



Illinois Health Care Fraud Elimination
TASK FORCE

Initial Six-Month Report

October 2016

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I. Executive Summary



The Illinois Health Care Fraud Elimination Task Force (the “Task Force”) is pleased to submit this six-month report, detailing the Task Force’s fraud, waste, and abuse identification efforts, to Governor Bruce Rauner. State of Illinois (“State”) government-administered health care programs provide important services to citizens and State employees. The State, however, must be ever-diligent in the administration and monitoring of such programs in order to ensure that taxpayer funds are being spent properly and in the best interest of the taxpayers. The value of reducing fraud, waste, and abuse is immense, and in these economic times, would allow the State to utilize funds currently being misspent to provide better programs and services. The work of this Task Force offers the State an important opportunity to utilize existing State resources to address fraud, waste, and abuse in State-administered health care programs.

The State devotes a substantial amount of resources and taxpayer dollars to its health care programs, making these programs particularly vulnerable to fraud, waste, and abuse. In federal fiscal year (“FY”) 2015,¹ all of the states and the federal government spent approximately \$548 billion on Medicaid, and the State and federal government spent about \$18 billion on Illinois Medicaid.² The United States Department of Health and Human Services (“HHS”) estimates that in federal FY 2015, Medicaid made about \$29 billion in improper payments.³ In Illinois during FY 2016,

the Office of Inspector General for the Department of Healthcare and Family Services (“HFS-OIG”) will report \$220.2 million in savings, recoupment, and avoidance in the State Medicaid program (references to Medicaid savings and recoveries include State and federal dollars). In addition, during federal FY 2015, referrals to the Illinois State Police Medicaid Fraud Control Unit (“ISP-MFCU”) led to 42 fraud convictions and \$16.9 million in recoveries through criminal prosecutions, civil actions, and/or administrative referrals.⁴

In addition to the Medicaid program, the State of Illinois also administers insurance for over 450,000 State employees, dependents, and retirees,⁵ and administers the Workers’ Compensation Program for approximately 100,000 State employees. State employee health insurance benefits cost Illinois taxpayers approximately \$3 billion on an annual basis.⁶ For FY 2017, the Illinois Department of Central Management Services (“Illinois CMS”) estimates the liability for employee health insurance benefits to be \$2.86 billion.⁷ This estimate represents a 4.1 percent growth rate from FY 2016 to FY 2017.⁸ The State’s cost per participant for FY 2017 is estimated to be \$8,156.⁹ Per-participant costs have increased 49.5 percent over a ten-year period.¹⁰ In addition, in FY 2016 State employees filed 5,063 workers’ compensation claims, and the State paid \$113,153,685 in workers’ compensation payments.

While efforts of various agencies and units across State government have been successful in recouping or avoiding wasteful or fraudulent spending in certain State-administered programs, the initial work of the Task Force has confirmed that there is potential for additional savings based on improving fraud prevention efforts and recovery. After analyzing the State’s current efforts and benchmarking those efforts against fraud, waste, and abuse savings and prevention numbers in other states and in the private sector, the Task Force believes that, through improved fraud, waste, and abuse identification and prevention efforts, the State could realize approximately \$50 million in additional savings

in the State Medicaid program, which includes State and federal funds. These savings are on top of the \$220.2 million in savings, recoupment and avoidance for the State Medicaid program that HFS-OIG will report for FY 2016. In other words, additional fraud, waste, and abuse prevention efforts in health care have the potential to save the State a substantial amount of money.

The Task Force was created by the Governor via Executive Order on April 5, 2016, with the purpose of:

[D]evelop[ing] and coordinat[ing] a comprehensive effort to prevent and eliminate health care fraud, waste, and abuse in State-administered health care programs using a cross-agency, data-driven approach. Building on anti-fraud work being done across State agencies, the Task Force will develop strategies to ensure that the State has the proper internal controls and analysis and enforcement tools to prevent and eliminate fraud, waste, and abuse in taxpayer-funded health care programs, including but not limited to the State Employees Group Insurance Program, the Workers' Compensation Program for State of Illinois agencies, boards, commissions, and universities, and the Illinois Medicaid system.¹¹

The Task Force is made up of a diverse membership of agency leaders with experience administering health care programs and leading fraud, waste, and abuse prevention and enforcement efforts. The expertise of the Task Force has allowed it to be constantly mindful of striking the important balance of addressing fraud, waste, and abuse in health care programs, without imposing unnecessary barriers to service.

Since April 2016, the Task Force has focused on understanding the State-administered health care programs and resources, studying best practices among other states, private entities, and the federal government, identifying areas in health care programs that can offer Illinoisans the greatest return on their investment, and creating a strategic plan and structure within the Task Force to ensure it efficiently and effectively uses its time and resources.

During its initial six months of existence, it has become clear to the Task Force that the State can reduce

fraud, waste, and abuse and save taxpayer money by concentrating its efforts and recommendations within four areas:

- Collaboration and Coordination. Increased collaboration and coordination among State agencies, and between State agencies and private sector partners, is necessary to strengthen the State's efforts to address fraud, waste, and abuse in State-administered health care programs. During the Task Force's initial meetings and survey efforts, it became clear to the Task Force members that information, resources, and efforts to address fraud, waste, and abuse in State-administered programs were, for the most part, isolated within individual agencies. State agencies did not have clear practices or procedures for regular communication about health care fraud, waste, and abuse elimination efforts.
- Data Analytics and Metrics. Data analytics and the use of consistent, data-based metrics are critical in ensuring that an organization is properly monitoring spending in its health care programs and preventing and addressing fraud, waste, and abuse. Effectively using data and metrics is a key component of a successful program integrity system. When benchmarked against other states and the private sector, improving our use of data analytics and metrics is an area where Illinois has room for improvement, and such improvement will yield monetary savings to the State.
- Accountability and Efficiency. The State of Illinois is accountable to its taxpayers, and must use their money in an efficient and proper manner. The State is also accountable to those to whom it provides health care services, and must provide quality care in a manner that complies with both State and federal law. The Task Force understands that accountability and efficiency are important principles for all State-administered programs. Furthermore, these values are particularly relevant when reviewing the State's health care programs and their potential areas of fraud, waste, and abuse, because Illinoisans expect the State to provide such services in the most effective and efficient manner possible.

- Safety and Wellness. Workplace fatalities, injuries, and illnesses cost employees and employers across the country billions of dollars every year. Employers that promote workplace safety and preventative health initiatives see significant reductions in overall numbers of injuries and illnesses, as well as reductions in the costs associated with these injuries and illnesses, including workers' compensation payments, medical expenses, and lost productivity. Moreover, employers often find that process changes made to improve workplace safety and health may result in significant improvements to their organizations' productivity and profitability, as well as to employee satisfaction. In addition, it is crucial that providers and agencies work to ensure the safety of beneficiaries in Medicaid funded programs.

This report will provide an overview of the Task Force's first six months of operations, including its initial activities, meetings, data collection, and benchmarking efforts. This report will also discuss each of the four focus areas listed above in detail, giving specific examples of how, by focusing our fraud, waste, and abuse elimination efforts on these four sets of core values, the State can drive savings for the taxpayers while providing quality and efficient health services for its employees and beneficiaries served by State-administered health care programs.

II. Background

A. Executive Order 5 (2016)—the Creation of the Task Force

In April 2016, Governor Rauner issued Executive Order 5 (2016), an Executive Order Establishing the Health Care Fraud Elimination Task Force. The Task Force was created in part because “a more comprehensive and cross-disciplinary approach is needed to harness the State’s various fraud-prevention resources to further prevent and eliminate fraud, waste, and abuse and ensure that taxpayers are receiving the best return on investment for the State’s fraud prevention efforts.”¹²

The Executive Order outlines the following specific duties for the Task Force:¹³

1. Identify and catalog the forms of health care fraud existing within State-administered health care programs and identify all Executive Branch agencies and resources currently involved or that should be involved in health care fraud prevention and enforcement.
2. Review best practices being utilized in the private sector, the federal government, and other states to prevent and reduce health care fraud, waste, and abuse and assess how those best practices could be applied to anti-fraud, waste, and abuse efforts in Illinois.
3. Explore the use of data analysis, predictive analytics, trend evaluation, and modeling approaches to better analyze and target oversight of State-administered health care programs.
4. Identify priority prevention and enforcement areas in order to ensure that the State’s fraud prevention and enforcement efforts are providing the best return on investment for taxpayers.
5. Collaborate with industry experts to develop a multifaceted strategy to reduce the State’s exposure to health care fraud and recover taxpayer funds that have been wrongly paid out as a result of fraud, waste, or abuse.
6. Analyze patterns of system-wide fraud, waste, and abuse in order to make recommendations to State agencies for improved internal controls to prevent future wrongdoing.
7. Work with other State agencies, boards, commissions, and task forces to obtain information and records necessary to carry out its duties.
8. Periodically report to the Governor and the public on the Task Force’s fraud, waste, and abuse identification, prevention, and elimination efforts and activities.

The Task Force is also required to conduct at least one public meeting each quarter.

The Task Force is scheduled to dissolve on June 30, 2019, but may be renewed by a new executive order.

B. Task Force Members

Executive Order 2016-05 appointed the following individuals to the Illinois Health Care Fraud Elimination Task Force:

MAGGIE HICKEY (Chair)

Executive Inspector General, Office of Executive Inspector General for the Agencies of the Illinois Governor (“OEIG”)

TREY CHILDRESS

Deputy Governor and Chief Operating Officer, Office of the Governor

GEORGIA MAN

Chief Compliance Officer and Deputy General Counsel, Office of the Governor

GREG BASSI

Policy Advisor for Healthcare and Human Services and Special Counsel, Office of the Governor

BRADLEY HART

Inspector General, Office of Inspector General for the Department of Healthcare and Family Services

CAPTAIN BRIAN LEY

Director, Illinois State Police Medicaid Fraud Control Unit

JEAN BOHNHOFF

Acting Director, Department on Aging (“DoA”)

MICHAEL HOFFMAN

Acting Director, Department of Central Management Services (“CMS”)

FELICIA NORWOOD

Director, Department of Healthcare and Family Services (“HFS”)

JAMES DIMAS

Secretary, Department of Human Services (“DHS”)

HARDIK BHATT

Acting Secretary, Department of Innovation and Technology (“DoIT”)

ANNE MELISSA DOWLING

Acting Director, Department of Insurance (“DoI”)

C. Defining Fraud, Waste, and Abuse

The purpose of the Task Force is to “develop and coordinate a comprehensive effort to prevent and eliminate health care fraud, waste, and abuse in State-administered health care programs using a cross-agency, data-driven approach.”¹⁴ Addressing fraud, waste, and abuse is often cited as a way that organizations can save money and increase efficiency. However, many fraud, waste, and abuse elimination efforts focus solely on the prosecution of criminal fraud. While the prosecution of criminal fraud is an important tool in fighting fraud, waste, and abuse, an organization must be equally focused on fraud prevention. In the context of this report, the terms “fraud,” “waste,” and “abuse” are defined as follows:

fraud

Fraud involves an intentional deception or misrepresentation.¹⁵ Examples of fraud include a doctor billing for services that were never provided or a worker claiming her injury prevents her from working when she is still able to perform work duties.

waste

Waste involves the overutilization or inappropriate utilization of services or misuse of resources.¹⁶ Examples of waste include a provider ordering excessive testing, failing to coordinate patient care, or implementing unnecessary administrative procedures.¹⁷

abuse

Abuse involves action that is inconsistent with acceptable business practices.¹⁸ Abuse results in unnecessary costs for health care programs.¹⁹ Examples of abuse include paying for services that the patient was not legally entitled to receive or failing to meet professionally recognized standards of health care.

