligibility factors. Investigation findings on one particular case revealed the withdrawal of a portion of the balance in an investment account that was held in the applicant's Trust and deposit of those funds to another Trust account that was not owned by the applicant. The transfer resulted in a \$208,613 savings for the State. Asset documentation on another case reported transferring assets to fund a Trust that did not allow accessibility to the principle by the owner/applicant resulting in savings to the taxpayer amounting to \$314,294. Yet another investigation revealed changing real property from sole ownership to establishing a life estate creating a transfer for less than fair market value amounting to \$147,581, saving the State \$108,841 in long-term care expenditures.

In June 2007, the LTC-ADI three-year contract with the state approved vendor ended. In an effort to keep the program running without interruption, the LTC-ADI staff began conducting investigations on referrals sent by DHS. In addition, resources were diverted from other areas of the OIG to help with this effort. A total of 230 referrals were completed by the OIG staff before the new vendor was operational in early November 2007.

Routinely, LTC-ADI staff communicates with DHS local offices providing on-going education regarding LTC-ADI. This open communications between LTC-ADI staff and local offices proved beneficial in increasing the number of referrals received from DHS in 2007. The OIG made recommendations on 748 referrals for investigation during the 2007 calendar year. The gross savings realized in 2007, for not providing public assistance to ineligible persons due to LTC-ADI was \$16,264,556. For every \$1 spent on administration costs relevant to the LTC-ADI program, \$14.84 of savings was realized.

Predictive Modeling Medicaid Transformation Grant

In February 2007, the OIG was awarded a two year federal Medicaid Transformation Grant of \$4,849,200 to transform its Medicaid program integrity efforts by developing a predictive modeling system. The system will leverage Illinois' historical data from previous fraud and abuse cases in order to develop well-honed fraud predictors. OIG will use this capability to improve care for asthmatic patients and identify collusion between psychotherapy and non-emergency transportation providers. The initial focus will be on identification of previously undiscovered or emerging fraud patterns and providers in the following areas:

- Providers rendering a substandard level of care to the asthmatic recipient population
- Undiscovered fraudulent providers or undetected criminal networks that may be participating in organized fraudulent activity as part of ever-evolving fraud scheme in which psychotherapy, transportation services, and other entities bill unnecessarily for the same group of patients.

The OIG has partnered with two state universities to manage, administer, and implement the technical infrastructure and perform the various predictive modeling components. The Medical Data Warehouse platform is also being enhanced to expand the Department's data mining

capabilities which will allow the OIG to establish a robust analytical dataset and build an infrastructure that supports far-reaching data analyses and predictive modeling campaigns.

The long term goal of the project is to build a sustainable predictive modeling system that functions well beyond the two-year grant period. This endeavor holds significant promise to transform Illinois' approach to preventing and detecting fraud and abuse in the Medicaid program. Ultimately, the outcomes of this system will:

- Improve the quality of care rendered to the Medicaid recipient population
- Identify emerging provider fraud schemes rapidly, accurately and efficiently
- Focus on the dynamic environment of the health care delivery system and the latest treatment schemes
- Focus on problem areas identified through federal and other state medical program integrity initiatives
- Reduce expenditures and increase overpayment recoupments

Non-Emergency Transportation Provider Re-enrollment

In March 2007, the OIG completed the criminal background checks and on-site visits for non-emergency transportation (NET) providers re-enrolling with the department. Government entities and newly enrolled providers that had already submitted fingerprints for criminal background checks were excluded from this process. NET providers enrolled before the criminal background check requirement was implemented, but subjected to a site visit within the last two years, were not required to undergo another site visit. As part of their re-enrollment they were required to submit to the criminal background check.

The OIG received a total of 230 NET referrals. Of the 230 re-enrollment applications, 9 were duplicates (originally returned and later enrolled), 214 were re-enrolled, and 7 were not re-enrolled. Of the 7 not re-enrolled, 6 applications were returned due to various reasons: (2) - incomplete or incorrect information on application, (2) - unable to contact the provider, (1) - provider requested withdrawal, and (1) - provider out of business. One application was denied re-enrollment due to a Class X Felony discovered through the criminal background check process.

MEQC Reviews

The Medicaid program began in 1966 with the passage of Title XIX of the Social Security Act. The Medicaid program was established by Congress to help maintain the health care of needy Americans. Aged, blind, and disabled individuals, families with dependent children and pregnant women who cannot afford necessary medical treatment are primarily the ones for whom the program was designed. The program is jointly funded by the Federal Government and the participating States. Currently, eligibility determinations for this program are administered by the State's Department of Human Services. State funding for this program comes from the Department of HealthCare and Family Services (HFS).

The Medicaid Eligibility Quality Control (MEQC) program was initiated by Centers for Medicaid and Medicare Services (CMS) as a self-management tool to help states identify and correct problems in issuing benefits to clients and to reduce erroneous expenditures by monitoring eligibility determinations. Measurement of the accuracy of eligibility determinations was based on certain non-financial and financial factors including things such as residency, age

or disability. Financial factors included such things as income and assets. Error rates (case and payment) were computed based on a random sample of Medicaid eligibles in the universe and reported to CMS on an annual basis.

In the late 1970s, CMS became concerned that the state error rates were too high. As a result, the requirements for the MEQC were formalized by CMS in Part 7 of the State Medicaid Manual and sanctions were imposed. After several changes to the tolerance level for error rates and a court suit, in 1994, CMS decided to allow states to operate pilots instead of the random samples. A pilot is any other type of sample or study that addresses error reduction in the Medicaid program. A major advantage of the pilot program is that states are not subject to MEQC sanctions while conducting pilots. Another advantage is that states can use the resources to target areas of error reduction using MEQC resources. CMS approves the pilots as long as the state proves a workload equivalency to the prior MEQC random sample.

