Illinois Department of Healthcare and Family Services

Office of Inspector General

Annual Report

Fiscal Year 2018

Bruce Rauner, Governor

Bradley K. Hart, Inspector General

OIG Mission

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

OFFICE OF INSPECTOR GENERAL

Illinois Department of Healthcare and Family Services

Bradley K. Hart
Inspector General

I am pleased to submit the Inspector General's annual report for the Fiscal Year 2018 (FY18) to Governor Bruce Rauner, the Legislature, and the citizens of Illinois.

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

The OIG realized $191.1 million in cost savings for the tax payers of Illinois, resulting in a return on investment (ROI) of $8.50 for every $1 spent. For FY18, a strong focus of the OIG was Long Term Care – Asset Discovery Investigations (LTC-ADI) investigations and the program integrity aspects of managed care.

The OIG has experienced success despite the lack of available resources. The ROI statistic above is absolute proof that the efforts of OIG are maximizing value to the taxpayers of Illinois, further justifying the need for OIG expansion. Through the Governor's Rapid Results initiative, the OIG has been able to streamline internal processes to work smarter, not harder. While the OIG ended FY18 with 157 on-board staff, the OIG has reached the pinnacle of ROI which that level of staffing can produce. As additional duties continue to mount, current staff must be diverted to achieve daily operational goals. This situation prevents the OIG from enhancing our current capabilities and being proactive with topics and trends in modern health care.

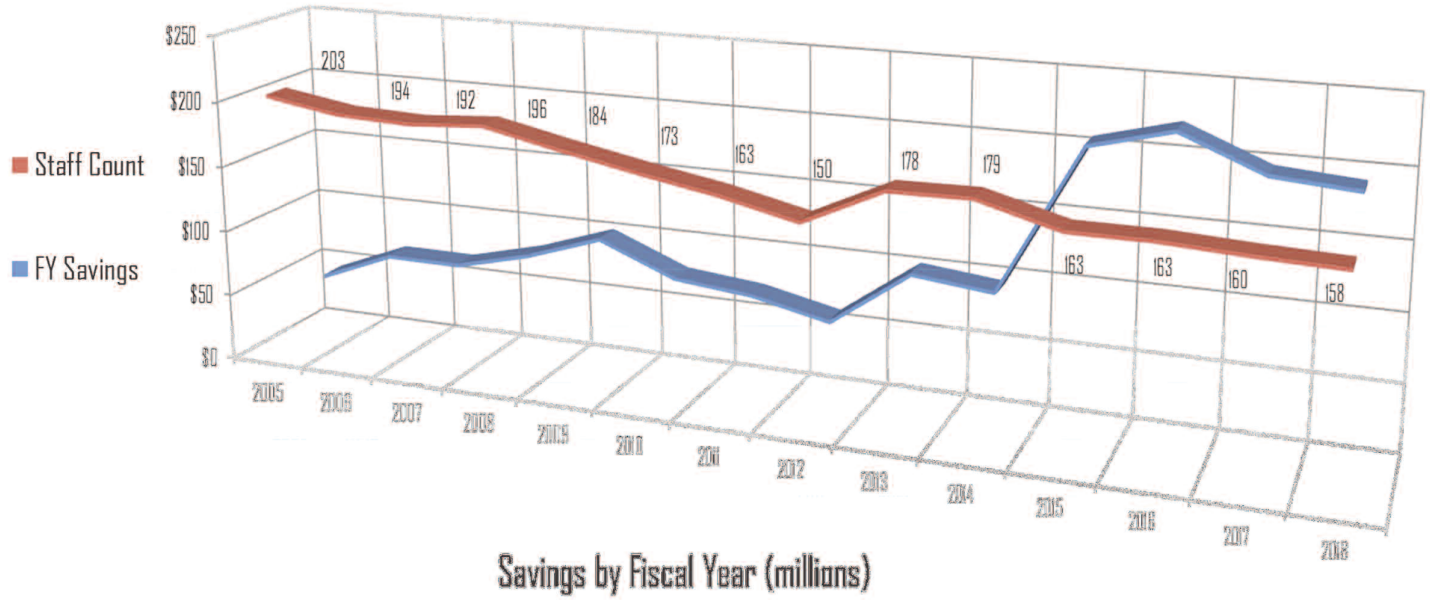
The OIG is continuing to identify ways to boost efficiency and cost savings for taxpayers, including developing a triage process for referrals, working collectively with the Bureau of Managed Care (BMC) on contract compliance and encounter data issues, and collaboration with law enforcement and managed care special investigations units.