D. Background—Medicaid and Medicare, Workers’ Compensation, and State Employee Group Insurance in Illinois

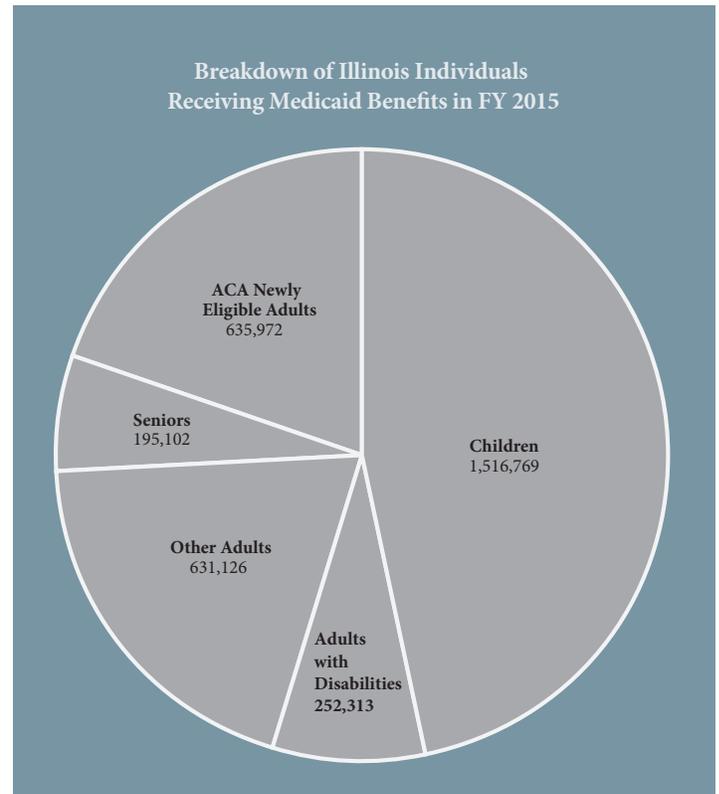
1. Medicaid and Medicare Programs

Medicaid and Medicare, government programs created by federal legislation in 1965, are programs that provide health care coverage for individuals who meet program eligibility requirements. According to Medicaid.gov, “Medicaid is the single largest source of health coverage in the United States.”²⁰

In 2014, the United States provided health care assistance to approximately 64 million individuals through Medicaid, and Medicaid spending by the federal government and individual states totaled approximately \$496.3 billion.²¹ Federal spending on Medicaid represented \$301.5 billion, with states spending a combined amount of \$194.8 billion.²² In federal FY 2015, the State and federal government spent approximately \$18 billion on Illinois Medicaid.²³

Medicaid is administered through a joint federal-state partnership by providing health care to individuals who meet certain financial and non-financial program requirements.²⁴ Currently in Illinois, the State receives an approximate 51 percent reimbursement from the federal government for Medicaid-funded expenses.²⁵ The Affordable Care Act (“ACA”), enacted in 2010, allowed states to expand Medicaid coverage to additional adults under age 65 and children that meet certain income requirements. Illinois opted to expand its Medicaid coverage, and the State is currently reimbursed by the federal government at a rate of 100 percent for individuals included under this expanded coverage. This reimbursement rate, however, will be reduced over the next three years by the federal government, and in 2020, the reimbursement rate will be 90 percent for this expanded population.²⁶

HFS administers the Medicaid program in which services are provided to, on average, approximately 25 percent of the State’s population. In State FY 2015, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to over 3.2 million Illinois residents and partial benefits to 16,440 Illinois residents.²⁷



The Illinois Medicaid program consists of both a fee-for-service delivery system as well as managed care models. In the fee-for-service delivery system, health care providers are paid for each service (e.g., office visit, test, procedure) they provide to a Medicaid beneficiary. In contrast, Managed Care Organizations (“MCOs”) participating in the Medicaid program are reimbursed on a capitation basis (per-person payments rather than per-service payments). HFS’s actuary develops the MCO payment rates based on several factors including fee-for-service claims experience, health plan claims experience, and enrollment data.

In 2011, the Illinois Public Aid Code was amended to mandate that at least fifty percent of all full-benefit Medicaid participants be in some form of risk-based care coordination, such as managed care, by January 1, 2015.²⁸ At the beginning of 2015, just over 50 percent of Medicaid beneficiaries were part of managed care programs. Today, approximately two-thirds of beneficiaries are in risk-based managed care plans. There are currently thirteen MCOs serving

Illinois Medicaid beneficiaries.

Medicare is federal health insurance that serves individuals 65 years old or older, or individuals who have disabilities or certain health conditions.²⁹ Medicare consists of parts A, B, C, and D, with each part offering different coverage.³⁰ Approximately 55 million individuals participate in Medicare, and in 2015, Medicare benefit payments totaled \$632 billion.³¹ Some individuals who are eligible for Medicare are also eligible for Medicaid. In those situations, Medicaid will generally cover expenses that are not covered by Medicare.

2. Workers' Compensation Program

The State of Illinois administers the Workers' Compensation Program for about 100,000 State employees. Like workers' compensation for private sector employers, workers' compensation for the State as an employer involves a no-fault system of benefits the employer pays to employees who experience work-related injuries or diseases.

At the beginning of the 20th century, states began to enact workers' compensation laws as a substitute for the common-law system that required an injured employee to file a lawsuit against the employer.³² Under the common-law system, "the employer could present a defense that blamed the injured employee's contributory negligence, attributed the injury to the negligence of a fellow employee, or argue that the employee assumed certain risks in accepting the job."³³ This reliance on tort law created a long and uncertain legal process when it came to resolving workplace safety claims.³⁴ Workers' compensation replaced the system of common-law rights and liabilities and provided injured employees with the financial protection of an automatic recovery in return for limiting the liability of employers.³⁵

The Illinois Workers' Compensation Commission ("IWCC") administers the judicial process that resolves disputed workers' compensation claims between employers and employees in Illinois. A worker's compensation case commences when an injured employee files an Application for Adjustment of Claim with the IWCC. The IWCC assigns a case number and an arbitrator to the case. Either party may request a trial before the arbitrator. After trial, the

arbitrator issues a decision containing findings of fact, conclusions of law, and an award of benefits, if any. A party dissatisfied with the arbitrator's decision may file a petition for review with the IWCC. A panel of three commissioners will review the arbitrator's decision, the evidence introduced at the trial, and the trial transcript. Both sides may submit written arguments to the IWCC and participate in a hearing where the parties present brief oral arguments. The Commission issues a decision within sixty days of the hearing. The IWCC's decision becomes final for cases involving employees of the State of Illinois. In all other cases, either party may appeal to the Circuit Court with further appeals to the Illinois Appellate Court and the Illinois Supreme Court. However, the vast majority of cases (both involving State employees and private sector employees) settle prior to arbitration.

3. State Employee Group Insurance Program

The State Employee Group Insurance Program provides insurance coverage for the vast majority of the 450,000 State employees and their dependents, as well as for retired State employees.³⁶ As part of the State Employee Group Insurance Program, the State offers several health plan and prescription options for its employees. Illinois CMS and its Bureau of Benefits manage the State Employee Group Insurance Program.

For health insurance, the State offers employees a choice of Quality Care Health Plans (QCHPs) and managed care plans. Managed care plans are administered by various plan administrators, including Cigna, Health Alliance, HealthLink, BlueCross BlueShield of Illinois, and Coventry. For each covered employee, the managed care plans cover medical, prescription drugs, and behavioral health services at different premium and copay amounts. The managed care plans offered include both Health Maintenance Organizations (HMOs) and Open Access Plans (OAPs). Each covered employee has a choice of managed care provider and may change such provider during the annual benefit choice period. Medicare-eligible retirees and their dependents that are Medicare-eligible are covered under Medicare Advantage (MA) plans.

In addition, the State offers employees the following health benefit plans:

- Prescription drug coverage, administered by CVS/Caremark.
- Behavioral health, administered by Magellan.
- Vision benefits, administered by Eyemed.
- Dental benefits, administered by Delta Dental.
- Life insurance benefits, administered by Minnesota Life.

In FY 2016, the State Employee Group Insurance Program had an estimated 365,609 participants. For FY 2017, Illinois CMS estimates the following plan breakdown of employees, dependents, and retirees:

| Plan Type | Employees | Dependents | Retirees |
|----------------------------|-----------|------------|----------|
| QCHP | 16,894 | 21,688 | 12,862 |
| Medicare Advantage HMO/PPO | - | 16,324 | 55,860 |
| Non-Medicare Advantage HMO | 49,784 | 75,599 | 13,062 |
| OAP | 31,746 | 49,098 | 8,429 |

Illinois offers employee benefits that, on average, are more generous than state employee health insurance plans in other states, and State of Illinois employees make a lower percentage premium contribution than their counterparts in other states. In 2013, Illinois' average per-employee premium was \$1,181.³⁷ This average premium was higher than the national average for state employee plans of \$959, and higher than state employee health plans offered by all but eight other

states.³⁸ In addition, Illinois' average per-employee premium contribution (the percentage contributed by the employee versus the employer) was nine percent for individual employees, and 13 percent for employees with dependents.³⁹ By comparison, the national average state employee contribution is 13 percent for individual employees and 20 percent for employees with dependents.⁴⁰ Fourteen states have a lower average state employee contribution for individual employees, and thirteen states have a lower average state employee contribution for employees with dependents.⁴¹

The PEW Charitable Trust and the MacArthur Foundation found that “states and their employees spent about \$30.7 billion to insure 2.7 million employee households” in 2013.⁴² Out of that \$30.7 billion, states paid \$25.1 billion, with the rest being paid via employee contributions.⁴³ In Illinois, State employee health insurance benefits cost taxpayers approximately \$3 billion on an annual basis.⁴⁴ For FY 2017, Illinois CMS estimates the liability for employee health insurance benefits to be \$2.86 billion.⁴⁵ This estimate represents a 4.1 percent growth rate from FY 2016 to FY 2017.⁴⁶ The State's cost per participant for FY 2017 is estimated to be \$8,156.⁴⁷ Such per-participant costs have increased 49.5 percent over a ten-year period.⁴⁸

III. Overview of Task Force Activities



In order to carry out its duties, the Task Force has focused its initial six months on gathering information from its members, State agencies, government bodies, MCOs, private industry experts, federal entities, and published data and studies. The purposes of this information gathering were: (1) to understand the work and resources currently involved in addressing health care fraud, waste, and abuse in the State of Illinois; (2) to learn how Illinois' system compared to best practices being implemented by other states, the federal government, and industry partners; and (3) to develop a strategic focus and plan for the Task Force in order to pursue savings for the taxpayers in the most efficient and effective manner possible.

This section provides a summary of the Task Force's meetings with private sector and federal stakeholders and partners, the two quarterly public meetings that have been held by the Task Force, the Task Force's benchmarking of best practices in other states, the Task Force members' survey, and the formation of several Task Force working groups with specific subject-area focuses.

A. Meetings with Experts and Stakeholders

The Task Force has met with a number of private sector and federal experts in the field of health care fraud, waste, and abuse elimination to gather information regarding trends, current efforts, and best practices. In addition, the Task Force has studied the programs and resources currently utilized in Illinois State-administered health care programs. Task Force members collaborated with each other to learn from their respective areas of expertise in preventing and addressing health care fraud, waste, and abuse. The Task Force's information gathering efforts included:

- Meetings with Assistant United States Attorneys involved in the Health Care Fraud Prevention & Enforcement Action Team of the U.S. Attorney's Office for the Northern District of Illinois.⁴⁹
- Meetings with U.S. Department of Health and Human Services Office of Inspector General ("HHS-OIG") staff.
- Consulting with industry experts regarding Illinois fraud, waste, and abuse prevention efforts and practices as compared to other states.
- Meeting with the Illinois Workers' Compensation Program claims manager.
- Meetings with the Illinois Workers' Compensation Commission.
- Meetings with MCOs regarding best practices.
- Engaging in a survey of Task Force members regarding issues the Task Force should address and resources at each member's agency.
- Organizing and participating in break-out brainstorming sessions among Task Force members and other State agencies and groups regarding fraud, waste, and abuse trends, best practices, and current use of State resources to address those issues.
- Researching scholarly articles and data regarding

best practices and trends in fraud, waste, and abuse prevention.

B. Public Meetings

The Task Force is charged with holding at least one public meeting each quarter. Since its creation in April 2016, the Task Force has held two public meetings. The first meeting took place on June 28, 2016, and the second meeting was held on September 28, 2016.

At the June 28, 2016 public meeting, Chair Executive Inspector General Hickey outlined the Task Force's goals and the progress it had made since it was created. At this meeting, the Task Force discussed the formation of the working groups (described in more detail below) and how the working groups would assist the Task Force in focusing its efforts. The Task Force also heard separate presentations from HHS-OIG Special Agent in Charge Lamont Pugh III, HFS-OIG Inspector General Hart, and ISP-MFCU Director Captain Ley. After the presentations, the Task Force members engaged in an open discussion about the direction and focus of the Task Force.

At the September 28, 2016 public meeting, Chair Executive Inspector General Hickey discussed the Task Force's focus and progress, and the working groups presented information regarding their activities and focus areas. The Task Force also heard separate presentations from Director of Centene/IlliniCare's Special Investigations Unit Daniel Kreitman and the Division Manager of Liberty Mutual Insurance Company's Risk Control Services Division Bill Rankin.

C. Benchmarking Illinois' Practices Against Best Practices

The Task Force reviewed state best practices related to program integrity in the Medicaid program. Below is a summary of some of the best practices broken down into five categories: (1) analytics; (2) vendor management; (3) information technology (IT); (4) prevention; and (5) enablers.⁵⁰ On the right of this page is a chart detailing the Task Force's findings.

The preliminary review of Illinois' practices revealed that some of Illinois' best practices include:

- Regular audits of vendors, focusing audits on high-fraud areas such as long-term care, in-home care, and hospice.
- Strong partnership with ISP-MFCU.
- Membership in the Healthcare Fraud Prevention Partnership, which is a voluntary partnership between state and federal government, law enforcement, private health insurance plans, and health care anti-fraud associations.⁵¹ As a member of the Healthcare Fraud Prevention Partnership, Illinois engages in the regular exchange of ideas and information with other public- and private-sector stakeholders.

However, the preliminary review also identified opportunities for improvement. Most notably, Illinois could strengthen its system by:

- Engaging in greater collaboration and coordination between Illinois agencies and vendors.
- Using data analytics and metrics more efficiently by leveraging current information technology resources.
- Instituting and enhancing pre-payment review capabilities for at-risk providers.
- Increasing proactive outreach to educate and increase communication with providers.
- Sharing data and analytics systems across State agencies.