Each federal fiscal year (FFY), the OIG operates the MEQC program according to 42 CFR 431.800 and completes approximately 13,650 (6,825 each six months) hours of Medicaid (Title XIX) eligibility reviews. The OIG has been conducting pilot (targeted) reviews of Medicaid eligibility since it was offered by CMS in 1994. During 2007, the OIG finalized the FFY06 pilot, operated the FFY07 pilot and implemented the FFY08 pilot. The following is a description of those reviews for each FFY.

Income Verification Reviews

In July 2007, the OIG finalized the federally mandated MEQC pilot project - the Income Verification Review. This review was designed to determine if one pay stub used to determine eligibility for all Family Health Plans is truly representative of 30 days income. The review was conducted to determine what effect, if any, the income would have had on the most recent eligibility determination (approval or redetermination). The OIG also verified any additional income sources that should have been used to determine eligibility.

For the first six-month review period (October 2005 through March 2006), a total of 712 cases were selected. Of those, 618 cases were completed and 94 (13.2%) cases were dropped because income could not be verified to determine eligibility. Of the 618 cases, 171 were coded as “0” income cases and verified as such and 8 were self-employment cases.¹

Of the remaining 439 cases, 92% were determined correct (eligible for Medicaid) and 8% were in error (not eligible for Medicaid). Of the error cases, 5% were attributed to the inaccuracy of the one pay stub policy, 2% was due to processing errors and the other 1% was due to the identification of additional income. This six-month review determined that the one pay stub policy requirement was effective for 95% of the 439 cases reviewed.

For the second six-month period (April through September 2006), “0” income cases were excluded from the sample. A total of 696 cases were selected, of which, 562 cases were

¹ “0” income cases and self-employment cases did not fit the criteria of “one pay-stub” and therefore were not included in the total of cases reviewed. They were however reviewed and determined correct for Medicaid eligibility. The “0” income cases will be excluded from the next six-month review period. Identification of the self-employment cases is not possible because they are not coded as such and therefore cannot be removed from the sample selection.

completed and 134 (19.3%) cases were dropped. The majority of dropped cases were due to the inability to verify the income coded. Of the 562 cases, 26 were self-employment cases.²

Of the remaining 536 cases, BMI determined that 87% were correct (eligible for Medicaid) and 13% were in error (not eligible for Medicaid). Of the error cases, 9% were attributed to the inaccuracy of the one pay stub policy, 3% was due to processing errors and the other 1% was due to the identification of additional income. This six-month review determined that the one pay stub policy requirement was accurate for 91% of the 536 cases reviewed.

Throughout the reviews, DHS was notified of the individual case findings. Because this was a study and all elements of eligibility were not verified, the majority of cases did not require individual corrective case action. However the minimal cases requiring corrective action were monitored to ensure completion of such. A summary of findings was submitted to CMS as required.

Redetermination Accuracy Reviews

In October 2006, the OIG implemented a review project designed to verify the accuracy of redeterminations. In 2007 the OIG reviewed approximately 204 Medicaid cases. The review uses the same review techniques required of caseworkers when completing a Medicaid redetermination. As in prior pilots, ongoing monitoring and analysis has been used throughout the review to feed immediate corrective action. The required summary of findings will be prepared and submitted to CMS in 2008.

Health Benefits for Workers with Disabilities

In October 2007, the OIG implemented the federally mandated MEQC pilot project for FY08. The OIG targeted the Health Benefits for Workers with Disabilities (HBWD) program, which was implemented in January 2002 and designed to help people with disabilities return to work with full Medicaid (Title XIX) health care benefits. The MEQC project is designed to determine the correctness of the eligibility determinations to ensure the appropriateness of Medicaid (Title XIX) payments for the HBWD program. Cases will be reviewed throughout 2008 with a summary of findings prepared in 2009.

Negative Correction Reviews

The Medicaid Eligibility Quality Control (MEQC) negative case action sample and the submission of the Negative Corrective Action Report (NCAR) are federally required and operated in according to 42 CFR 431.800.

In January 2007 the OIG finalized the completion of the FY06 NCAR reviews. From November 2005 through October 2006, 237 negative case actions (i.e., denials of assistance and terminations of assistance) were sampled for the October 2005 through September 2006 review period. The universe included Temporary Assistance for Needy Families (TANF) cases receiving medical only such as zero grant cases, TANF Medical Assistance No Grant (MANG), Assistance to the Aged, Blind or Disabled (AABD), Medical Assistance Grant (MAG) and MANG, and all other Medicaid coverage codes such as TANF Medicaid Extensions. Cases receiving assistance under Foster Care and KidCare (Title XXI) are excluded from the universe.

² Self-employment cases did not fit the criteria of "one pay-stub" and were not included in the total of cases reviewed. The cases, however, were reviewed and determined correct for Medicaid eligibility. Systemic identification of the cases with self-employment income is not possible and cannot be removed from the sample.

Cases that have been terminated or denied assistance are reviewed to determine the accuracy of the negative actions and to determine if timely advance notice was sent. A case is considered to be in error if there is no valid reason for the denial or termination or if the notice of termination or denial was not sent or not sent timely. If the cited reason for termination or denial is incorrect, an investigation is conducted to determine if there was a valid reason. If a valid reason exists, the review is correct. Most reviews are desk reviews, with client or collateral contact only when the case record information is inconclusive. For this reporting period, there were no notice errors.