The OIG is charged with program integrity for the Illinois Medicaid program. This includes recommending changes to Medicaid policy, rules, and contract language. In this report, you will find examples of how the OIG has made great strides in collaborating with the Department in identifying policy changes to safeguard taxpayer funds, as well as making proactive recommendations to further enhance the department's program integrity functions. For example, in FY18, the Department had no language allowing the Department to share in program integrity recoveries from the managed care providers. The OIG is collaborating with the Department to implement program integrity language into our managed care organization (MCO) contracts to comply with 42 CFR Part 438 and will allow the Department to share in financial recoveries, audit MCOs/providers, and to monitor MCO plan compliance. The OIG is also developing several risk-based reports, which will highlight several issues of concern for the Department, due to be released in Fiscal Year 2019 (FY19). Topics include provider enrollment, narcotic/opioid prescribing and other areas of concern to the OIG.

The OIG's staff is dedicated to safeguarding the fiscal integrity of the Medicaid program, as well as ensuring the safety and well-being of recipients. In FY19, the OIG will continue to achieve positive, demonstrable results in preventing, detecting and eliminating fraud, waste, abuse, misconduct and mismanagement in programs within the Illinois Medical Assistance Program.

Respectfully,

Bradley K. Hart
Inspector General



Contents

Reinforcing OIG Infrastructure

Education and Training

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

Inspector General Bradley K Hart Presentations FY18

August 2017, NAMPI (Speaker and Treasurer)

March 26-29, 2018 Emerging Trends in Medicaid, Beneficiary Fraud (Speaker)

April 9-12, 2018 MFCU and PI Director's Symposium (Speaker)

April 12, 2018 HFPP Columbia, SC

April 17-19, 2018 CMS Baltimore, MD

May 18, 2018 Southern Illinois Health Policy Institute (Speaker)

May 29, 2018 MCO/OIG/MFCU Training (Speaker)