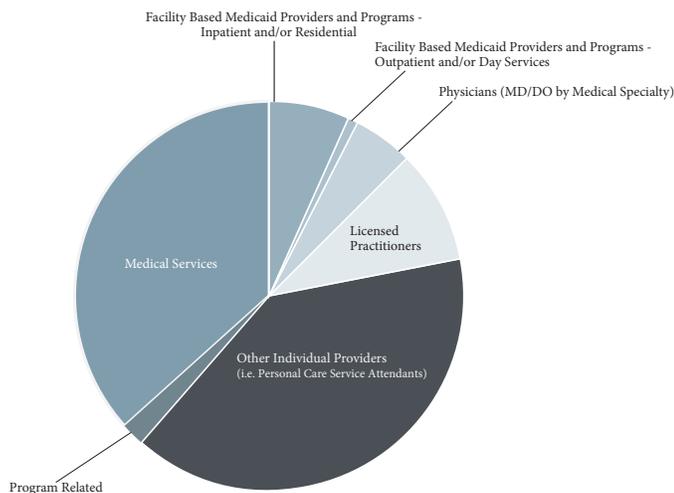
The Task Force used the preliminary review and other research to formulate areas of focus for the working groups.

| Task Force's Review of State Best Practices | |
|---------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Category | State Best Practice |
| Analytics | <ul style="list-style-type: none"> • Employ an internal analytics team of approximately 15-20 employees who possess coding and data-mining capabilities. |
| Vendor Management | <ul style="list-style-type: none"> • Actively manage vendors for performance. • Structure contracts to incentivize vendors. |
| IT | <ul style="list-style-type: none"> • Leverage federal funding for advanced analytics. • Provide analytics teams with tools to identify fraud, waste, and abuse. • Prioritize technology and systems updates based on the largest return on investment. |
| Prevention | <ul style="list-style-type: none"> • Educate providers regarding fraud, waste, and abuse in health care. • Conduct pre-payment reviews of high-risk providers. • Clarify medical policies. |
| Enablers | <ul style="list-style-type: none"> • Hold cross-organization meetings to exchange recovery and prevention opportunities across teams. • Engage the national Healthcare Fraud Prevention Partnership membership to exchange opportunities with other state Medicaid organizations. |

D. Task Force's Review of Common Fraud, Waste, and Abuse Practices

Research by the federal government, other states, and private industry make clear that fraud, waste, and abuse are pervasive in the Medicaid program. HHS estimates that in federal FY 2015, the Medicaid program made approximately \$29 billion in improper payments.⁵² In Illinois, during State FY 2016, HFS-OIG will report \$220.2 million in savings, recoupment, and avoidance in the Illinois Medicaid program, which includes State and federal funds. In addition, during federal FY 2015, referrals to ISP-MFCU led to 42 fraud convictions and \$16.9 million in recoveries, which includes State and federal funds, through criminal prosecutions, civil actions, and/or administrative referrals.⁵³

ISP-MFCU BREAKDOWN OF INITIATED CASES IN FEDERAL FY 2015



While Illinois' recovery numbers are already in the millions per year, there is potential for additional savings based on improving actual recovery and increasing internal controls and other preventative operations. Through improved use of data analytics, more robust recovery efforts, working more closely with MCOs, and other initiatives described in this report, the Task Force believes that the State likely can realize approximately \$50 million in additional savings in the Illinois Medicaid program, which includes State and federal funds.

Certain individuals and providers who perpetrate fraud on the Illinois Medicaid program do so in a variety of ways. In order to examine potential prevention and recovery efforts, the Task Force first sought to understand the most common fraud and abuse schemes committed in Medicaid and Medicare programs.⁵⁴ The most common types of Medicaid and Medicare fraud include:

- **Unbundling.** Unbundling is when a provider should be billing for a group of services at the same time, yet separates out each service for billing purposes. Normally this increases the payment to the provider because the individual service payments exceed the sum total of the global billing procedure. For example, a doctor orders a laboratory to perform a blood test with seven components. This test has a global billing code, but instead of using that code, the laboratory bills for seven separate tests in order to achieve a higher reimbursement rate.
- **Upcoding.** Upcoding is when a provider bills for a higher level service than the service actually performed, resulting in a higher reimbursement rate. For example, a physician sees a patient in her office for a mid-level 30-minute visit, but bills for the highest in-office visit available.
- **Billing for Services Not Performed.** This is when a provider bills for a service or services that were never performed. For example, a laboratory performs one dipstick urinalysis, but bills for five different urinalysis tests, four of which were never performed.
- **Kickbacks.** Kickbacks usually occur between providers or between a provider and another individual. An example of a kickback is a provider giving financial remuneration to an individual who refers clients to that provider for services. This often leads to clients receiving services that are not medically necessary.

In workers' compensation, employee fraud commonly occurs when employees make false statements regarding an accident or injury, mischaracterize the extent and nature of their injury, or give false symptoms and other medical information to a treating physician. The health care providers who

treat injured State employees can also commit workers' compensation fraud. Health care provider fraud can involve inflating medical bills or billing for treatment that never took place. Health care providers also may establish relationships with attorneys and then refer patients to the attorneys for kickbacks. Beyond the monetary consequences, fraud impacts employee morale and forces remaining workers to shoulder increased workloads and supervisors to spend time completing unnecessary paperwork and training replacement workers.

As stated above, although reducing and recovering on fraud remains an important part of the Task Force's focus, addressing waste and abuse in health care can also result in significant savings to the State. Some common practices that lead to waste and abuse in Medicaid and Medicare, workers' compensation, and State employee group insurance programs involve:

- A focus on evaluating bills after they are paid and then recouping funds ("pay and chase"), instead of reviewing bills before making payments.
- Lack of internal controls to accurately determine eligibility for programs before benefits are transmitted.
- Not educating and communicating with providers regarding State policies and State and federal laws.
- Outdated policies and rules that allow expenditures beyond what is medically necessary under current standards.
- Ordering medication, testing, and procedures for patients when sound medical practices would direct that these services are not medically necessary.
- Agency procedures that require complex processes that are not efficient.

E. Survey of Task Force Members

Shortly after the Task Force was created, it engaged its members in a written survey about, among other things, agency health care programs, current fraud, waste, and abuse efforts, and ideas on focus areas for the Task Force. The Task Force then held an initial meeting to discuss its goals and the survey results. The survey revealed that agencies were already engaging in activities regarding fraud, waste, and abuse prevention efforts. However, the survey also revealed that the Task Force members' agencies were somewhat segregated in their functions and there was an opportunity for greater interagency cooperation. The survey reflected that members believed that there was great opportunity in data sharing and data analytics to address health care fraud, waste, and abuse.

F. Formation of Working Groups



To fully explore the issues in State-administered health care programs, the Task Force formed three working groups, focused on the three health care program areas within State government: (1) Medicaid Programs, (2) the State Employee Group Insurance Program, and (3) the Workers' Compensation Program for State agencies. These working groups allow the Task Force to efficiently manage its broad mandate. The focus of each working group has been to engage in a thoughtful analysis of the current status of its program and to compare Illinois' system with the best practices in other states, the private sector, and the federal government. Each working group has reviewed documentation related to its focus, held multiple meetings, and engaged third parties to obtain recommendations. This section contains a summary of the initial focus areas identified by each working group.

1. Medicaid Working Group

The Medicaid Working Group was formed to focus on identifying and addressing areas of fraud, waste, and abuse that may exist within the Illinois

Medicaid system. The working group has focused its efforts on engaging members in discussions regarding areas within Illinois' Medicaid programs that should be studied by the Task Force. The working group also has engaged MCOs to learn about MCO processes for investigating fraud, waste, and abuse in Medicaid. As a result of these initial meetings, the Medicaid Working Group is focusing its efforts on reviewing the following areas:

- Medicaid managed care, including exploring opportunities to share data with Medicaid MCOs, thereby developing the maximum collaboration and coordination of resources.
- In-home care programs, including efforts to increase the dialogue among agencies that administer in-home programs, share agency data, and educate home health providers.
- Greater use of data analytics to prevent and address Medicaid fraud, waste, and abuse, including efforts to increase the focus on prevention and to utilize third-party data sources.

2. State Employee Group Insurance Working Group

The State Employee Group Insurance Working Group was formed to focus on identifying areas of potential fraud, waste, and abuse that may exist within the State Employee Group Insurance Program. The working group has focused on learning about the structure of the State Employee Group Insurance Program from the Illinois CMS Bureau of Benefits, as well as obtaining DoI's insight into best practices from private sector insurance companies. As a result of this research, the State Employee Group Insurance Working Group is focusing its efforts on reviewing the following areas:

- Program analysis and evaluation, including how data reviews can be used to analyze State spending, and detect fraud, waste, and abuse in the Employee Group Insurance Program.
- MCOs, including how these entities monitor and report fraud, waste, and abuse, and how the State interacts with MCOs to develop its own internal controls and procedures.
- Use of auditing and internal controls, including exploring what auditing tools Illinois CMS can use to ensure that only qualified State employees, retirees, and dependents receive taxpayer-funded insurance.

- State-wide best practices for safety, fraud education, investigations, documenting workers' compensation claims, and return-to-work programs.
- Collaborating and coordinating with the Workers' Compensation Program claims manager to efficiently utilize State resources in investigating and reporting fraud, waste, and abuse in the Illinois Workers' Compensation Program.
- Reviewing Illinois' vendor contract to ensure appropriate standards regarding investigation and reporting of workers' compensation fraud claims.



3. Workers' Compensation Working Group

The Workers' Compensation Working Group was formed to identify areas of potential fraud, waste, and abuse that may exist within the Illinois Workers' Compensation Program. The working group has concentrated its efforts on engaging members in discussions regarding areas within Illinois' Workers' Compensation Program for State agencies that should be studied by the Task Force. The working group also engaged Tristar Risk Management, Illinois' claims manager, to learn about its process for investigating fraud, waste, and abuse in workers' compensation. As a result of these meetings, the working group is focusing its efforts on reviewing the following areas:

IV. Addressing Fraud, Waste, and Abuse: Where We Started, Where We Are, and Where We Need To Go

The Task Force's study of state best practices, Illinois' current practices, and federal and private sector best practices has led it to develop four areas of focus. The Task Force believes that issues with fraud, waste, and abuse in State-administered programs can be addressed and alleviated by the State and its agencies devoting greater attention to the following areas: (1) collaboration and coordination; (2) data analytics and metrics; (3) accountability and efficiency; and (4) safety and wellness. These areas have been used by the Task Force to focus its resources and working groups. Going forward, the Task Force's work, planning, and recommendations to State agencies will focus on improvement of the State's fraud, waste, and abuse elimination efforts in these four areas.

A. Collaboration and Coordination

Increased collaboration and coordination among State agencies, and between State agencies and private sector partners, is necessary to strengthen the State's efforts to address fraud, waste, and abuse in State-administered health care programs. During the Task Force's initial meetings and survey efforts, it became evident that information, resources, and efforts to address fraud, waste, and abuse in State-administered programs were, for the most part, isolated within individual agencies. Moreover, State agencies did not have clear practices or procedures for regular communication about health care fraud, waste, and abuse elimination efforts.

The Task Force has organized leaders from numerous State agencies, and has begun an important interagency dialogue on tackling fraud, waste, and abuse. The Task Force has brought together agency staff administering health care programs, agency

leadership working to ensure that services are delivered in a manner that drives value both for the recipients of those services and the taxpayers, and inspectors general focused on oversight and program integrity. Though each of these groups plays different day-to-day roles in the administration of State health care programs, all have the responsibility to ensure that taxpayer resources are not wasted, abused, or used in a fraudulent manner. Task Force members and their respective staffs are now regularly discussing fraud, waste, and abuse efforts, and how coordinating efforts, including programmatic coordination, will help improve their respective agencies' delivery of health care services.

The Task Force will continue to facilitate collaboration and coordination between State agencies. In addition, the Task Force aims to increase collaboration and coordination with private sector partners and stakeholders. This will ensure that the State is learning and taking advantage of private sector best practices, as well as holding its private sector partners accountable to provide the best quality services at the best value to the taxpayers.

One area where increased collaboration and coordination could yield increased savings for the State's taxpayers is through better monitoring and engaging of the MCOs that provide services to beneficiaries in the Medicaid program and the State Employee Group Insurance Program. As part of the Task Force's focus on managed care, it launched a MCO Initiative. Below, the Task Force has laid out the work that its members and participating State agencies are currently undertaking to improve collaboration and coordination with MCOs, and the next steps identified as part of the MCO Initiative.