Of the 237 cases sampled, 207 were completed with no errors identified, resulting in an accuracy rate of 100%. Thirty cases were dropped from review, or not completed either because the validity of the negative action could not be verified or the client had Medicaid coverage during the review month and therefore the case should not have been selected for review. Throughout 2007 the OIG has been working diligently with DHS to eliminate certain drop cases from this sample in an effort to reduce the drop rate.

Illinois Healthy Women Surveys

In June 2003, HFS was awarded approval by CMS to implement the Family Planning Expansion Initiative. This initiative was implemented on April 1, 2004 as the Illinois Healthy Women program and provides family planning/birth control and related reproductive health care for women between the ages of 19 and 44 when they lose their Medicaid benefits.

Approval of the initiative was contingent upon compliance with Special Terms and Conditions (STCs). Included in the STC was a requirement to conduct customer satisfaction surveys to assist in assessing whether Family Planning participants were able to access family planning services, satisfied with the service provided, referred for primary services and expressed an ability to access those services, as needed. The survey was also designed to provide feedback regarding resource/referral assistance provided to waiver participants.

To satisfy the STC requirement, in October 2007, the OIG began conducting client satisfaction surveys on clients enrolled in the IHW program.³ A minimum of 250 surveys for those receiving services will be completed and 50 surveys on those not receiving services will be completed. As of December 31, 2007, 73 (35 with services and 38 without services) surveys were completed. The remaining surveys and a report will be completed in 2008.

COOPERATIVE EFFORTS

Medi Medi

The OIG continues to partner with the federal CMS Program Safeguard Contractor (PSC) in the on-going Medi Medi project which is charged with identifying potential fraud and overpayments by merging claims data together from both the Medicaid and Medicare programs. Significant achievements during 2007 included collaboration with the PSC on a project designed to identify cross-program vulnerabilities across the Medicare and Medicaid Programs in the adult day

³ The OIG committed to conducting these surveys for year one (2002), year three (2005) and year five (2007) of the waiver.

training arena. The PSC submitted findings and recommendations on this issue and is now pursuing additional analyses that were generated from the adult day training study.

Technical challenges were also overcome in 2007 to obtain mutual access to Medicaid and Medicare data. By the end of 2007, the PSC had successfully gained direct access to the Medical Data Warehouse and the OIG had re-gained direct access to the Medicare data. This independent access to the data will permit more autonomous and in-depth data exploration, analysis and subsequent fraud detection routine development.

OIG / DOR State Income Tax Initiative

Providers are required (305 ILCS 5/5-16.6) to be in compliance with State Income Tax requirements. A provider who is delinquent with State Income Tax may be suspended from participation in the Medical Assistance Program after an opportunity for hearing, unless there is an acceptable payment arrangement with the Department of Revenue (DOR). The DOR Professional License Unit refers matters to OIG Bureau of Administrative Litigation (BAL) for suspension of providers from participation in the Medical Assistance Program based on 305 ILCS 5/5-16.6. Referrals submitted to BAL include certification form the Director of Revenue that the provider is not in compliance.

In CY05 and CY06, DOR referred a limited number of revenue cases to BAL. The OIG proposed an initiative in which OIG would share provider information with DOR to assist in identification and enforcement of providers with delinquent State Income Tax requirements. Toward that end, an interagency agreement was entered into between HFS and DOR, and information was transmitted to DOR in September 2007.

As part of this initiative, DOR issued 99 letters to providers requesting payment of delinquent State Income Tax, citing DOR's intent to refer the provider to the OIG for suspension from the Medical Assistance Program. To date, the initiative has resulted in the identification of hundreds of providers delinquent with State Income Tax requirements, including well over a million dollars of tax delinquency. As a result of the initiative between OIG and DOR, over \$221,821 of delinquent taxes has been collected. Additionally, twelve providers were referred to the OIG for suspension. Two of the providers have been suspended. The other providers have either paid the delinquency or are in discussions with DOR to enter payment plans. It is anticipated that the initiative will effectuate substantial recovery of State Income Tax delinquency.

TAG White Paper / Survey

During 2007, the OIG partnered with program integrity staff from Washington and Louisiana as part of the Center for Medicare and Medicaid Services, Fraud and Abuse Technical Advisory Group's (TAG) initiative to prepare a white paper for submission to the National Association of State Medicaid Directors (NASMD) that illustrates the difficulties and burdens that states are experiencing in complying with new federal program integrity mandates.

This white paper, entitled "Medicaid Program Integrity: Making the New Federal-State Partnership Work", describes the struggles that state Medicaid program integrity programs are undergoing to meet all of the new federal program integrity initiatives in a time when most states are operating their programs with fewer resources. Many states are being forced to allocate fewer resources to their core activities because they are being forced to expend more resources performing activities required by the federal government. The paper concludes with various

recommendations that include: coordinating and leveraging both federal and state efforts and talents in completing of the various initiatives; marshalling federal resources in the beginning years to assist states in achieving their initiatives and completing their audit queues; enhancing the Federal Financial Participation (FFP) match for state program integrity staff; providing states with options to acquire specialized technical assistance through federal contracting arrangements; providing a centralized, coordinated mechanism for satisfying data requests, and establishing and updating a federal repository of state documentation. Overall, the paper presented the challenges that states are facing in meeting the new mandates at hand, but also encouraged collaboration and coordination between federal and state governments in their efforts to decrease Medicaid fraud and abuse and safeguard public funds.