OIG Staff trainings at the NAC/MII FY18

Specialized Skills and Techniques in Medicaid Fraud Detections

Program Integrity Partnership in Managed Care Symposium

Emerging Trends in Medicaid

Medical Record Auditing

Medicaid Provider Enrollment Seminar

Emerging Trends in Medicaid-Opioids

HCPro'S Certified Coder Boot Camp

Data Experts Symposium

Healthcare Fraud Prevention Partnership Meeting

Basic Skills and Techniques in Medicaid Fraud Detections

Collaboration and training with external organizations and partners

MCO/OIG/MFCU Training May 2018

IMPACT Training for OIG and MFCU June 2018

FY18 Financial Highlights

Dollars Recovered

Provider Audits: $13,542,710

Global Settlements: $6,450,932

Restitution: $124,562

TOTAL: $20,118,204

Questioned Costs

Providers: $13,599,077

Recipients: $ 9,590,991

Restitution: $419,323

TOTAL: $23,609,391

Funds Put to Better Use

LTC ADI: $140,730,671

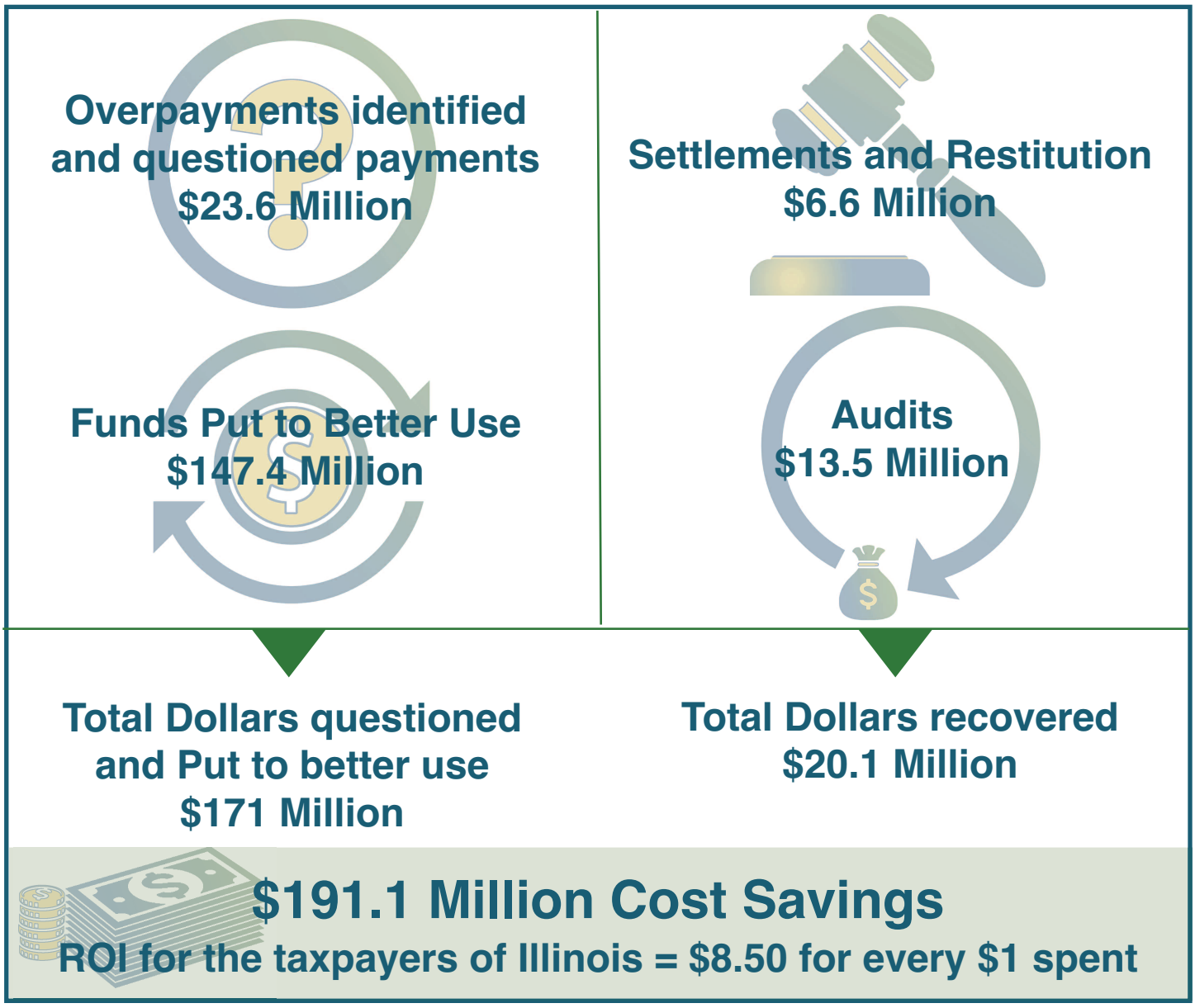
Client Program Overpayments: $940,229

Provider Sanctions: $1,515,719

Recipient Restriction Program: $2,209,495

SNAP: $2,024,876

TOTAL: $147,420,991



How results are measured - An investigation, audit or review that is performed, managed or coordinated by the OIG can result in: Dollars recovered: Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection, or review; Questionable costs (formerly listed as overpayments): Questioned costs include overpayments identified for recover during an OIG investigation, audit or review due to: an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds or for their intended purpose or were unnecessary, unreasonably spent, or wasteful; Funds put to better use (formerly listed as dollars identified as cost avoidance): Putting funds to better use results in: avoidance of unnecessary expenditure of funds for operational, medical, contract, or grant costs. These measures align with those used by the federal Government Accountability Office.

FY18 Successes

Litigation Activity - Office of Counsel to the Inspector General (OCIG) secured $725K settlement with hospice provider

OCIG filed a Termination and Recoupment Notice against Harbor Light Hospice alleging various Medicaid recipient patients were improperly classified as eligible for hospice care. HFS's consultant determined that these patients met the criteria for hospice care for approximately 52% of the days in which the audit firm had determined that the patients did not qualify. Although the hospice provider initially made an offer of $550,000 to settle the case, this initial offer was rejected. The provider's subsequent offer of $725,000 was accepted in exchange for the Department's agreement to withdraw its request for termination.

Fraud Detection Operations: Topical Creams/Ointment schemes and change in Department Policy

Working in conjunction with a fraud referral received from an MCO, the OIG Provider Analysis Unit (PAU) nurses investigated allegations of cases involving schemes of dispensing large quantities of very expensive ointments and compounding those ointments, it was determined that the Department needed to take action to prevent any further waste and abuse of the program. PAU nurse analysts worked with HFS' pharmacy unit, which was also finding similar schemes and issues surrounding these medications. As a result, the HFS pharmacy unit implemented changes on several specific medications, including quantity restrictions and negotiating a lower price for one of the medications from $6 per gram to $2.20 per gram. It is estimated that this change in policy would have provided cost savings of approximately $1.1 million for the time period of July 2017 through December 2017. [1]

FY18 OIG Case Highlights

Provider enrollment and revalidation applications reviewed: 329

Provider Investigations completed: 824

OIG referrals to MFCU: 31

Global Settlement Agreements executed: 14

Medicaid providers terminated, denied, suspended, and excluded: 114

Audits completed: 1,170

Fraud Detection Operations: Over $664K in Assets discovered during Asset Discovery Investigations

During the course of performing a review of an application for long-term care benefits, an Analyst determined that an applicant's parents created an irrevocable trust containing farm ground and had named the applicant as the beneficiary. Years later, the applicant sold the farm ground and used the proceeds to purchase financial CD's in their own name. The Analyst deemed $664,709 as available funds for the applicant to use for their own nursing home care. This was appealed and the Bureau of Administrative Hearings upheld the Department's decision.