1. Review of Current Practices in Monitoring and Engaging MCOs

Today, approximately two-thirds of Illinois Medicaid beneficiaries are in risk-based managed care

plans. The Task Force has worked closely with HFS and HFS-OIG to study HFS's processes for engaging and monitoring Medicaid MCOs. To accommodate the State's rapid change from a fee-for-service-based care system to a managed care-based system, both HFS and HFS-OIG have developed practices and procedures to engage and monitor the thirteen Medicaid MCOs operating in Illinois. These practices were developed by researching state best practices, working with state and federal partners at the Medicaid Integrity Institute, and reviewing the program integrity activities within Medicaid MCOs to obtain an understanding of the structure, staffing, and program integrity capabilities of the MCOs. As a result of those efforts, HFS and HFS-OIG have adopted the following practices:

- Increased Communication with MCOs. Previously, HFS and HFS-OIG conducted one-on-one meetings with Medicaid MCOs to share emerging areas of fraud, waste, and abuse and to discuss investigations, audits, and referrals. After studying best practices from other states, it became clear that more frequent, larger group meetings would facilitate better information sharing and the adoption of more consistent practices between the State and Medicaid MCOs, and between the Medicaid MCOs themselves.

In September 2016, HFS-OIG began conducting more frequent "task force" meetings with all Medicaid MCOs. ISP-MFCU also participates in these meetings. This increased collaboration will provide all investigative personnel across the network of Medicaid MCOs the opportunity to learn best practices, enhanced investigative techniques, and cutting-edge algorithmic development from the experienced Special Investigations Units (SIUs) located in the MCOs, as well as from HFS-OIG. At the same time, these meetings allow Medicaid MCOs to hold open discussions on emerging areas of fraud, waste, and abuse, ensuring that those who wish to perpetrate fraud against any MCO (and ultimately against the taxpayers who fund the programs administered by the MCOs) cannot jump from MCO to MCO without being caught by the MCOs' own investigators and/or the State's investigatory personnel. In addition, the State will increase its own knowledge and oversight of each Medicaid MCO program integrity unit and develop stronger relationships between private and

public entities to enhance the quality of Illinois' investigations and internal controls.

- Standardized Reporting Tool for Medicaid MCOs. In order to ensure that the State is collecting relevant data on fraud, waste, and abuse from all MCOs providing services in the Medicaid program, the State currently requires each MCO to complete a monthly report and submit it to HFS-OIG. The State has moved to a standardized reporting tool that includes several data categories, allowing HFS-OIG to identify fraud trends and high-risk providers.
- Online Tracking of Medicaid MCO fraud referrals. HFS-OIG has a dedicated web portal for Medicaid MCOs to allow for efficient reporting and effective tracking of all fraud referrals.

HFS, as part of the capitation reimbursement system to Medicaid MCOs, also engages in the following practices to ensure safeguards by contractually requiring:

- Pay-for-performance measures to incentivize spending on care that produces healthy quality-of-life outcomes.
- Payment withholding when the MCOs do not spend their capitation payments on care that produces quality outcomes.
- A medical loss ratio (MLR) of 85 to 88 percent, meaning that 85 to 88 percent of the revenue from the contract must be spent on health care services for enrollees.

2. MCO Initiative:
*Next Steps in Pursuing Better
Collaboration Between State Agencies
and MCOs in Addressing Fraud,
Waste, and Abuse*

The Task Force recognizes that managed care is a rapidly developing area in the landscape of Illinois' State-administered health care programs. The shift toward

managed care presents the State with an opportunity to collaborate and coordinate efforts among groups with a shared stake in preventing and addressing health care fraud, waste, and abuse. Through stronger collaboration and coordination, the State can effectively maximize the resources of the MCOs and its own agencies involved in administering and monitoring State-funded programs to address fraud, waste, and abuse in those programs.

As part of the MCO Initiative, the Task Force and the agencies involved in the administration of Medicaid programs will collaborate with MCOs to:

- Share best practices. The Task Force will continue to meet with MCOs and hold discussions with other states regarding best practices for operating a managed care system.
- Share data analytics and metrics to improve program integrity. The Task Force will explore opportunities to increase data sharing between the State and MCOs and to utilize third-party expertise to ensure that the State is following the most up-to-date best practices in the areas of metrics and data analytics.
- Review provider screening and alerts efforts. The Task Force will study how MCOs screen and educate providers. Based on our meetings and discussions with MCOs and other private sector experts, the Task Force believes that there are opportunities for MCOs to collaborate and coordinate efforts to identify high-risk providers.
- Review standardized Medicaid MCO reporting tools. As stated above, HFS-OIG uses a standard reporting tool to collect relevant data from Medicaid MCOs to assist the State and MCOs in addressing fraud, waste, and abuse. The Task Force intends to review reporting tools that other states require Medicaid MCOs to complete, in order to ensure that Illinois' reporting tools and procedures are collecting the most relevant information in a format that most easily allows the State and its MCO partners to identify and prevent fraud, waste, and abuse.

B. Data Analytics and Metrics



Data analytics and the use of consistent and data-based metrics are critical to ensuring that an organization is properly monitoring spending in its health care programs and preventing and addressing fraud, waste, and abuse. Effectively using data and metrics is a key component of any successful program integrity system. When benchmarked against other states and the private sector, improving our use of data analytics and metrics is an area where Illinois has room for improvement, and such improvement could yield monetary savings to the State.

As noted above, one of the Task Force's first actions was to conduct a survey of its members. When members were asked their opinion regarding the biggest issue the Task Force should address, the majority of responses focused on better data sharing and the increased use of cross-agency analytics.

WHAT IS DATA ANALYTICS?

Data analytics involves the examination of data for the purpose of drawing conclusions by identifying patterns and/or correlations. Examples of data analytics include:

- Predictive analytics: the comparison of data to known patterns of data to identify fraud and errors before payments are made.
- Holistic views: using data to provide a holistic view of an individual, family, and/or household to review eligibility for programs.

- Data mining or data matching: cross-referencing data sets to identify improper payments. For example, matching benefits data with state, county, and municipal incarceration data to ensure the State does not provide benefits to incarcerated individuals.

The Task Force’s study of Illinois data sharing and data analytics systems reflects that several agencies are using data analytics and data sharing as part of efforts to combat fraud, waste, and abuse in State-administered health care programs. However, there is room for improvement. It is important that all relevant agencies not only share data, but use data analysis tools and personnel to gain a broad, cross-agency view of pertinent information. Success in this area would confirm that fraud, waste, and abuse identified and cut off in one agency are also being identified and addressed by other agencies.

WHAT ARE METRICS?

*Standards of measurement by which efficiency, performance, progress, or quality of plan, process, or product can be assessed.*⁵⁵

1. The First Step: Data Sharing

In May 2016, thirteen State agencies signed an Enterprise Memorandum of Understanding (eMOU), which provided for interagency data sharing. The agencies signing the agreement include almost all of the agencies involved in the Task Force, as well as several additional agencies. Those agencies are: DoA, the Department of Children and Family Services, the Department of Commerce and Economic Opportunity (“DCEO”), the Department of Corrections, the Department of Employment Security, HFS, DHS, DoIT, the Department of Juvenile Justice, the Department of Public Health, the State Board of Education, the Department of Veterans’ Affairs, and Illinois CMS.

The push for the eMOU was led by Hardik Bhatt, State Chief Information Officer and Acting Secretary of DoIT. DoIT and the agencies involved in the eMOU studied data-sharing best practices from a number of other states, including Indiana. The eMOU is an important tool both for agency operations and for the State’s efforts to fight fraud, waste, and abuse.

Operationally, the eMOU will: enable greater customer-centric service delivery, providing information tailored to a citizen’s needs; assist in effective strategic policymaking, offering executives trustworthy data to make informed decisions; and encourage efficient program management, leading to increased productivity of State employees. This is a vast improvement over the old system, which wasted both taxpayer time and money because it required recipients of State services to fill out time-consuming and confusing paperwork at multiple agencies, often asking for the same information, in order to receive State services.

In addition to the eMOU, DoIT formed the Statewide Data Practice (SDP), which is in the process of developing an enterprise-wide capability to perform analytics. As part of the SDP, DoIT is building a Secure Harmonized Data Pool with data from Illinois’ health and human services agencies, such as DHS, DoA, and HFS, as well as data from other government entities and open data. The Secure Harmonized Data Pool will provide for a “360-degree view” of each person and/or family who receives government services. The State intends to use this system to, among other things, perform analytics for early intervention and prevention, and reduce fraud, waste, and abuse.

DoIT’s recent data-sharing efforts will allow the State to use its data analytics system to review data involving State health care programs across the board versus viewing them in the silos of individual programs or agencies.

2. Analytics in Action—How the State Is Using Analytics to Combat Fraud, Waste, and Abuse

The State currently uses one data analytics system—the Dynamic Network Analysis (DNA) System—to analyze, detect, and prevent fraud, waste, and abuse by providers and recipients in the Medicaid programs. The analytics work is performed by the HFS-OIG staff, which includes four employees with coding and data-mining capabilities.⁵⁶ The DNA System pulls data from HFS, as well as third-party data sources, to obtain information regarding long-term care, Medicare funding, and drivers’ and business services, as well as death and incarceration records. The DNA System, put

into production in September 2011, is a Centers for Medicare and Medicaid Services (“Federal CMS”) “best practice.”⁵⁷

WHAT IS FEDERAL CMS?

*Federal CMS, part of HHS, is the federal agency that administers Medicare, and works with states to run Medicaid, Children’s Health Insurance Programs, and the federally facilitated marketplace. Federal CMS also gathers data, conducts research, and issues regulations and guidance regarding federal and state health care programs. Federal CMS also reviews state program integrity efforts to assess whether these efforts comply with laws and regulations and whether they are effective.*⁵⁸

The DNA System was funded by a Federal CMS Medicaid Transformation Grant offered to build a predictive analytics system. In order to continue to develop and maintain the DNA System, the State has formed a collaborative relationship with Northern Illinois University (“NIU”) to ensure that the State stays on the cutting edge of academic research and advancements in the area of data analytics. Through an ongoing Intergovernmental Agreement, NIU works with HFS-OIG to continually upgrade, program, and maintain the DNA System. Five research associates in NIU’s Division of Outreach, Engagement, and Regional Development, Center for Governmental Studies work full time on DNA System development. This collaborative effort has generated new graphical user interfaces, algorithmic development, and cutting-edge industry standard tools to assist the State in fighting fraud, waste, and abuse within the Medicaid system.

The State currently is using the DNA System to research, develop, and implement selection criteria to identify: providers with potentially fraudulent behavior; program integrity solutions; pre-payment claims processing edits; policy innovations; operational innovations; fraud referrals; and desk, field, and self-audit reviews. The DNA System also assists the State in the following functions:

- Providing early warning and monitoring by analyzing service and payment trends.
- Identifying exception processing through outlier analysis.⁵⁹
- Incorporating Surveillance and Utilization

Review System (SURS) functions.⁶⁰

- Creating provider and recipient profile reports.⁶¹
- Compiling Statewide trends to help support administrative decision-making.
- Summarizing all State Medicaid, transportation, and post-mortem payments.⁶²
- Compiling data on sanctioned, disciplined, or terminated providers from HHS and the Illinois Department of Financial and Professional Regulation.

3. Moving from 1980s Technology to 21st-Century Technology

While the DNA system is constantly being updated and improved through the State’s work with NIU, other State systems are out of date and require a shift to a new system. HFS’s current Medicaid Management Information System (“MMIS”) supports management of client eligibility, provider enrollment, and medical claim processing. The existing MMIS was fully implemented in 1982 and was primarily built to support a fee-for-service Medicaid program. Even though many enhancements have been made to the current MMIS, it is a legacy system that is becoming increasingly more challenging for the State to maintain. With the transition of the Medicaid program to managed care, and additional federal requirements, a new system was critical to support the demands of the Medicaid program. Through an intergovernmental agreement with the Michigan Department of Health and Human Services, HFS has implemented a new provider enrollment system and continues to work with Michigan on the next phase of the core MMIS.

The project has been named the Illinois Michigan Program Alliance for Core Technology (“IMPACT”). The IMPACT system works to facilitate collaboration with the State of Michigan as well as with agencies in Illinois that provide programs supported by Medicaid funds. In addition to HFS and HFS-OIG, other agencies serving Medicaid clients, such as DoA, DHS, the Illinois Department of Children and Family Services, and the University of Illinois at Chicago Department of Specialized Care for Children, will be working with IMPACT.

In addition to incorporating 21st-century (as opposed to 1980s) technology and functionality, a key feature of the IMPACT system is its capacity to assist in fraud investigations. For example, the IMPACT system utilizes the LexisNexis electronic verification process to perform background screenings. The use of the LexisNexis verification process will have a significant impact on fraud reduction because it allows the State to conduct detailed, thorough background checks through one quick and easy-to-use program. Additionally, using the IMPACT system, the State will also be able to investigate any provider or individual who is flagged during the enrollment and re-validation process. If an individual or provider is flagged, the approval of HFS-OIG is required in order for that individual or provider to complete enrollment.

The IMPACT implementation project is a three-phase initiative that delivers: (1) a system to support the Electronic Health Record/Provider Incentive Payment program, (2) a system to support provider enrollment, and (3) the eventual full implementation of a cloud-enabled MMIS. The Task Force is pleased to report that the first two phases of the IMPACT project have been successfully implemented. The full implementation of the cloud-enabled MMIS is expected to occur by the end of 2018.