Joint Terrorism Task Force

In 2007, the Bureau of Investigations (BOI) has continued to work with the Joint Terrorism Task Force (JTTF). Cooperation with the JTTF began in 2006 when the Joint Terrorism Task Force, a federal anti-terrorism task force, determined that the subjects of several of their investigations were recipients of public assistance benefits in Illinois. Based on information obtained through JTTF investigations, the JTTF believed that these subjects had either failed to report, or had under reported, their assets and/or income to the Department of Human Services (DHS) in order to fraudulently receive public assistance benefits. Since October of 2006, at the request of the JTTF, BOI has had an investigator assigned to the task force. As of the date of this report, BOI has opened five joint investigations with the JTTF. These five investigations are still pending and active at this time.

Criminal Prosecutions

The OIG partners with State and Federal law enforcement agencies in the prosecution of providers, alternate payees, and individuals whose actions under the Medicaid program violate Federal and State statutes or program rules. The Office provided assistance on these cases by performing data research, providing program related documentation and arranging expert witnesses from within the agency. A total of 91 law enforcement data requests were handled by the OIG during 2007. In addition, the OIG's administrative actions (audits and provider peer reviews) aid law enforcement actions.

The OIG worked with both State and Federal prosecutors and law enforcement officials in this effort. Prosecutors generally handled the legal enforcement of our statutes as a criminal or civil prosecution. Qui tam, or whistleblower cases, are often handled as multi-state jurisdiction prosecutions. Several of the prosecutions completed during 2007 are described below.

- The Attorney General's office obtained an eight count felony indictment against McDonough County provider Dr. Khalid Dabash. Dr. Dabash required his staff to keep his medical practice open, treat patients, and bill Medicaid and other insurance carriers during a period of time when the doctor was out of the country. Dr. Dabash was found guilty in a stipulated bench trial on Friday September 14, 2007. The agreed outcome was a Class 3 Felony Vendor Fraud conviction, full restitution, fines, fees and assessments totaling \$25,000 and 24 months felony probation. A civil settlement with Dr. Dabash is pending.
- The Attorney General's office obtained the conviction of two individuals who disguised their ownership in a transportation provider because the two had been permanently

excluded from any federally funded medical program as a result of a 1999 federal civil settlement. Cook County Circuit Court found Irit Gutman guilty of Vendor Fraud, Theft, and Money Laundering sentencing her to five years in the Illinois Department of Corrections and ordering her to pay \$2 million in restitution to Healthcare and Family Services. The transportation provider, Universal Public Transportation was also convicted by the same court. Another defendant, Ilya Lubenskiy pled guilty to vendor fraud and was incarcerated for 63 months and ordered to pay \$180,000 in restitution.

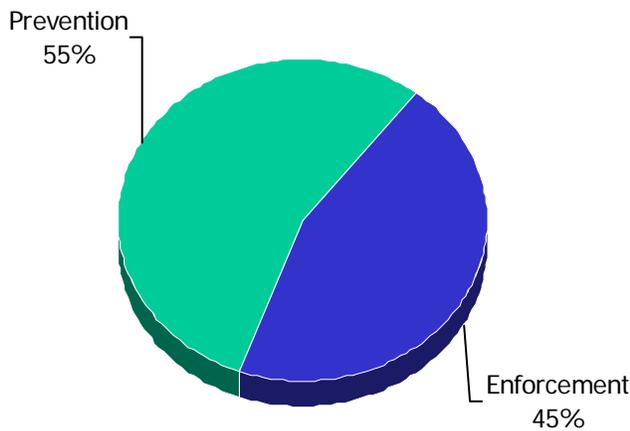
- The Attorney General's office and the United States Attorney's Office for the Southern District obtained a conviction of Downstate Transportation Services, Inc. and owner Richard Wallace for one count of Health Care Fraud and seventeen counts of Mail Fraud. Downstate Transportation Services is a non-emergency transportation provider headquartered in Carterville. The provider routinely billed Healthcare and Family Services for excessive mileage and billing for mileage when recipients were not being transported. The corporation was sentenced to five years probation and Wallace was sentenced to 36 months incarceration and ordered to pay restitution of \$401,556.

FISCAL IMPACT

Fiscal Year Savings

During Fiscal Year 2007, the OIG realized a savings of approximately \$66.3 million through collections and cost avoidances. This savings was more than triple the OIG FY2007 budget of \$19.3 million.

FY07 Savings



Total = \$66,276,055



Prevention Activities:

- Food Stamp Cost Avoidance
- Fraud Prevention Investigations
- Long Term Care—Asset Discovery Investigations
- Recipient Restrictions
- New Provider Verification
- Provider Sanctions Cost Avoidance

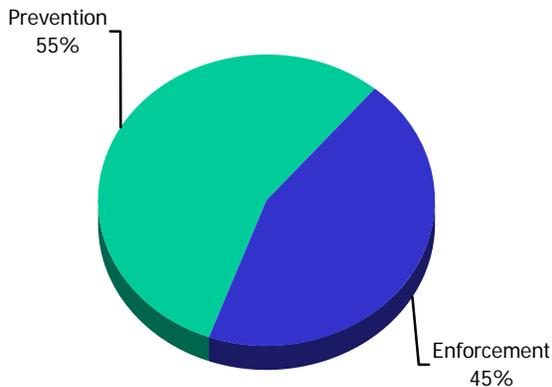
Enforcement Activities:

- Provider Audit Collections
- Fraud Science Team Overpayments
- Restitution
- Global Settlements
- Provider Sanctions Cost Savings
- Client Overpayments
- Food Stamp Overpayments
- Child Care Overpayments

Calendar Year Savings

During Calendar Year 2007, the OIG realized a savings of over \$78.6 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings. The exact dollar amount associated with each prevention and enforcement activity can be found in the *2007 OIG Savings and Cost Avoidance Tables* portion of this report on the page numbers indicated in parentheses next to the activities listed below.