Fraud Detection Operations: Pharmacy – Federal Healthcare Fraud Guilty Plea

PAU nurse analysts investigated allegations of false billings totaling over $100,000 in Medicaid dollars by a Southern Illinois Pharmacy. Working in conjunction with ISP-MFCU, this case was reviewed, referred, investigated, and finalized within 12 months, resulting in the pharmacist pleading guilty to two counts of federal healthcare fraud.

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

FY18 Successes

Bad Debt Recovery: $34K Recovery from out-of-state doctor

The Department filed a Notice of Termination and Action to Recover against a former Medicaid provider, Dr. Lorrie Richardson-O'Neal, who left the State of Illinois and relocated her medical practice to a small town outside of Atlanta, Georgia. HFS-OIG alleged that the physician improperly refused to satisfy her financial obligations after the HFS Director had previously issued a 2012 Final Administrative Decision in an ordinary 2008 HFS Audit recoupment and compliance case. The evidence showed that numerous attempts were made by employees in OIG Fiscal Management, as well as counsel, to recover the full amount of the HFS debt, $34,343, that was due. The Notice further alleged that the provider improperly ignored, failed to respond, or otherwise refused to comply with reasonable requests for payment. The provider later stated she did not have the funds to satisfy her obligation. After repeated communication between the OIG and the provider, she ultimately settled her debt in full to avoid termination from the Medicaid Program.

Administrative Audits: Recoupment of over $21K for billing deceased recipients scheme

The OIG continued initiatives focused on areas of identified Program vulnerabilities, including preventing payments and recovering overpayments made for deceased recipients. In FY18, the OIG performed 42 audits to identify and recover overpayments made by the Department for deceased Medicaid recipients.

Payment Suspensions: OIG withholding over $7 million dollars in provider payments

The OIG utilizes its statutory authority to impose payment suspensions when credible allegations of fraud are identified. Cases can be under criminal, civil or administrative investigation. In FY18, the OIG imposed several payment suspensions on Medicaid providers, with one suspension alone resulting in over $3.3 million dollars being held.[2]

Fraud Investigation: Referred for prosecution

An Investigation was completed for a client eligibility case that alleged a client received assistance benefits for absent children, three of which could not be located by BOI. During the course of the investigation, BOI found that medical benefits had been issued, but never used, for the three absent children since birth. After being unable to make contact with the client after multiple attempts, an overpayment was established. For the period of January 2007 until August 2017, the estimated SNAP benefits overpayment totaled $54,826, grant benefits overpayment totaled $6,721, and Medical benefits overpayment totaled $8,151. BOI requested that the overpayment be calculated by BOC and placed on hold, as it will be presented for prosecution.

Fraud Investigation: $900K in overpayments identified

An Investigation was completed for a client eligibility case that alleged the client received assistance benefits in Illinois while using the identity of another individual. The investigation revealed the client was using the identity of a Wisconsin resident and that they used a second Social Security Number (SSN) for other fraudulent activities. The client was found to be a non-citizen without a social security number who received SNAP benefits of $12,081 during the period of December 2011 through March 2017. Additionally it was found that the client received Medicaid benefits of $899,971, for services, including a heart transplant, while using the identity of the Wisconsin resident.

[2] The total monies held include monies being held within HFS as well as sister agencies under the jurisdiction of the OIG.

Medicaid Program Integrity Spotlight

Risk Analyses

The OIG has identified multiple areas for program integrity concerns and is proactively addressing them, both internally and externally, among our fraud, waste and abuse counterparts. New for FY18, the Medicaid Program Integrity Spotlight (MPIS) section highlights risk areas and issues which the OIG has identified as vulnerabilities for Medicaid program integrity. By highlighting areas of concern, the OIG is focused on finding creative, collaborative and effective solutions for program integrity issues in hopes of being a role model for Illinois' Medicaid program and program integrity units around the nation.

Collections: Out of State Vendors/Individuals

When a provider moves out of state, the OIG's resources for collection of any outstanding debts are limited to contacting the provider via US mail and e-mail. The Bad Debt Unit generally receives little communication from these providers. In the case of Lorrie Richardson-O'Neal, the threat of termination from Medicaid/Medicare participation was an effective strategy to assist in debt recovery because she is a licensed physician. Threats of termination like this, however, have no bearing on providers or unlicensed individuals, such as medical transportation providers. These types of unlicensed providers can abandon their debt in Illinois by simply relocating out of state and/or seeking employment in other fields. These providers may own property or other viable assets, but the OIG Collections Unit cannot pursue these cases because the individual no longer resides within Illinois' legal jurisdiction.

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

Collections: Federal Tax Refunds

The OIG's Bad Debt Unit does not have the ability or authority to intercept Federal tax refunds. State tax refunds can be withheld as a result of a C-33 being entered with the Illinois Office of the Comptroller. HFS-Child Support has the authority to intercept Federal tax refunds. The OIG is investigating the manner and means to which the State could proceed with intercepting Federal tax refunds, but obtaining the authority would likely require a legislative change.