4. Expanding Our Knowledge—Looking to Third Parties for Information

In order to gain information to determine if current State technology, software, and hardware programs may be improved in order to further reduce costs and efficiently address fraud, waste, and abuse, DoIT issued a request for information. The request for information seeks “responses from providers in designing, implementing, and supporting the detection, correction, and prevention of Health Care fraud to present information about both their own products and services, and also about industry standards, best practices, and trends (both current and those under development), that would assist the State in better understanding this topic.” The Task Force will be reviewing the request for information responses as part of its effort to ensure the State is utilizing the most effective technology and data analytics systems and processes.

5. Audits—the Unsung Hero of Fraud, Waste, and Abuse Elimination

The Task Force’s review of agency practices in addressing fraud, waste, and abuse in health care programs has revealed that audits are integral to providing organizations with material data on their health care programs and tracking whether an organization is meeting certain performance metrics and goals. Below, the Task Force highlights two successful audit initiatives from Illinois State agencies that directly resulted in high-value savings to the State. The Task Force is working with State agencies to determine if agencies should undertake similar audit initiatives to address other potential instances of waste in State health care programs.

a) HFS-OIG Global Billing Audits

In April 2016, HFS-OIG started a global billing audit initiative. This initiative involves allowing hospitals to self-audit potential overpayments identified by HFS-OIG and correct any billing errors. Specifically, HFS-OIG asks hospitals to verify potential improper billing for lab and x-ray services, whereby the hospitals received the global rate (technical and professional component) while the non-salaried pathologist and/or non-salaried radiologist also billed separately for the professional component of the rate for the same patients on the same day as the patient who was receiving services in an outpatient setting.

As a result of this initiative, the hospital provider reviews all instances of global billing overpayments identified by HFS-OIG and submits repayments for all services determined to be inaccurately billed. The pilot phase of this initiative resulted in a 100% recoupment of all accurately identified overpayments. This initiative is now being expanded to all 272 hospitals identified by the State as potentially having global billing issues. In FY 2017 HFS-OIG anticipates recovering approximately \$4.5 million as a result of the global initiative. From April 2016 through October 2016, HFS-OIG has collected about \$893,000 as a result of the Initiative.

b) Illinois CMS Audit of Dependents

In 2015, Illinois CMS took a simple but impactful step to root out fraud, waste, and abuse in the State Employee Group Insurance Program. Illinois CMS conducted an audit of dependents, requiring all employees and retirees in the health plans it administers to provide documentation confirming that the individuals listed as dependents for that covered person actually met the criteria to qualify as dependents under their respective health care plans. In addition to reviewing dependents for State employees, the audit also covered local government employees, State university employees, individuals enrolled in the College Insurance Program, and Teachers' Retirement Insurance Program members.

The audit identified 6,454 individuals who were receiving benefits from the State but did not actually qualify as dependents under the terms of the various benefits plans listed above. Those 6,454 individuals were terminated from their respective benefit programs, saving approximately \$22.6 million in FY 2016 and an estimated \$32.4 million in FY 2017.

Illinois CMS's Bureau of Benefits has also implemented a new internal control based on the findings from this audit. Beginning in the second half of 2016, the Bureau of Benefits is now requiring State employees in the Group Insurance Program, as well as individuals in the other programs listed above, to certify their marriages every three years. This certification process will occur on a rolling basis. By instituting this new verification requirement, Illinois CMS has strengthened its internal controls and made it less likely that the State will expend money on dependents who are ineligible for coverage.

C. Accountability and Efficiency

The State of Illinois is accountable to its taxpayers, and must use their money in an efficient and proper manner. The State is also accountable to those to whom it provides health care services, and must provide quality care in a manner that complies with both State and federal law. The Task Force understands that accountability and efficiency are important principles

for all State-administered programs. However, these values are particularly relevant when reviewing the State's health care programs and their potential areas of fraud, waste, and abuse, because State taxpayers and recipients of services expect the State to provide such services in the most effective and efficient way possible.

During the Task Force's review of State-administered health care programs, one type of program in particular—the State's in-home care programs—stood out to the Task Force members as an area where increased accountability and efficiency could not only deliver better results for recipients of State services, but could also provide value for taxpayers through instituting better internal controls to address fraud, waste, and abuse. Thus, the Task Force launched an In-Home Care Initiative to focus specifically on in-home care programs in Illinois. As part of this Initiative, the Task Force studied current internal controls in two in-home care programs and identified areas for potential fraud, waste, and abuse, and potential solutions to prevent fraud, waste, and abuse. The work of the In-Home Care Initiative is outlined in this section.

1. In-Home Care Programs—Background

DHS and DoA each administer in-home care programs. The DHS Home Services Program (the "HSP") is a home- and community-based Medicaid waiver program designed to prevent the unnecessary institutionalization of individuals who may instead be satisfactorily maintained at home at a lesser cost to the taxpayers. Through the HSP, services are provided to individuals with disabilities so they can remain in their homes and live as independently as possible. Services provided to customers include individual providers, homemaker services, home health services, electronic home response services, home-delivered meals, adult day care, assistive equipment, environmental modifications, and respite services. In the HSP, the customer and DHS are considered "co-employers," whereby the customers select, hire, and manage their own provider and DHS pays the providers. There are approximately 28,590 open cases within the HSP, with approximately 41,700 individual providers paid to provide services to HSP customers. The HSP has a budget of approximately \$500 million, and is funded by the State's General Revenue Fund and by federal funds for customers who qualify for Medicaid.

The DoA Community Care Program (the “CCP”) is a Medicaid waiver program that assists adults who are 60 years old and older, who might otherwise need nursing facility care, to remain in their own homes, by providing in-home and community-based services. Through the CCP, seniors may receive adult day care, emergency home response, and in-home services to allow them to maintain independence within their home. Unlike in DHS’s HSP, DoA contracts with the CCP providers who hire and monitor in-home care workers. There are approximately 179 CCP providers that oversee the workers that provide direct in-home services to the CCP customers. In FY 2016, approximately 80,000 senior citizens received services through the CCP. In FY 2015, the CCP had a budget of approximately \$844 million. The CCP is funded through General Revenue Funds, and also by federal funds for customers who qualify for Medicaid.

2. Task Force’s Review of Current Practices to Address Fraud, Waste, and Abuse in DHS’s HSP and DoA’s CCP

There are two types of fraud that commonly occur in the in-home care programs—provider fraud and customer fraud. Provider fraud may involve billing for services not provided, agreeing to “split” checks with the customer, providing services when the customer is not in the home, or forgery. Customer fraud may consist of approving hours not worked by the provider, forgery of signature(s), and “splitting” checks with the provider.

The Task Force’s review reflects that HFS-OIG, OEIG, DHS, and DoA each have certain practices in place to address fraud, waste, and abuse in in-home care programs.

a) HFS-OIG’s Investigations of In-Home Care Programs

In FY 2015, HFS-OIG’s evaluation process included review of 573 cases involving suspected fraud and abuse of in-home care programs at DHS. As a result of these evaluations, over 39 cases of potential fraud were referred to ISP-MFCU. In addition to criminal referrals, HFS-OIG also takes administrative actions against in-home care providers, which results

in recoupment and sanctions, including termination. HFS-OIG also works closely with DHS to screen new providers and review current providers.

b) OEIG’s Investigations of In-Home Care Programs

The OEIG investigates fraud, waste, abuse, mismanagement, misconduct, nonfeasance, misfeasance, malfeasance, and violations of the State Officials and Employees Ethics Act. As such, the OEIG has investigated matters related to in-home care programs, including allegations of conflicts of interest between an in-home care worker and customer, fraudulently reporting hours worked, and State employees improperly approving individuals for in-home services benefits. When the OEIG completes an investigation where the allegations are founded, it issues a report with recommendations. These recommendations address improper conduct, and may also include recommendations for systematic changes to prevent similar fraud, waste, or abuse in the future. If the OEIG identifies criminal conduct it may make a referral to the appropriate law enforcement authority.

c) DHS’s HSP Fraud, Waste, and Abuse Prevention Efforts

DHS has created an HSP Fraud Unit that conducts investigations related to allegations of fraud within the HSP. Investigations focus on issues with customer and individual provider eligibility, benefits, and services rendered. Once an investigation has been completed and the alleged fraud is substantiated, the case is either forwarded for prosecution or returned to the HSP for the establishment of an overpayment claim. The customer and/or individual provider are then notified an overpayment has been identified and that misspent funds will be recovered. Overpayment claims are forwarded to the DHS Bureau of Collections, which has the authority to establish repayment agreements and enforce collection activity. In FY 2015, there were 231 claims worth \$369,376 established for the HSP and forwarded to the DHS Bureau of Collections. The Fraud Unit staff coordinates investigations with collaborative partners such as DHS field offices, and local, state and federal law enforcement agencies, if applicable.

d) DoA's CCP Fraud, Waste, and Abuse Prevention Efforts

DoA has recently implemented several procedures to address fraud, waste, and abuse in the CCP. For example, the DoA uses an electronic billing system that checks billings against the clients' personal identifiers like social security numbers, and compares clients to death records. DoA also has a program that allows participants and the public to report fraud, abuse, or other issues related to the CCP. DoA staff follows up on each report of fraud, waste, or abuse.

e) Electronic Visit Verification System

In January 2014, the State established an Electronic Visit Verification (EVV) system that DHS utilizes for its HSP. In July 2015, the EVV system was fully integrated. EVV is a timekeeping system that requires the provider to use the customer's telephone to "call in" and record the time that he or she starts and stops working for the customer. The EVV system is designed to prevent payment to unauthorized individual providers, individual providers with overlapping visits, and individual providers who claim to work for active cases that are actually non-active cases. Illinois law requires anyone providing in-home services to customers in the HSP to use the EVV system. The system processes approximately 600,000 individual provider visits for the HSP each month for provider payment. The DHS HSP EVV data contributed to the recovery of 1,428 hours of individual providers' overpayments, and serves as the data source for identifying other potential fraudulent activities to be investigated by the HSP's Fraud Unit.

DoA's CCP also utilizes EVV programs to verify the hours worked by in-home care workers. All CCP providers are required to use a type of EVV system, and as part of DoA's fraud prevention, its staff conduct audits of the EVV data collected by the CCP providers.

**3. In-Home Care Initiative:
Next Steps for Implementing Stronger
Accountability and Efficiency
Measures in the In-Home Care
Programs**

Despite the agency efforts described above, fraud, waste, and abuse remain prevalent in Illinois' in-home care programs. The data from State agencies confirm in-home care programs continue to be an area of vulnerability for the State of Illinois. DHS data reflect that, from January 2015 through August 2016, at least \$600,000 in overpayments were made in its HSP.⁶³ As a result of DHS's review of overpayments and fraud, waste, and abuse, 469 individual providers were terminated from the HSP.

The Task Force will continue to explore and make recommendations on ways that the State can identify and stop fraud, waste, and abuse in its in-home services programs. The first step in this process is continuing to increase the dialogue among the agencies that administer in-home care programs, and between those agencies and the agencies that investigate and prosecute fraud, waste, and abuse in these programs. Best practices must not be siloed within one agency or program. The Task Force has been working with DoA, DHS, HFS-OIG, HFS, and OEIG to, among other things, increase data sharing, coordinate provider oversight and education efforts, and review billing practices.



D. Safety and Wellness

Workplace fatalities, injuries, and illnesses cost employees and employers across the country billions of dollars every year. Employers that promote workplace safety and health initiatives see significant reductions in overall numbers of injuries and illnesses, as well as reductions in the costs associated with these injuries and illnesses, including workers' compensation payments, medical expenses, and lost productivity. Liberty Mutual Insurance Company conducted a survey of 200 executives responsible for workers' compensation and other commercial insurances that found over 60 percent of those executives believed their companies received a return on investment of \$3 or more for each \$1 invested in safety.⁶⁴ Moreover, employers often find that process changes made to improve workplace safety and health may result in significant improvements to their organization's productivity and profitability, as well as to employee satisfaction.

In Illinois, workplace safety plays an important role in ensuring the well-being of State employees and providing an optimal environment for State employees to provide the best customer services to the citizens and taxpayers of our State. In addition, workplace safety and wellness also result in lower costs and less waste in the Employee Group Insurance Program.

In addition, employee wellness and the safety of those receiving Medicaid services is crucial. As part of the safety and wellness focus, the Task Force intends to examine preventative measures to further ensure the safety and wellness of Medicaid beneficiaries and State employees.

With respect to the Workers' Compensation Program for State agencies, the Task Force launched a Workers' Compensation Program Safety Initiative to explore whether targeted uniform workplace safety efforts can be used to drive down the amount of waste in the Workers' Compensation Program for State agencies. This Section outlines the work of that Initiative to study Illinois' current safety programs and its next steps in using safety to address waste.

1. Current Illinois Safety Programs

The Task Force's study of workers' compensation safety programs in State agencies reflects that Illinois lacks a Statewide workers' compensation safety program that operates above the minimum standards set by the federal Occupational Safety and Health Administration ("OSHA"). While Illinois has Statewide safety standards, including a safety program approved by, and in accordance with OSHA standards, it lacks a Statewide safety program that operates above the minimum requirements OSHA has established, and it may not be in accordance with industry standards best practices.