CY07 Savings



Total = \$78,669,629



Prevention Activities:

Provider Sanctions Cost Avoidance (*refer to page 25*)
 Food Stamp Cost Avoidance (*refer to page 27*)
 Fraud Prevention Investigations (*refer to page 29*)
 Long Term Care - Asset Discovery Investigations (*refer to page 29*)
 Recipient Restrictions (*refer to page 30*)
 New Provider Verification (*refer to page 32*)

Enforcement Activities:

Provider Audit Collections (*refer to page 23*)
 Fraud Science Team Overpayments (*refer to page 23*)
 Restitution (*refer to page 23*)
 Global Settlements (*refer to page 23*)
 Provider Sanctions Cost Savings (*refer to page 25*)
 Client Overpayments (*refer to pages 26 and 28*)
 Food Stamp Overpayments (*refer to page 27*)
 Child Care Overpayments (*refer to page 28*)

CONCLUSION

During 2007, the OIG has moved forward on numerous fronts to expand the depth and breadth of its program integrity mission. By relying on the hard work of OIG staff, cooperation with various government agencies and deployment of new technology and scientific methods, the OIG has continued to strive to fulfill its mandate of preventing and detecting fraud and abuse in HFS programs. While not predictive of future results, the dividends have been better prevention methods, faster and broader detection tools and increased financial recoveries. The savings realized not only benefit Healthcare and Family Services, but several other state agencies as well. Through these efforts, the OIG has succeeded in raising awareness of the importance of program integrity among clients, providers and the citizens of Illinois. All OIG activity figures have already been assumed in HFS budget presentations.

2007 OIG SAVINGS AND COST AVOIDANCE TABLES

Medical Provider Audits

The OIG initiates provider audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Audits cover either an 18 or 24-month audit period and are conducted on both institutional and non-institutional providers. The OIG conducts field audits, desk audits and self audits of providers. When a provider is selected for a field audit, the provider is contacted, and records are reviewed onsite by the audit staff. When the OIG performs desk audits of providers, claim information is reviewed without having an auditor physically visit the providers' facilities. Self audits allow an opportunity for providers to review their own records and report billing irregularities.

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

Medical Provider Audits

| Type of Audit | # Recoupments Established | Total Dollars Established |
|----------------------|----------------------------------|----------------------------------|
| Field | 297 | \$22,167,912.27 |
| Desk | 301 | |
| Self | 51 | |

Medical Provider Collections

Monies collected are from fraud convictions, provider criminal investigations, civil settlements and global settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or by installments, and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

Medical Provider Collections

| Type of Collection | # Cases | Total Dollars Collected |
|--|----------------|--------------------------------|
| Provider Audits (includes Fraud Science Team Overpayments) | 848 | \$28,649,239.45 |
| Restitution | 26 | |
| Global Settlements | 4 | |

Medical Provider Peer Reviews

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

OIG staff nurses schedule onsite reviews with providers to review original medical records. A written report documenting findings and recommendations is then completed. Possible recommendations may include case closure with no concerns, case closure with minor deficiencies identified, or referral to a department physician consultant of like specialty for further review of potentially serious deficiencies. Based upon the seriousness of the concerns, the physician consultant's recommendations may include: case closure with no concerns identified, case closure with minor concerns addressed in a letter to the provider, Continuing Medical Education, Intra-agency or inter-agency referrals, onsite review by the consultant, or appearance before the Medical Quality Review Committee (MQRC). In addition to the above recommendations, the provider may be referred for suspension or termination from the Medical Assistance Program based on recommendations from the MQRC.

Medical Provider Peer Reviews

| Peer Review Outcomes | # Cases |
|-------------------------------------|---------|
| Letter to Provider with Concerns | 220 |
| Letter to Provider without Concerns | 90 |
| Referral for Sanction | 6 |

Sanctions

The OIG acts as the Department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

Sanctions

| Hearings Initiated | # Cases |
|---------------------------------|---------|
| Termination | 33 |
| Termination/Recoupment | 5 |
| Recoupment | 59 |
| Suspension | 2 |
| Denied Application | 7 |
| LTC/Hospital Assessment | 0 |
| Decertification | 13 |
| Child Support License Sanctions | 130 |

| Final Decision | # Cases | Total Medical Provider Sanction Dollars |
|---------------------------------|---------|--|
| Termination | 19 | Cost Avoidance: \$3,283,686.49 Cost Savings: \$2,675,405.14 |
| Termination/Recoupment | 2 | |
| Recoupment | 5 | |
| Suspension | 4 | |
| Voluntary Withdrawal | 2 | |
| Settlement | 3 | |
| Denied Application | 4 | |
| Reinstatement | 4 | |
| Barment | 12 | |
| Child Support License Sanctions | 46 | |

Medical Provider Analysis: Narrative Review Committee

The OIG's Surveillance Utilization Review exception processing system routinely targets and identifies provider billing and payment patterns that exceed established norms for their peer group, e.g., pediatricians, pharmacies, laboratories. This information is analyzed and presented on a monthly basis to the Narrative Review Committee (NRC). The NRC is comprised of representatives from the OIG, Division of Medical Programs, Illinois State Police Medicaid Fraud Control Unit (MFCU), Department of Public Health and other agencies as required. The NRC discusses each case and recommends whether the provider should be audited, reviewed for quality of care, referred for criminal investigation, receive a letter regarding committee's concerns such as over utilization of specific procedure codes, or excluded from further scrutiny at that time.