Managed Care: Program Integrity Concerns

The OIG is working collaboratively with Healthcare and Family Services (HFS) Bureau of Managed Care (BMC) to address concerns regarding encounter data quality and contract compliance with the MCOs. The OIG is encountering difficulties, given the lack of program integrity language in the present contract and is working diligently to establish stronger contract language to assist in the fighting of fraud, waste and abuse in the Medicaid managed care system. The OIG is also working collaboratively with the department regarding any other areas of concern related to managed care.

The OIG, in conjunction with our law enforcement counterparts, has completely revised the Fraud, Waste and Abuse section of the HealthChoice Illinois contract for FY19. The OIG is moving forward to clarify its role, as well as Program Integrity in general, over MCOs, while working collaboratively with the department and the managed care plans on identifying ways to fight fraud, waste and abuse to save taxpayer dollars.

Medicaid Program Integrity Spotlight

Narcotic Withdrawal Agents and Prescribing Patterns

The OIG has identified concerning trends in the prescribing of narcotic withdrawal agents. Through investigations and reviews, OIG staff has identified cash for script schemes, non-medical necessity for the prescribing of narcotic withdrawal agents as well as anomalies with treatment patterns and quality of care concerns.

Narcotic withdrawal prescribing trends identified from 2015 through 2017:

- Recipient use from 2015 to 2017 quadrupled
- Prescribing providers doubled
- Prescription payments skyrocketed

Chart 1 shows the costs associated between FFS and MCO. These numbers represent Medicaid expenditures only – not Medicare or private pay/commercial costs. Chart 2 below is a visual depiction from the Medicaid claims processing system, showing the number of individuals receiving narcotic withdrawal agents.

Chart 1 - Medicaid Payments: Narcotic Withdrawal Agents *in millions*

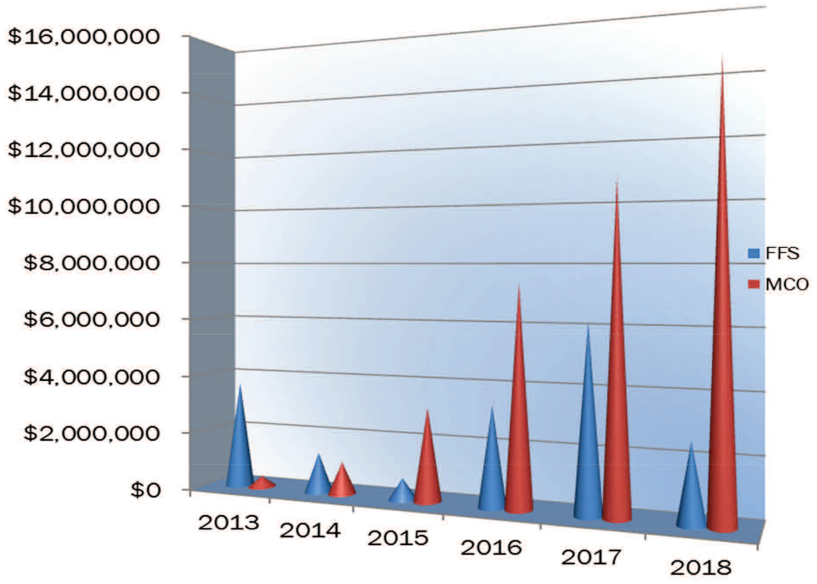
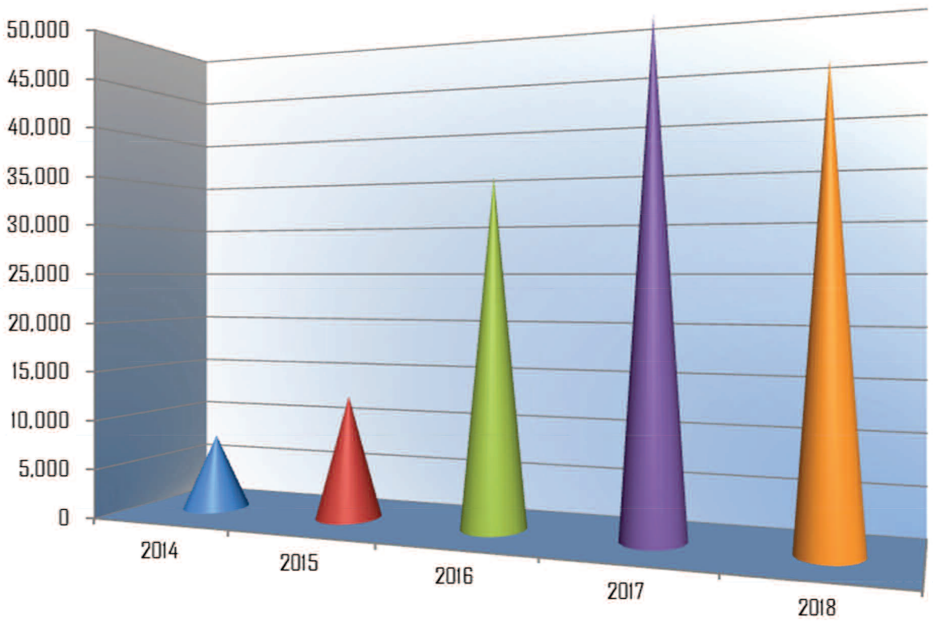