One safety program the Task Force is studying is the program at IDOT. The Task Force identified IDOT as an agency that has implemented a quality safety program. As part of this program, IDOT issued an order providing guidelines to help its employees prevent personal injuries or property damage. The order directed supervisory personnel to: (1) provide necessary training to employees; (2) require all employees to obey Department safety policies and procedures and comply with its internal Employee Safety Code; (3) monitor work activities and equipment to identify and reduce hazards; and (4) take prompt action in accident situations. IDOT also offers over 30 health and safety courses for employees that cover topics such as job safety analysis, ergonomics, equipment and tool safety, worksite safety, hazardous communication, and material handling. IDOT actively tracks the employees who complete these courses. IDOT's employee safety program goes beyond the minimum standards of OSHA, but does not cover the employees of other agencies and lacks any central authority or accountability. A Statewide workplace safety initiative would fill in these gaps and lead to fewer workers' compensation claims.

2. *Workers' Compensation Safety Initiative:*

Next Steps for Using Safety Initiatives to Address Waste in the Workers' Compensation Program

By placing a greater emphasis on safety, training, and prevention, the State can address waste in the workers' compensation system as it lowers the number of overall claims and claims that resulted from a lack of education, or unclear policies and procedures. The Task Force will work with State agency stakeholders to evaluate existing safety and health programs of particular agencies in order to identify effective and practical strategies that it can incorporate into a Statewide initiative for reducing injuries and illness among Illinois State employees. The development of best practices will require management and employee engagement and accountability, a framework of processes and procedures to achieve safety and health objectives, proactive efforts to reduce risk, and measurable goals to track performance. Any efforts to reduce workplace injuries and illness will require better recordkeeping to assess the progress toward these stated goals.

As a next step in developing workplace safety and wellness measures, the Task Force will focus on developing cross-agency best practices in the following areas:

- Injury Prevention and Training. This includes State agency education programs and safety rules, such as rules prescribing proper techniques for performing job tasks.
- Accident Report. This includes identifying agency procedures for completing accident reports to determine what training individuals receive with respect to completing accident reports. Examples of training elements include whether appropriate questions are asked for each incident, whether there is a follow-up regarding statements, and what standards are used to determine if the accident report is fully completed. Among other things, properly reporting accidents can assist agencies in understanding safety risks and allow agencies to continue to review and update safety programs.



V. Conclusion

The Task Force is proud of the work it accomplished in its initial six months, but recognizes that there is a lot more work to be done. In the next several months the Task Force will continue to meet collectively and within its working groups to develop the focus areas and initiatives outlined above. Our efforts will include continuing to involve, among others, industry experts, Illinois' vendors, federal entities, and other State experts to utilize best practices and the latest technology to provide the best services in the most cost-effective manner. In addition, the Task Force will continue to meet publicly at least quarterly, and will submit periodic reports to the Governor and the public outlining its progress in preventing and eliminating health care fraud, waste, and abuse.

A. Executive Order 5 (2016)



EXECUTIVE ORDER

EXECUTIVE ORDER ESTABLISHING THE HEALTH CARE FRAUD ELIMINATION TASK FORCE

WHEREAS, State government-administered health care programs should operate in a transparent and efficient manner with the goal of delivering quality services while providing value to taxpayers; and

WHEREAS, fraud, waste, and abuse in State-administered health care programs increase the State's health care costs, resulting in a bad deal for taxpayers and less resources for critical services; and

WHEREAS, in fiscal year 2015, the State of Illinois spent over \$19 billion on the State Employee Group Insurance Program and the State-administered Medicaid program; and

WHEREAS, the federal Department of Health and Human Services estimates that on a national level, over \$29 billion of taxpayer funds are spent each year on improper Medicaid payments; and

WHEREAS, the private sector, the federal government, and other states across the country are beginning to employ innovative and comprehensive strategies to reduce fraud, waste, and abuse in health care programs; and

WHEREAS, current efforts led by various units across State government have been successful in recouping or avoiding unnecessary spending in certain State agencies and certain State health care programs; and

WHEREAS, notwithstanding these successes, a more comprehensive and cross-disciplinary approach is needed to harness the State's various fraud-prevention resources to further prevent and eliminate fraud, waste, and abuse and ensure that taxpayers are receiving the best return on investment for the State's fraud prevention efforts;

THEREFORE, I, Bruce Rauner, Governor of Illinois, by virtue of the executive authority vested in me by Section 8 of Article V of the Constitution of the State of Illinois, do hereby order as follows:

I. CREATION

There is hereby established the Health Care Fraud Elimination Task Force (the "Task Force").

II. PURPOSE

The purpose of the Task Force is to develop and coordinate a comprehensive effort to prevent and eliminate health care fraud, waste, and abuse in State-administered health care programs using a cross-agency, data-driven approach. Building on anti-fraud work being done across State agencies, the Task Force will develop strategies to ensure that the State has the proper internal controls and analysis and enforcement tools to prevent and eliminate fraud, waste, and abuse in

taxpayer-funded health care programs, including but not limited to the State Employees Group Insurance Program, the Workers' Compensation Program for State of Illinois agencies, boards, commissions, and universities, and the Illinois Medicaid system.

III. DUTIES

The Task Force shall:

1. Identify and catalog the forms of health care fraud existing within State-administered health care programs and identify all Executive Branch agencies and resources currently involved or that should be involved in health care fraud prevention and enforcement.
2. Review best practices being utilized in the private sector, the federal government, and other states to prevent and reduce health care fraud, waste, and abuse and assess how those best practices could be applied to anti-fraud, waste, and abuse efforts in Illinois.
3. Explore the use of data analysis, predictive analytics, trend evaluation, and modeling approaches to better analyze and target oversight of State-administered health care programs.
4. Identify priority prevention and enforcement areas in order to ensure that the State's fraud prevention and enforcement efforts are providing the best return on investment for taxpayers.
5. Collaborate with industry experts to develop a multifaceted strategy to reduce the State's exposure to health care fraud and recover taxpayer funds that have been wrongly paid out as a result of fraud, waste, or abuse.
6. Analyze patterns of system-wide fraud, waste, and abuse in order to make recommendations to State agencies for improved internal controls to prevent future wrongdoing.
7. Work with other State agencies, boards, commissions, and task forces to obtain information and records necessary to carry out its duties.
8. Periodically report to the Governor and the public on the Task Force's fraud, waste, and abuse identification, prevention, and elimination efforts and activities.

IV. COMPOSITION AND FUNCTION

1. The Task Force shall consist of:
 - a. The Executive Inspector General for the Agencies of the Illinois Governor, who will serve as Chairman of the Task Force;
 - b. The Deputy Governor;
 - c. The Chief Compliance Officer;
 - d. The Special Counsel and Policy Advisor to the Governor for Healthcare and Human Services;
 - e. The Inspector General for the Department of Healthcare and Family Services;
 - f. The Director of the State Police Medicaid Fraud Control Unit;
 - g. The Director of the Department on Aging;
 - h. The Director of the Department of Central Management Services;
 - i. The Director of the Department of Healthcare and Family Services;
 - j. The Secretary of the Department of the Human Services;
 - k. The Secretary of the Department of Information Technology; and
 - l. The Director of the Department of Insurance.
2. A majority of the members of the Task Force shall constitute a quorum, and all recommendations of the Task Force shall require approval of a majority of the total members of the Task Force. The Task Force shall conduct at least one public meeting each quarter.

3. The Governor's Office shall provide administrative support to the Task Force as needed, including with respect to compliance with State ethics laws and the Freedom of Information Act.
4. The Task Force shall submit an initial report to the Governor within six months of this Executive Order, outlining its initial fraud, waste, and abuse identification efforts. Thereafter, the Task Force shall submit periodic reports to the Governor and the public outlining its progress in preventing and eliminating health care fraud, waste, and abuse.
5. The Task Force may adopt whatever policies and procedures are necessary to carry out its duties and functions.

V. TRANSPARENCY

In addition to whatever policies or procedures it may adopt, the Task Force shall be subject to the provisions of the Freedom of Information Act (5 ILCS 140). This section shall not be construed as to preclude other statutes from applying to the Task Force and its activities.

VI. SAVINGS CLAUSE

This Executive Order does not contravene, and shall not be construed to contravene, any federal law, State statute, or collective bargaining agreement.

VII. PRIOR EXECUTIVE ORDERS

This Executive Order supersedes any contrary provision of any other prior Executive Order.

VIII. TERM

The Task Force shall be dissolved on June 30, 2019, subject to renewal by a succeeding Executive Order.

IX. SEVERABILITY CLAUSE

If any part of this Executive Order is found invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect. The provisions of this Executive Order are severable.

X. EFFECTIVE DATE

This Executive Order shall take effect immediately upon filing with the Secretary of State.



Bruce Rauner, Governor

Issued by Governor: April 5, 2016
Filed with Secretary of State: April 5, 2016

B. Illinois Health Care Fraud Elimination Task Force Member Biographies

MAGGIE HICKEY, Executive Inspector General, Office of Executive Inspector General for the Agencies of the Illinois Governor

Maggie Hickey is the Executive Inspector General for the Agencies of the Illinois Governor. She was nominated by Governor Rauner in 2015. Before then, she served the U.S. Attorney's Office for the Northern District of Illinois for over 10 years. From 2010 to 2015, she was the Executive Assistant United States Attorney, overseeing a staff of approximately 300 employees. Prior to her supervisory role, Executive Inspector General Hickey served as an Assistant United States Attorney in the Criminal Division, Financial Crimes and Special Prosecution Section where she investigated and prosecuted a wide array of white collar crimes, including health care fraud, mortgage fraud, and bankruptcy fraud. Executive Inspector General Hickey tried multiple cases to verdict and she also briefed and argued many appeals before the U.S. Court of Appeals.

TREY CHILDRESS, Deputy Governor and Chief Operating Officer, Office of the Governor

Trey Childress currently serves as Deputy Governor & Chief Operating Officer (COO) of Illinois under Governor Rauner, and is responsible for executive branch transformation efforts. Prior to his current role, Mr. Childress served as the COO for the State of Georgia under two governors. He was responsible for leadership and supervision of Georgia's 50 state departments, agencies, and boards and commissions while leading government transformation initiatives. Prior to that, he served as the Director of the Governor's Office of Planning & Budget. Mr. Childress previously served as Senior Adviser and Director of Policy for the Office of the Governor with the successful passage of more than 30 signature policy initiatives in education, health care, transportation, taxation, and natural resources. He began his career in public service working with the former Georgia Information Technology Policy Council, the Georgia Technology Authority and the Office of Planning & Budget. Mr. Childress earned a

master's degree in Public Policy and bachelor's degrees in Industrial and Systems Engineering and International Affairs from the Georgia Institute of Technology in Atlanta.

GEORGIA MAN, Chief Compliance Officer and Deputy General Counsel, Office of the Governor

Georgia Man serves as Chief Compliance Officer for the State of Illinois and Deputy General Counsel to Governor Rauner. In this role, she is spearheading the creation and implementation of the State's first comprehensive compliance program, focused on raising ethical standards in Illinois State government and ensuring that State government works more efficiently and effectively for Illinois taxpayers. In addition to oversight of compliance and ethics, Ms. Man also oversees all legal functions of the Governor's Office related to transactional law, administrative law, and government operations. Prior to joining the Rauner administration, Ms. Man was in private practice in the Chicago office of Kirkland & Ellis, LLP. Her practice focused on counseling leveraged buyout and private equity funds and their portfolio companies on structuring and negotiating complex business transactions, including mergers, acquisitions and divestitures of public and private companies, corporate restructurings and recapitalizations, and debt and equity financings. She received her law degree from the University of Virginia and a Bachelor of Arts degree in East Asian History and Political Economy from the University of Tennessee.

GREG BASSI, Policy Advisor for Healthcare and Human Services and Special Counsel, Office of the Governor

Greg Bassi is the Policy Advisor for Healthcare and Human Services and Special Counsel in the Office of Governor Bruce Rauner. Before joining the Governor's Office on July 1, 2016, Mr. Bassi was Chief of Staff for DHS. Mr. Bassi joined DHS in February 2015, and

also served as the Department's General Counsel and Acting Secretary. Previously, Mr. Bassi worked as an attorney in private practice at Barnes & Thornburg, LLP and Winston & Strawn, LLP in Chicago. Mr. Bassi has also served in positions with two separate branches of the federal government, including the United States Court of Appeals for the Tenth Circuit and the Criminal Division of the U.S. Department of Justice. Mr. Bassi earned his law degree from Northwestern University School of Law in Chicago and a Bachelor of Arts Degree in Government from Georgetown University in Washington, D.C.

BRADLEY HART, Inspector General, Office of Inspector General for the Department of Healthcare and Family Services

Bradley Hart was appointed as the Inspector General of HFS-OIG in 2011. Prior to that appointment, Inspector General Hart served as Deputy Bureau Chief for the Illinois Attorney General's Medicaid Fraud Control Bureau, where he prosecuted health care fraud while assigned to ISP-MFCU. While employed by the Illinois Attorney General's Office, Inspector General Hart was cross-designated as a Special Assistant United States Attorney in the Central and Southern Districts of Illinois, where he prosecuted civil and criminal health care fraud-related matters in federal court. Prior to prosecuting health care fraud, Inspector General Hart was in private practice where he worked on family law matters, trusts and estates, municipal representation, civil litigation, criminal defense, and appellate practice.