Medical Provider Analysis: Narrative Review Committee

| Outcomes | # Cases |
|-----------------------------------|------------|
| Referrals | 633 |
| Recommendations to Provider | 9 |
| Refer for Audit | 102 |
| Refer for Quality of Care Review | 282 |
| Refer to Professional Regulation | 3 |
| Refer to Bureau of Investigations | 1 |
| Refer for MFCU Investigation | 0 |
| No Further Action at This Time | 236 |

Law Enforcement

The OIG is mandated to report all cases of potential Medicaid fraud to the Illinois State Police Medicaid Fraud Control Unit (MFCU). Along with reporting the occurrence of the fraud, the OIG also provides data and data analysis support to MFCU, and other law enforcement entities such as HHS OIG, U.S. Attorney, Illinois Attorney General and the FBI to support its criminal investigations.

Law Enforcement

| Enforcement Activities | # Cases |
|-------------------------------|----------------|
| Referrals to Law Enforcement | 97 |
| Law Enforcement Data Requests | 91 |

Client Eligibility

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public assistance. Investigation results are provided to DHS caseworkers to calculate the recoupment of overpayments. In cases with large overpayments or aggravated circumstances, the OIG prepared for criminal prosecution and presented to a state's attorney or a U.S. Attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits.

Client Eligibility

| Enforcement Activities | # Cases | Total Overpayments Established |
|-------------------------------|----------------|---------------------------------------|
| Investigations Completed | 771 | \$2,456,721 |
| Founded | 495 | |
| Unfounded | 276 | |
| Convictions | 28 | |

| Type of Investigations | Percent |
|---------------------------------|---------|
| Absent Children | 13% |
| Absent Grantee | 1% |
| Assets | 5% |
| Duplicate Assistance | 2% |
| Employment | 14% |
| Expenses Exceed Income | 1% |
| Family Comp/RR In Home | 16% |
| Family Composition | 12% |
| Food Stamp Trafficking | 5% |
| Impersonation | 1% |
| Interstate Duplicate Assistance | 2% |
| Other Income | 10% |
| Questionable Situation | 1% |
| Questionable Residence | 2% |
| Residence Verification | 11% |
| SSN Misuse/Discrepancy | 1% |
| Third Party Liability | 3% |

Food Stamp Fraud

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

Food Stamp Fraud

| Enforcement Activities | # Cases | Total Dollars Established |
|---|---------|---|
| Reviews Completed | 3,072 | Cost Avoidance: \$1,950,911 Food Stamp Overpayments: \$1,131,682 |
| Pending Administrative Disqualification Hearing | 6,893 | |
| Disqualifications | 1,049 | |
| Unsubstantiated | 38 | |

Child Care

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

Child Care

| Enforcement Activities | # Cases | Total Dollars Established |
|-------------------------------|----------------|----------------------------------|
| Investigations Completed | 8 | \$146,548 |
| Founded | 7 | |
| Unfounded | 1 | |
| Convictions | 0 | |

Client Medical Card Misuse

The OIG conducts investigations when clients or vendors are suspected of misuse or misrepresentations concerning the medical programs. Client fraud occurs when clients are suspected of misusing their medical cards or their cards are used improperly without their knowledge. Typical examples include loaning their 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 made for care not provided or for care at inappropriate rates. Depending on the results of the investigation, the case may be referred for a physician or pharmacy restriction or a policy letter may be sent to the client. The case may also be forwarded to another bureau or agency for some other administrative or criminal action.

Client Medical Card Misuse

| Enforcement Activities | # Cases | Total Dollars Established |
|-------------------------------|----------------|----------------------------------|
| Investigations Completed | 66 | \$10,467 |
| Founded | 26 | |
| Founded In-Part | 16 | |
| Unfounded | 24 | |

Fraud Prevention Investigations

Fraud Prevention Investigations (FPI) program targets error-prone public assistance applications which contain suspicious information or meet special criteria for pre-eligibility investigations. The FPI program has provided a twelve-year estimated average savings of \$13.32 for each \$1.00 spent by the state. FPI has averaged a 66% denial, reduction or cancellation rate of benefits for the 35,945 referrals investigated since fiscal year 1996. In addition, since Fiscal Year 1996, the program's estimated total net savings has reached over \$84.8 million.

The FPI program continues to prove its value to help ensure the integrity of public assistance programs in Illinois and to increase savings for the taxpayers. During calendar year 2007, the program generated 4,916 investigations, of which, 3,564 cases led to reduced benefits, denials or cancellation of public assistance. BOI calculated an estimated net savings for calendar year 2007 of approximately \$19.2 million for all assistance programs: Medicaid, Temporary Assistance for Needy Families (TANF) and Food Stamps.