Chart 2 - Medicaid Recipients Receiving Narcotic Withdrawal Agents *in thousands*



Medicaid Program Integrity Spotlight

The OIG is seeking to address these new issues within the Medicaid population through policy suggestions, data analytics and clinical analyses. The OIG is also working collaboratively with the federal government and other partners to identify and address these concerns.

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

Nationwide, personal care service programs are known for fraud, waste, and abuse. This provider type is notorious for fraud schemes such as: services not-rendered, collusion with the recipient, check splitting, and sexual/physical abuse. The risks to Program Integrity are fiscal, administrative, and legal. This risk has been highlighted by Federal HHS-OIG in prior program reviews as well as a White paper entitled "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services" published in 2017.[1] A 2016 HHS-OIG investigative advisory report entitled "Patient Harm Involving Personal Care Services (PCS)" recommended that CMS take regulatory action to establish safeguards to prevent fraudulent or abusive providers from enrolling or remaining as PCS attendants, to protect the PCS program from the risk of fraud, patient harm, and neglect.[2] Per this report, HHS-OIG investigations have also shown that abuse and neglect by PCS attendants has resulted in deaths, hospitalizations, and less severe degrees of patient harm. Stronger controls are needed to screen and monitor PCS attendants and the program, as well as to ensure that only screened and qualified providers oversee or provide care to recipients.[3]

Given the present enrollment process, the OIG does not receive the applications for review of any Personal Assistant (PA) until after the provider has started providing services and has potentially been paid. If the screening and approval/denial of applications were done initially, before the IP was allowed to provide services, the process would be much more efficient and cost effective for taxpayers. More importantly, it would prevent providers who otherwise do not meet the requirements of becoming a Medicaid provider from becoming a full Medicaid provider, therefore requiring a lengthy legal administrative process to terminate them from the program. The OIG has proposed multiple solutions to the problem, including making this provider type high risk providers, requiring fingerprint-based background checks. The OIG continues to work collaboratively with DHS to guarantee access to care for those that need services to remain in the community, while preventing the abuse of the system through fraudulent means.

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

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

[3] Reference article: External Intelligence Note from the FBI Chicago Field Office dated 8/31/18 entitled "Purportedly Homebound Patients Employed as Personal Care Assistants Are Almost Certainly a New Indicator of Home Health Fraud, Resulting in Significant Losses for the Medicare Program."

Administration

Section 1

Administration

Fiscal Management, MRA and FAE

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

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

Highlights

Collections:

Open Receivables: $58,000,000

New Receivables Established: $14,000,000

Collected: $13,600,000

Fiscal Management

The duties of HFS-OIG's Fiscal Management Unit include overseeing all fiscal matters, including general collections, bad debt recovery, procurement, and budget responsibilities. Since the OIG budget is projected annually, Fiscal Management staff monitors the expenditures and requests additional funds as needed for special projects and initiatives. In FY18, this unit struggled as duties had to be absorbed by existing staff due to retirements and vacancies.

HFS-OIG's Fiscal Management Unit is made up of General Collections and Bad Debt Recovery. General Collections tracks overpayments identified as a result of OIG audits on Medicaid providers and court ordered restitution. This process involves establishing accounts receivable and monitoring of accounts until the debt is collected.[1] If the debts are not collectable, they are forwarded to Bad Debt Recovery. In FY18, General Collections monitored, on average, $58,000,000 in open receivables, established $14,000,000 in new receivables, and collected $13,600,000.

One successful highlight for General Collections for FY18 is the implementation of interest charges for providers who choose the installment payment option after the finalization of a BMI Audit case. While installment payment options are not a new procedure, the charging of interest is a process that was newly implemented in FY18. Additionally, the OIG is requiring that payments be made by check. This action is a result of providers being paid directly through MCOs, not the Department. In FY18, the amount of interest identified for receivables totaled $9,347. The total interest collected in FY18 totaled $7,130.

Fiscal Management is also responsible for procuring and monitoring of all contracts, inter-agency agreements, and vouchering for the OIG. The OIG secures procurement and continually monitors approximately 50 contracts and 13 inter-agency agreements per year. The OIG contracts with external entities to provide consultation services in a variety of capacities, such as medical consultants, CPA firms, and court-reporting services.