CAPTAIN BRIAN LEY, Director, Illinois State Police Medicaid Fraud Control Unit

Captain Brian A. Ley was appointed as the Director of ISP-MFCU in July 2015. Prior to that appointment, Captain Ley served as the ISP First Deputy Director where he served as second-in-command of a full-service police department with approximately 2,900 employees engaged in emergency response, patrol, investigations, forensic services, police training, and law enforcement administration. Captain Ley has spent his entire career dedicated to law enforcement, all 26 years with ISP. Captain Ley has enjoyed a professional affiliation with the National Association of Medicaid Fraud Control Units. He has a bachelor's degree in Law Enforcement

Administration from Western Illinois University.

JEAN BOHNHOFF, Acting Director, Department on Aging

Jean Bohnhoff is the Acting Director of the DoA, appointed by Governor Rauner in January 2016. She previously served with Effingham City/County Committee on Aging as the Executive Director, where she oversaw the day-to-day operations of the not-for-profit agency and its five offices that cover nine counties in central Illinois. Previously, she served as an associate manager of sales administration for Yellow Book USA and a dealer services coordinator for Nova Solutions. Ms. Bohnhoff is an active community member, dedicating her free time to many boards, commissions, and clubs including the Effingham County Chamber, the Effingham County Youth Commission, the Effingham County United Way, and the Dieterich Women's Club, as well as twelve years of service to the Dieterich Unit #30 School District. Ms. Bohnhoff received a bachelor's degree in Business Administration from Simon Fraser University.

MICHAEL HOFFMAN, Acting Director, Department of Central Management Services

Michael M. Hoffman was appointed Acting Director of CMS in January 2016. Mr. Hoffman most recently worked as the COO of DCEO, where he ran the day-to-day operations of the Agency and led DCEO's strategic planning effort. Prior to his work for the State of Illinois, Mr. Hoffman worked for RockTenn (now WestRock), a Fortune 500 company that manufactures consumer and corrugated packaging. Mr. Hoffman is a retired Major in the Marine Corps, where he served the U.S. for 15 years. Mr. Hoffman served in a variety of command and operations leadership positions, including serving as the Operations Officer for a 1200-person organization during combat operations in Afghanistan. Mr. Hoffman earned his bachelor's degree from Tulane University and holds a master's degree from the Naval Postgraduate School.

FELICIA NORWOOD, Director, Department of Healthcare and Family Services

In January 2015, Governor Rauner appointed Felicia Norwood to serve as the Director of HFS. Ms. Norwood has more than twenty years of experience in public policy, business operations, and healthcare delivery systems. Before her appointment, Ms. Norwood was a senior executive in the health insurance industry. In the private sector, Ms. Norwood was the President of the Mid-America region for Aetna. Ms. Norwood previously served as a Senior Policy Advisor on Health and Human Services for Governor Jim Edgar, where she led health care reform initiatives and chaired the Human Services Cabinet. She also served as a Policy Adviser on Human Services to Governor Jim Thompson, where she developed and implemented policies regarding children and family services, public aid, and mental health. Ms. Norwood earned her law degree from Yale Law School, a master's degree in Political Science from the University of Wisconsin, and a bachelor's degree in Political Science from Valdosta State University in Georgia.

JAMES DIMAS, Secretary, Department of Human Services

James Dimas was appointed the Secretary of DHS by Governor Rauner. Mr. Dimas is an experienced leader in transforming human services departments at the state and local level, including Illinois. Mr. Dimas has worked in a number of roles at DHS, including the Acting Director of Community Operations. Mr. Dimas began working for the State of Illinois in 1995 on the Governor's Task Force on Human Services Reform under Governor Edgar. He led the development and marketing for the consolidation effort into DHS's current organizational structure. DHS was consolidated into the State's largest agency in 1997 from seven previously separate health and social services agencies. Mr. Dimas is a graduate of Knox College, where he earned a bachelor's degree in Political Science. He holds a master's degree in Public Affairs from the University of Texas. Mr. Dimas also attended Harvard University's Executive Program for Government Performance.

HARDIK BHATT, Acting Secretary, Department of Innovation and Technology and State Chief Information Officer ("CIO")

Hardik Bhatt is the Acting Secretary Designate of DoIT and the State CIO in Governor Rauner's cabinet. Mr. Hardik leads 1,700 IT employees and an over \$1 billion technology budget, for digital transformation of Illinois government. Previously, Mr. Hardik was a Senior Director with Cisco and led the global market development of Internet of Everything for the public sector. He worked with mayors, governors and prime ministers around the globe to extract value by connecting public assets. Prior to that, Mr. Hardik was the CIO for the City of Chicago and Commissioner for the Chicago Department of Innovation and Technology. Mr. Hardik also built and led the Smart Chicago program, which is considered a national model for organizations seeking to improve lives through technology. Before joining the City of Chicago, Mr. Hardik worked with Oracle Corporation in the U.S. and Tata Consultancy Services in India. Mr. Hardik has a Master of Business Administration ("MBA") from Northwestern University's Kellogg Graduate School of Management and earned a bachelor's degree in Engineering (Computer Science) in India.

ANNE MELISSA DOWLING, Acting Director, Department of Insurance

Anne Melissa Dowling, Acting Director of DoI, was appointed by Governor Rauner in May 2015. Prior to this role, she was the former Acting and Deputy Commissioner of the Connecticut Insurance Department, and was responsible for the day-to-day oversight of all divisions, including consumer affairs, market conduct and financial regulation, and served as the representative on Connecticut's Health Insurance Exchange Board. Previously she served as a Senior Vice President at MassMutual. Ms. Dowling is a Chartered Financial Analyst (CFA) with more than 25 years of career experience in financial services. In July 2014, Insurance Business America Magazine named her one of the "50 Elite Women in Insurance," highlighting her commitment to consumer protection and regulatory innovation. She earned a Bachelor of Arts from Amherst College in Fine Arts and French Literature and an MBA from Columbia University with a focus on Finance and Real Estate.

C. Review of Health Care Programs Administered by State Agencies and Resources Agencies Devote to Address Fraud, Waste, and Abuse within Those Programs

The Task Force reviewed State resources involved in addressing health care fraud, waste, and abuse by those agencies that work with programs related to Medicaid, workers' compensation, and/or State Employee Group Insurance, as well as those agencies and entities that investigate and enforce rules and laws that apply to those programs. Below is a non-exhaustive summary of health care programs and fraud, waste, and abuse resources at HFS, HFS-OIG, ISP-MFCU, OEIG, DHS, DoIT, DoA, CMS, DoI, and IDOT.

1. Department of Healthcare and Family Services

a) Overview

As stated above, HFS is responsible for providing health care coverage for adults and children who qualify for Medicaid. The Division of Medical Programs administers and, in conjunction with the federal government, funds medical services provided to about 25 percent of the State's population. Illinois' medical assistance programs, consisting of Medicaid and numerous other medical programs associated with it, provide comprehensive health care coverage to about 3.2 million Illinoisans. The programs cover children, parents or relatives caring for children, pregnant women, veterans, seniors, eligible individuals, persons who are blind, and persons with disabilities.

The medical assistance programs are administered under provisions of the Illinois Public Aid Code, Illinois Children's Health Insurance Program Act, Covering All Kids Health Insurance Act, and Titles XIX and XXI of the federal Social Security Act. HFS's mission is to improve the health status of the individuals enrolled in its programs, while simultaneously containing costs and maintaining program integrity.

HFS-OIG is maintained within HFS, but functions as a separate, independent entity. The Division of Medical Programs routinely coordinates with HFS-OIG for the prevention of health care fraud,

waste, and abuse. In addition, HFS has a Bureau of Long Term Care that devotes resources to ensure the integrity of Medicaid payments made to nursing facilities.

b) Office of Inspector General for HFS

HFS-OIG is devoted to addressing fraud, waste, and abuse in Medicaid-funded programs administered by HFS, DHS, and DoA. Specifically, HFS-OIG is responsible for "prevent[ing], detect[ing], and eliminat[ing] fraud, waste, abuse, mismanagement, and misconduct" by, among other things, carrying out the following program integrity functions:⁶⁵

- Auditing providers to ensure appropriate payments.
- Collecting overpayments.
- Monitoring quality assurance programs.
- Implementing quality control measurements of the CCP and any program administered by HFS.
- Investigating fraud by HFS program participants.
- Representing HFS in administrative actions against medical providers or contractors.
- Serving as the primary liaison with law enforcement.
- Reporting all sanctions taken against vendors, contractors, and medical providers to HFS as well as to any agency responsible for regulating or licensing the sanctioned person or entity.

The professionals that make up HFS-OIG staff include investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers, and information technology specialists. During FY 2015, HFS-OIG had a staff totaling 160 employees. HFS-OIG is divided into several units to

carry out its mission:

- Administrative Support Unit. This Unit is responsible for the Welfare Abuse Recovery Program, which processes fraud and abuse referrals concerning recipients and providers from citizens, local DHS offices, state and federal agencies, and law enforcement entities.
- Fraud and Abuse Executive Unit. This Unit coordinates federal and State law enforcement activities related to the Illinois Medicaid program. For example, this Unit evaluates and transmits criminal referrals to ISP-MFCU.
- Office of Counsel to the Inspector General. This Office provides general legal services to HFS-OIG, rendering advice and opinions on Department programs and operations, and providing all legal support for HFS-OIG's internal operations. For example, this Office is responsible for the enforcement of provider sanctions, and represents HFS-OIG in provider recovery actions; actions seeking the termination, suspension, or denial of a provider's program eligibility; and civil remedies to recover unauthorized use of medical assistance.
- Bureau of Fraud Science and Technology. This Bureau uses sophisticated technology to analyze, detect, and prevent fraud, waste, and abuse by providers and recipients. This Bureau is responsible for maintenance and enhancement of HFS-OIG's data analytics system, and other programs that assess provider risk, analyze billing, and compare third-party data. The Bureau also identifies program integrity solutions, pre-payment claims processing edits, policy innovations, operational innovations, and targets for fraud referrals, desk audits, field audits, and self-audit reviews.
- Bureau of Investigations. This Bureau provides professional investigative services and supports HFS, DoA, and DHS in an effort to prevent, identify, investigate, and eliminate fraud, waste, and abuse by providers and recipients in all programs under HFS-OIG's jurisdiction.
- Bureau of Medicaid Integrity. This Bureau performs compliance audits (desk, field, and self-audits) of providers, quality of care reviews,

Medicaid eligibility quality control reviews, and special project reviews. For example, this Bureau audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, and durable medical equipment suppliers.

- Bureau of Long-Term Care-Asset Discovery Investigations. This Bureau conducts reviews of long-term care applications that meet specified criteria related to the transfer and disclosure of assets on the application for Long-Term Care Medicaid eligibility. These reviews are designed to prevent taxpayer expenditures for individuals that have private funding available for their Medicaid Long-Term Care costs.
- Bureau of Internal Affairs. This Bureau investigates misconduct of State employees and contractors, and engages in efforts to identify fraudulent staff activity and security weaknesses.

As discussed in more detail above, HFS-OIG uses data analytics to focus its resources. HFS-OIG has several fraud detection programs, including the following:

- Home Health and Hospice study and data validation.
- Durable Medical Equipment provider study, data preparation, and validation.
- Post-Mortem study, data preparation, and validation.
- Continuous Positive Airway Pressure (CPAP) masks study, program development, and data validation.
- Ping-Pong report (common client) data and program preparation.
- Recipient Restriction Report data and program preparation.

As discussed above, during FY 2016, HFS-OIG will report approximately \$220.2 million through savings, recoupment, and avoidance in the Illinois Medicaid program, which includes State and federal funds. This figure represents an increase of

approximately \$16 million from the amount reported in FY 2015. In FY 2015, HFS-OIG reported \$204 million in savings, recoupment and avoidance for the State Medicaid program, which includes State and federal funds.

2. Illinois State Police Medicaid Fraud Control Unit

ISP-MFCU investigates criminal and civil allegations of fraud and abuse in Medicaid programs. On average, this MFCU opens approximately 300 cases a year, and approximately two-thirds involve fraud and one-third involve allegations of abuse and neglect. ISP-MFCU is currently comprised of 28 sworn officers, five non-sworn investigators, four attorneys, three analysts, and one accountant supervisor. In addition, eleven attorneys from the Illinois Office of Attorney General are assigned to ISP-MFCU to prosecute cases. The Unit works with Illinois State agencies, including HFS and HFS-OIG, to obtain referrals and information. ISP-MFCU is a member of the National Association of Medicaid Fraud Control Units (NAMFCU), a professional organization made up of 50 different state-run MFCUs.