Fraud Prevention Investigations

| Enforcement Activities | # Cases | Total Cost Avoidance |
|-------------------------------|----------------|-----------------------------|
| Investigations Completed | 4,916 | \$19,176,852 |
| Denied Eligibility | 801 | |
| Reduced Benefits | 2,546 | |
| Cases Canceled | 217 | |
| Approved | 1,352 | |

Long Term Care-Asset Discovery Investigations

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

Long Term Care Asset-Discovery Investigations

| Enforcement Activities | # Cases | Total Cost Avoidance |
|---|----------------|-----------------------------|
| Investigations Completed | 748 | \$16,264,556 |
| Approved | | |
| Impose Sanction Period/Group Care Spenddown | 81 | |
| Impose Sanction Period/Regular Group Care Credit | 58 | |
| No Sanction Period/Group Care Spenddown | 328 | |
| No Sanction Period/Regular Group Care Credit | 133 | |
| Denied | | |
| Client Requested Application be Withdrawn | 68 | |
| Client Refused to Cooperate/Failed to Provide Verifications | 79 | |
| Other | | |
| Returned to Local Office without Recommendation | 1 | |

Client Medical Abuse

The OIG investigates allegations of abuse of the Medical Assistance Programs by clients. Abusive clients may be placed in the Recipient Restriction Program (RRP). After reviews by staff and medical consultants, clients whose medical services indicate abuse are restricted to a primary care physician, pharmacy, or clinic for 12 months on the first offense and 24 months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider, except in emergencies.

Client Medical Abuse

| 12 Month Restrictions | # Clients | Total Cost Avoidance Client Medical Abuse |
|-------------------------------------|------------------|--|
| Clients Restricted as of 12/31/2006 | 312 | \$1,467,481 |
| Client Reviews Completed | 355 | |
| New Restrictions | 234 | |
| Released or Canceled Restrictions | 63 | |
| Converted to 24 Month Restrictions | 30 | |
| No Restrictions | 28 | |
| Clients Restricted as of 12/31/2007 | 279 | |
| 24 Month Restrictions | # Clients | |
| Clients Restricted as of 12/31/2006 | 403 | |
| Client Reviews Completed | 120 | |
| New Restrictions | 70 | |
| Re-Restrictions | 0 | |
| Released or Canceled Restrictions | 50 | |
| Clients Restricted as of 12/31/2007 | 368 | |

Internal Investigations

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

Internal Investigations

| Enforcement Activities | # Cases |
|-------------------------------|----------------|
| Investigations Completed | 178 |
| Substantiated | 72 |
| Unsubstantiated | 101 |
| Administratively Closed | 5 |

| Types of Allegations Investigated | Percent |
|--|----------------|
| Non-Criminal (Work Rules) | 73.5% |
| Discourteous and Inappropriate Behavior | 6.8% |
| Failing to Follow Instructions | 2.6% |
| Negligence in Performing Duties | 11.1% |
| Conflict of Interest | 5.1% |
| Falsification of Records | 4.8% |
| Contract Violations | 4.3% |
| Sexual Harassment | 1.2% |
| Release of Confidential Agency Records | 2.6% |
| Misuse of Computer | 7.4% |
| Work Place Violence | 3.7% |
| Time Abuse and Excessive Tardiness | 1.4% |
| Conduct Unbecoming State Employee | 22.5 |
| Criminal (Work Rules) | 11.6% |
| Theft or Misuse of State Property | 0.9% |
| Misappropriation of State Funds | 0.3% |
| Commission of or Conviction of a Crime | 1.9% |
| Public Assistance Fraud ILCS 305 | 0% |
| Criminal Code ILCS 720 | 8.5% |
| Security Issue, Contract Violation | 14% |
| Special Project, Background Check, Assist other Agencies | 0.9% |

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. The outcomes for the internal investigations completed during 2007 are listed below.

| Misconduct Outcomes | # Actions |
|---|------------------|
| Misconduct Identified | 30 |
| Employee | 26 |
| Vendor | 1 |
| Other | 3 |
| Misconduct Resolutions | 29 |
| Discharge | 4 |
| Resignation | 3 |
| Suspension | 6 |
| Other, such as reprimands | 6 |
| Referred to Other Sources for Resolution | 1 |
| Administrative Action Pending at Year End | 3 |
| No Action Taken by Agency | 6 |

New Provider Verification

Since June 2001, the OIG has processed approximately 1,276 non-emergency transportation (NET) and Durable Medical Equipment (DME) provider applications. Part of the application process for these providers includes an on-site visit to the business address listed on the provider application. The visits are designed to verify the legitimacy of the businesses prior to enrollment into the Medicaid program. During the visits, the business' location and existence are confirmed, information provided on the enrollment application including ownership information is verified and the business' ability to service Medicaid clients is assessed.

Of the 1,276 (700–NET and 576–DME) applications reviewed, 144 (11%) have been returned (enrollment into the Medicaid program not authorized) due to one or more of the following reasons: incomplete enrollment package, non-operational business, inability to contact applicant, requested withdrawal by the applicant, the applicant applied for the wrong type of services and applicant did not comply with fingerprinting requirements. Approximately 12 (1%) applications have been denied enrollment into the program for reasons such as the applicant did not establish ownership of vehicles, fraud was detected from another site affiliated with the applicant, the applicant was participating in the Medicaid program using another provider's number and the applicant provided false information to the department. During 2007, the OIG processed 192 applications (117 NET and 75 DME).