A newly implemented policy in FY18 allows OIG to charge interest. In FY18, the amount of interest identified for receivables totaled $9,347. The total amount of interest collected in FY18 totaled $7,130.

[1] The federal government receives their FFP portion at the time the receivable is recorded in the Department's accounting system.

Bad Debt Recovery Unit

The Bad Debt Recovery Program pursues delinquent accounts of HFS providers when general collection efforts have been unsuccessful. These providers owe the Department monies as a result of actions taken against them related to program integrity activities.

When a case is received, it is reviewed for provider status. If the provider is found to be actively enrolled, the Office of Counsel to the Inspector General (OCIG) will place future payments on hold until the outstanding debt is addressed.

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

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

Referrals to the Attorney General for Collection Action

If property ownership and/or employment are established, a collection action is requested through the Illinois Attorney General's Office. The Attorney General's efforts may include wage garnishment, if wages are sufficient to justify deduction[2] and liens on personal property. A Collection Action Referral is prepared in accordance with the guidelines set forth by the Attorney General's Office. These referrals include all investigative and historical documentation that has been discovered during the entire investigation process. This can include provider enrollment documents, all communication between the Department and the provider, and any legal documents obtained during any administrative hearing.

If the Attorney General's Office is successful in obtaining funds from the provider and/or owner, these funds are collected by the Attorney General's Office and routed to the OIG and applied to the debt.

Bad Debt Recovery Highlights FY18

An OIG audit was conducted on a physician in 1996, resulting in a Notice of Intent to Terminate and Recover in 1997. In 2000, a Final Administrative Decision terminating the provider and entitling the Department to recover $957,148 was entered. The provider did not appeal the Director's final decision. Attempts to contact the provider for debt collection were unsuccessful and the case was referred to the Attorney General's Welfare Litigation Bureau for assistance. Between 2000 and 2009 the case was in court. The end result was an Appellate Court issuing a favorable decision upholding a Circuit Court ruling that the Department is entitled to recover $957,148.[3] After extensive research, it was discovered that the provider was working in Indiana providing services to Medicaid and Medicare clients and owned property in Illinois. In 2016, the Attorney General's Revenue Litigation Bureau filed a Citation to discover assets, but the Citation was dismissed due to the inability to obtain service after three attempts. In August 2017, a third party Citation was filed to obtain more information including data concerning

[2] 735 ILCS 5/12-801 et seq.

[3] The OIG revamped internal collection efforts between 2011 and 2014 to create the current process.

the provider's bank account. On October 17, 2017, OIG General Collections received a check in the amount of $269,711 as a result of the Citation.

An audit for a transportation provider was conducted in 2005 and finalized in 2007. The provider entered into a Settlement Agreement with the Department and signed an Installment Note to repay $13,655. By 2008, the provider's payments were delinquent and requests for payment by OIG proved ineffective. In 2010, the case was referred to the Attorney General's Welfare Litigation Bureau for assistance in collecting the remaining balance of $10,108. In 2016, the OIG discovered property ownership which resulted in the case being referred to the Attorney General's Revenue Litigation Bureau for collection action. A Verified Complaint with a 30 day Summons was filed. The provider's attorney submitted a Settlement offer and after negotiation with OIG, the provider paid $9,000.

Two pharmacies owned by a husband and wife, enrolled as providers in the Illinois Medicaid program, were found to have been overpaid $18,484. The owners entered into a Settlement Agreement to repay the Department in full over 12 months beginning in 2007. Over the next four years, they managed to repay $13,215 leaving an unpaid balance of $5,269. All attempts to collect from these providers were ignored, including a referral to a Collection Agency. Further research uncovered the husband and wife team were also the owners and operators of a convenience store in Chicago and were receiving SNAP benefits. [4] It was determined that these SNAP benefits were being used to purchase items in their own store. The case was referred to the Attorney General's Revenue Litigation Bureau for assistance. A Verified Complaint was filed and served, and the providers offered to settle the debt for 80% of the amount owed. OIG promptly denied this offer stating that the providers had ample time, 11 years, to repay their debt, and had already defaulted on one Settlement Agreement. The providers agreed to pay the full amount and have been submitting checks through the Attorney General's Office.

In 2008, a physician pled guilty to state Vendor Fraud and was ordered to pay Restitution to the Department in the amount of $146,000, to be paid in full by 2010. From 2008 through 2011 the provider paid $67,779, leaving an outstanding balance of $78,221. In 2011, a civil judgment was entered in favor of the State for the remaining balance, and the provider's probation was terminated as unsatisfactory. No further payments were made by the provider. In 2016, research found that the provider was employed and wages were sufficient to justify wage garnishment. In 2017, the case was referred to the Attorney General's Revenue Litigation Bureau for assistance. The Restitution Order was revived, recorded, and a Citation to Discover Assets was filed. In 2018, the Department began receiving checks through the Attorney General's Office as a result of the wage garnishment placed on the provider.