MFCUs operate in 49 states and the District of Columbia under the HHS-OIG to address Medicaid fraud and abuse. As such, ISP-MFCU receives direction and funding from the federal government. The HHS-OIG provides oversight for all of the state MFCUs, annually recertifies them, assesses performance and compliance with federal requirements, and administers a federal grant award to fund a portion of each MFCU's operational costs. The federal grant award received by the Illinois State Police involves a 75/25 percent match and finances the majority of the MFCU, with the federal government funding approximately \$8 million and the State funding approximately \$3 million. In federal FY 2015, ISP-MFCU referrals led to 42 fraud convictions and \$16.9 million in recoveries through criminal prosecutions, civil actions, and/or administrative referrals.⁶⁶

3. Office of Executive Inspector General for the Agencies of the Illinois Governor

The OEIG investigates allegations of fraud, waste, abuse, mismanagement, misconduct, nonfeasance, misfeasance, malfeasance, and violations of the State Officials and Employees Ethics Act. The OEIG also investigates violations of other related laws and rules involving public employees, appointees, officials, and others doing business with entities under the OEIG's jurisdiction. Thus, the OEIG investigates employees and entities that administer benefits funded by Medicaid, as well as recipients of State benefits. The OEIG employs approximately 43 investigators and attorneys devoted to OEIG investigations.

4. Department of Human Services

DHS administers several health care programs that receive Medicaid funding. Those programs include programs to assist pregnant woman, infants, and children in obtaining health care services, programs to assist individuals with alcoholism and substance abuse issues, and programs to assist individuals with developmental disabilities. DHS also administers a program that focuses on services to persons with disabilities so they can remain in their own homes. In addition, DHS operates seven psychiatric hospitals that utilize Medicaid funding for eligible patients. Further, DHS certifies community mental health centers that work with Medicaid recipients.

To address fraud, waste, and abuse in its health care programs, DHS engages in several measures. For example, DHS reaches out to providers to ensure they are familiar with eligibility requirements; conducts post-payment reviews of services funded through Medicaid, on-site visits, and annual audits of payments; and engages in on going data analytics to help update training and program guidelines. Also, as discussed above, HFS-OIG has jurisdiction over some DHS programs and assists in investigations of fraud, waste, and abuse for those programs.

5. Department of Innovation and Technology

DoIT has over fifteen employees dedicated to health care fraud, waste, and abuse prevention and enforcement. DoIT engages in data analytics efforts to strengthen program integrity in Medicaid programs. As part of its data analytics efforts, the DoIT team is focused on merging data from Illinois health and human services agencies, such as DHS, HFS, and DoA, with all Illinois agencies to provide a holistic view of services a household receives. In addition to helping agencies provide better services for families, this information will assist in detecting fraud in human services programs.

6. Department on Aging

DoA administers several programs for adults 60 years old and older that involve Medicaid funds. These programs include services that allow seniors to reside within their home or to receive services as a cost-effective alternative to a nursing facility placement. Some examples include meal services, routine housekeeping services, emergency response system, transportation, personal care, money management, and social activities. In addition, DoA administers the Senior Health Insurance Program, which provides health insurance counseling for Medicare beneficiaries and their caregivers. These programs are funded by General Revenue Funds, Medicaid funds, and in some cases federal grants.

DoA deploys several tools to address fraud, waste, and abuse in its health care programs. These tools include on-site monitoring of providers, review of billing and financial statements, surveying participants regarding the provider services they received, and internal and independent audits of providers. If DoA identifies improper billing, it may issue sanctions for non-compliance and recoup funds.

7. Department of Central Management Services

The State employee group insurance plans are administered by Illinois CMS. CMS's Bureau of Benefits oversees the administration of medical, dental, eye, and life insurance. Illinois CMS is the primary State agency involved in both administering these plans and working to monitor and prevent potential fraud, waste,

and abuse in the Employee Group Insurance Program.

In addition, the Illinois CMS Bureau of Benefits relies on its managed care administrators for the State's employee group health insurance plans to monitor and detect potential fraud, waste, and abuse. The Bureau of Benefits works closely with these managed care administrators to monitor potential fraud, waste, and abuse related to the health insurance of State employees and their dependents.

8. Department of Insurance

The Illinois Workers' Compensation Act required DoI to create a Workers' Compensation Fraud Unit to investigate allegations of workers' compensation fraud and insurance non-compliance. The Act specifically provides that it "shall be the duty of the [Workers' Compensation Fraud Unit] to determine the identity of insurance carriers, employers, employees, or other persons or entities that have violated the fraud and insurance non-compliance provisions"⁶⁷ of the Act. The fraud unit's primary responsibility involves conducting investigations and referring worthy cases to the Attorney General's Office or the applicable State's Attorney for prosecution. Investigators conduct field investigations, review surveillance footage, issue numerous subpoenas, and review insurance, payroll, medical, and other records.

9. Department of Transportation

IDOT is devoting resources to workers' compensation accountability and reforms within its own department. It identified specific areas for improvement including increased efforts to provide timely and appropriate benefits to injured employees; investigations of each reported accident; closer monitoring of "repeat offender" employees; increased use of social media, well-being calls and home visits; and a reevaluation of the Department's pre-employment physical examinations. IDOT cannot yet determine the financial impact of these efforts, but saw the average number of employees receiving workers' compensation benefits decline from 144 employees in FY 2015 to approximately 130 employees in the early months of FY 2017.

D. Endnotes

- ¹ Federal FY 2015 ran from October 2014 through September 2015.
- ² SYLVIA M. BURWELL, U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, 2015 ACTUARIAL REPORT ON THE FINANCIAL OUTLOOK FOR MEDICAID ii (2015), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2015.pdf> (hereinafter “FINANCIAL OUTLOOK FOR MEDICAID”); MFCU Statistical Data for Fiscal Year 2015, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2015-statistical-chart.htm (last visited Sept. 27, 2016) (hereinafter “FY 2015 MFCU Data”).
- ³ SYLVIA M BURWELL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, FISCAL YEAR 2015 AGENCY FINANCIAL REPORT 193 (2015), <http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf> (hereinafter “HHS FINANCIAL REPORT”). An improper payment is: “when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, the recipient uses the funds in an improper manner, or documentation is not available to verify the appropriateness of the payment.” *Id.* at 30.
- ⁴ FY 2015 MFCU Data, *supra* note 2.
- ⁵ The 450,000 individuals also include individuals in the Teachers’ Retirement Insurance Program (“TRIP”), College Insurance Program (“CIP”), and Local Government Health Plan (“LGHP”).
- ⁶ FY 2017 LIABILITIES OF THE STATE EMPLOYEES’ GROUP HEALTH INSURANCE PROGRAM, COMMISSION ON GOVERNMENT FORECASTING AND ACCOUNTABILITY 10 (Mar. 2016), <http://cgfa.ilga.gov/Upload/FY2017GroupInsuranceReport.pdf> (hereinafter “FY 2017 LIABILITIES”).
- ⁷ *Id.*
- ⁸ *Id.*
- ⁹ *Id.* at 12.
- ¹⁰ *Id.*
- ¹¹ State of Illinois Exec. Order No. 2016-05 (2016), <https://www.illinois.gov/Government/ExecOrders/Documents/2016/ExecutiveOrder16-05.pdf> (hereinafter “EO No. 2016-05”).
- ¹² EO No. 2016-05, *supra* note 11.
- ¹³ *Id.*
- ¹⁴ *Id.*
- ¹⁵ See 42 C.F.R. § 455.2 (2015).
- ¹⁶ HEALTH CARE FRAUD AND PROGRAM INTEGRITY: AN OVERVIEW FOR PROVIDERS, CENTERS FOR MEDICARE AND MEDICAID SERVICES (July 2016), <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf>.
- ¹⁷ See generally Donald M. Berwick & Andrew D. Hackbarth, Eliminating Waste in US Health Care, 307(14) J. AM. MED. ASS’N 1513 (Mar. 14, 2012).
- ¹⁸ See 42 C.F.R. § 455.2 (2015).
- ¹⁹ See *id.*
- ²⁰ Eligibility, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html> (last visited Sept. 27, 2016).
- ²¹ See FINANCIAL OUTLOOK FOR MEDICAID, *supra* note 2, at i–ii.
- ²² *Id.* at ii.
- ²³ FY 2015 MFCU Data, *supra* note 2.
- ²⁴ Eligibility, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html> (last visited Sept. 27, 2016).
- ²⁵ Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2016 through September 30, 2017, 80 Fed. Reg. 73779 (Nov. 25, 2015).
- ²⁶ Financing, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/affordablecareact/provisions/financing.html> (last visited Sept. 27, 2016).
- ²⁷ HFS’s programs currently cover approximately 3.2 million enrollees, including almost 1.5 million children, 195,102 seniors, 252,313 persons with disabilities, 635,972 federal Affordable Care Act eligible adults, 631,126 non-disabled, non-senior adults, and 16,440 enrollees with partial benefit packages.
- ²⁸ Illinois Public Act 99-106 defines “care coordination” as

a “delivery system where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care” Risk-based payment for care coordination usually consists of a capitated payment in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of the services.

²⁹ What’s Medicare?, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> (last visited Sept. 27, 2016).

³⁰ *Id.*

³¹ An Overview of Medicare, KAISER FAMILY FOUNDATION (Apr. 1, 2016), <http://kff.org/medicare/issue-brief/an-overview-of-medicare> (last visited Sept. 27, 2016).

³² ILL. WORKERS’ COMP. COMM’N, FISCAL YEAR 2015 ANNUAL REPORT 2 (2016).

³³ *Id.*

³⁴ *See id.*

³⁵ *See id.*

³⁶ The 450,000 individuals also include individuals in TRIP, College CIP, and LGHP.

³⁷ State Employee Health Plan Spending, THE PEW CHARITABLE TRUSTS & MACARTHUR FOUNDATION 37 (Aug. 2014), <http://www.pewtrusts.org/~media/assets/2014/08/stateemployeehealthcarereportseptemberupdate.pdf> (hereinafter “State Employee Health Plan Spending”).

³⁸ *See id.* at 37–39.

³⁹ *Id.* at 37.

⁴⁰ *Id.*

⁴¹ *See id.* at 37–39.

⁴² State Employee Health Plan Spending, *supra* note 37, at 2.

⁴³ *Id.*

⁴⁴ FY 2017 LIABILITIES, *supra* note 6, at 10.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.* at 12.

⁴⁸ *Id.*

⁴⁹ The Health Care Fraud Prevention & Enforcement Action Team is a joint initiative between the U.S. Department of Justice and the U.S. Department of Health and Human Services to prevent fraud and to enforce anti-fraud laws around the country. Dozens of defendants have been charged in numerous fraud cases since the Strike Force began operating in Chicago in 2011.

⁵⁰ “Enablers” are supporting structures and processes that help promote and enforce other capabilities in program integrity systems.

⁵¹ About the Partnership, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://hfpp.cms.gov/about/index.html> (last visited Sept. 27, 2016).

⁵² HHS FINANCIAL REPORT, *supra* note 3, at 193.

⁵³ FY 2015 MFCU Data, *supra* note 2.

⁵⁴ As stated above, Medicare is a federal system; however, the working group is also studying Medicare because Illinois uses Medicare data as part of its fraud, waste, and abuse prevention, some individuals are enrolled in both Medicare and Medicaid, and studying trends in Medicare fraud, waste, and abuse will assist the Task Force in identifying trends in Medicaid because “generally, a category of providers or suppliers that poses a risk to the Medicare program also poses a similar risk to Medicaid” *See* 81 Fed. Reg. 51120 (Aug. 3, 2016).

⁵⁵ What Are Metrics?, BUSINESSDICTIONARY.COM, <http://www.businessdictionary.com/definition/metrics.html> (last visited Sept. 28, 2016).

⁵⁶ HFS-OIG currently has four employees operating in the Bureau of Fraud Science and Technology that are dedicated to analytics work. HFS-OIG also contracts with Northern Illinois University (“NIU”) to assist in the development of the DNA System. NIU provides approximately four additional employees to the analytics team.

⁵⁷ Federal CMS often finds innovative and efficient systems or practices throughout the many Medicaid systems, and highlights those systems or practices for all other Medicaid agencies. Federal CMS labels these efforts as “best practices.”

⁵⁸ *See* About CMS, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.cms.gov/About-CMS/About-CMS.html> (last visited Sept. 29, 2016).

⁵⁹ The outlier analysis includes summaries with indicators of whether providers exceed the normal payment within their peer group (by the same provider type, geographic location, procedure codes, or other pre-defined clusters that share the same characteristics). This analysis allows HFS-OIG investigators to

detect providers who behave or perform outside the norm.

⁶⁰ For example, DNA-SURS is used to conduct a monthly analysis of providers based on their “risk score” and other predictive measurements.

⁶¹ The Provider Profile Reports and Recipient Profile Reports have combined information from various data sources and applied statistical approaches to offer a comprehensive view to examine a targeted provider or a targeted recipient in various categories of services of the Medicaid program. These programs analyze the patterns of fraud or abuse of the Medicaid system, and assess any data quality or billing error issues for future system enhancement or policy changes.

⁶² The DNA System provides a Statewide Executive Summary that gives an overview on total yearly payments in each county, or by provider type, or at a procedure and/or diagnostic code level.

⁶³ DHS is in the process of recouping those overpayments.

⁶⁴ A Majority of U.S. Businesses Report Workplace Safety Delivers a Return on Investment, LIBERTY MUT. INS. CO. (2001).

⁶⁵ 305 ILCS 5/12–13.1 (2016).

⁶⁶ FY 2015 MFCU Data, *supra* note 2.

⁶⁷ 820 ILCS 205/25.5 (2016).