New Provider Verification

| Enforcement Activities | # Cases | Total Cost Avoidance |
|-------------------------------|----------------|-----------------------------|
| Reviews Completed | 192 | |
| Enrolled | 169 | |
| Not Enrolled | | \$1,456,082.49 |
| Applications Returned | 23 | |
| Applications Denied | 0 | |

APPENDIX A - OIG PUBLISHED REPORTS

| Title | Date | Description |
|---|----------------|--|
| <i>New Provider Verification Report April 2001 to September 2003</i> | October 2005 | Provided oversight to the enrollment of 288 non-emergency transportation and 212 durable medical equipment providers by scrutinizing applications and performing on-site visits. |
| <i>Medicaid Eligibility Quality Control Report FFY02</i> | April 2005 | Cited a case error rate of 14.62% and a payment error rate of 3.06% for the Medicaid (Title XIX) population. |
| <i>Illinois Healthy Women Survey Report 1st Quarter 2005</i> | April 2005 | Conducted 253 surveys on women enrolled into the newly implemented IHW program who had utilized services and 53 surveys on those who had not. |
| <i>School Based Health Services Technical Assistance Report</i> | August 2004 | Identified the need to improve LEA providers' understanding of and compliance with policy when submitting claims for reimbursement. |
| <i>Fraud Prevention Investigations: FY02 Cost Benefit Analysis</i> | September 2002 | Identified \$9.8 million in net savings with a benefit of \$12.31 for every dollar spent. |
| <i>Fraud Prevention Investigations: FY01 Cost Benefit Analysis</i> | September 2001 | Identified an estimated \$8.6 million in annual net savings for 2001, boosting the total estimated savings to \$31.4 million since FPI began in 1996. |
| <i>Child Support Emergency Checks</i> | June 2001 | An OIG-initiated study determined that 99.9% percent of the nearly \$14 million in emergency child support checks were either legitimate or never cashed. Of the 0.1% of the checks that remain unresolved, four have been confirmed as fraudulent. |
| <i>Fraud Prevention Investigations: FY00 Cost/Benefit Analysis</i> | November 2000 | The program was expanded to all 23 local DHS offices in Cook County. It identified an estimated \$8.7 million in net savings, with a benefit of \$11.60 for every dollar spent. Since it's inception in 1996, the program's estimated net savings have been nearly \$23 million. |
| <i>Fraud Prevention Investigations: FY99 Cost/Benefit Analysis</i> | March 2000 | Identified \$4.5 million in annual net savings with a benefit of \$12.12 for every dollar spent. |

| Title | Date | Description |
|---|----------------|--|
| <i>Death Notification Project: Identifying the Cause of Delay in Notification</i> | February 2000 | Evaluated whether nursing homes or DHS local offices are responsible for case cancellations due to death. The workgroup found that neither party is completely accountable, and made recommendations for improvement in the notification process. The workgroup also proposed increased monitoring of the 26 nursing home's identified as having the highest incidences of overpayments due to late notice of death. |
| <i>Non-Emergency Medical Transportation Reviews: Focusing on Compliance</i> | December 1999 | A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation. |
| <i>Project Care: Exploring Methods to Proactively Identify Fraud</i> | December 1999 | Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children. |
| <i>Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments</i> | December 1999 | Recommended methods by which non-institutional post mortem payments could be identified more quickly. |
| <i>Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century</i> | September 1999 | Verified the cost-effectiveness of searching for assets of LTC applicants. |
| <i>Recipient Services Verification Project: RSVP II-Home Health Care</i> | August 1999 | Confirmed receipt by clients of home health care services. |
| <i>Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues</i> | June 1999 | Validated the effectiveness of the project's error-prone criteria and processes. |

| Title | Date | Description |
|---|---------------|---|
| <i>Fraud Prevention Investigations: FY98 Cost/Benefit Analysis</i> | December 1998 | Identified an estimated \$4 million in net savings with a benefit of \$14.25 for every dollar spent. |
| <i>Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices</i> | October 1998 | Examined weaknesses in the security of the agencies and proposes several recommendations for improvement. |
| <i>Fraud Prevention Investigations: FY97 Cost/Benefit Analysis</i> | February 1998 | Identified an estimated \$3.63 million in net savings with a benefit of \$13.02 for every dollar spent. |
| <i>Medical Transportation: A Study of Payment and Monitoring Practices</i> | December 1997 | Identified policy changes and monitoring strategies. |
| <i>Funeral and Burial: A Review of Claims Processing Issues</i> | October 1997 | Examined policies and procedures of the Department of Human Services in paying for client funeral and burial and made recommendations for improvement. |
| <i>Maintaining A Safe Workplace: Best Practices in Violence Prevention</i> | June 1997 | Identified best practices available to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors. |
| <i>Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings</i> | May 1997 | Recommended a thorough assessment of software systems for prospective review of billings which have the potential to save the State millions. |
| <i>Fraud Science Team Development Initiative Proposal</i> | April 1997 | Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments. |
| <i>Medicaid Client Satisfaction Survey: April 1996-September 1996</i> | April 1997 | Measured client satisfaction with quality and access in both fee-for-services and managed care. |
| <i>Prior Approval Study</i> | May 1996 | Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature. |

| Title | Date | Description |
|--|---------------|--|
| <i>Clozaril Report</i> | February 1996 | Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement. |
| <i>Hospital Inpatient Project Summary Report</i> | April 1994 | Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling. |

Most of these reports are available on our web site at www.state.il.us/agency/oig. They can also be obtained by contacting the Inspector General's office, Illinois Department of Healthcare and Family Services at 217-785-7030.

APPENDIX B - REFILL TOO SOON DATA

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

*Refill Too Soon Program
CY2007*

| | | |
|----------------------------|------------|-----------------|
| Total Number of Scripts | 24,252,224 | |
| Amount Payable | | \$1,327,032,895 |
| Scripts Not Subject to RTS | 49,912 | |
| Amount Payable | | \$5,460,936 |
| Scripts Subject to RTS | 24,202,312 | |
| Amount Payable | | \$1,321,571,959 |
| Rejected Number of Scripts | | 1,166,212 |
| Estimated Savings | | \$77,463,939 |

APPENDIX C - AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of Calendar Year 2007 Annual Report/Data. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type.



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