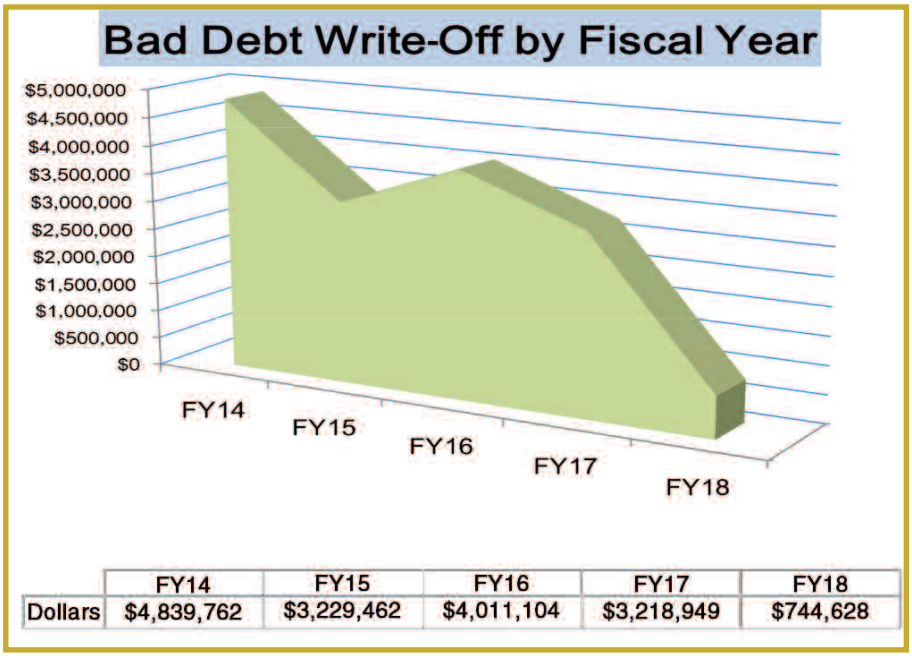
Referrals to the Attorney General for Bad Debt Write-Off

When all collection efforts have been exhausted, a request is submitted to the Attorney General's Office to have the debt certified as uncollectible. Certain situations prevent pursuit of an outstanding debt, including: a discharge in bankruptcy, dissolution of a corporate debtor, or death of an individual debtor, with no estate. A case packet is prepared and sent to the Attorney General's Office for processing. If the Attorney General's Office deems the debt uncollectible, the previously established receivable is reduced by the amount certified as uncollectible and written off. [5]

[4] The case was also referred internally for recipient eligibility review.

[5] The state receives their FFP portion at the time the receivable is written off.

As you can see from the chart, the process has reduced the held bad debt which results in the recovery of previously paid federal funds.



	FY14	FY15	FY16	FY17	FY18
Dollars	$4,839,762	$3,229,462	$4,011,104	$3,218,949	$744,628

OIG began an initiative in 2014 to tackle the backlog of bad debt cases outstanding for the prior decade. Initially, the cases were processed in order of largest debt to the Department. The process has reduced the backlog which has resulted in the recovery of previously paid federal funds.

Over the last three years, OIG has worked extensively on building a strong working relationship with the Attorney General's Office to actively pursue these cases. Both agencies have established an efficient process to coordinate referrals. Collection efforts can often be unsuccessful, but through this increased collaboration with the Attorney General's Office, OIG has had increased success rates of overpayment fund recovery.

Administration

Management, Research and Analysis Section (MRA)

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

The monitoring of non-emergency transportation providers began in June 2001. This was done by performing pre-enrollment on-site visits to verify their business legitimacy and by performing an analysis of their billing patterns to detect aberrant behaviors during a 180-day probationary period. This process has been expanded under the SMART Act to include monitoring of High, Moderate, and at times, Limited-risk providers. This expansion, called New Provider Verification (NPV), includes fingerprint-based background checks, verification of licenses, insurances, corporate standings, and on-site visits. High-risk and Moderate-risk providers are also continually monitored through their billings for one year. Limited-risk providers are monitored for a nine-month probationary period.

Highlights

230 New Provider Verification Applications Reviewed
Providers Denied: 4
Providers Enrolled: 110
Applications Returned: 94
Enhanced Screening: 3

98 Provider Revalidation Applications Reviewed
Providers Denied/Terminated: 5
Providers Revalidation Approved: 89
Applications Returned: 0
Enhanced Screening: 2

Depending on the provider type, the Bureau of Investigations (BOI) or the Bureau of Medicaid Integrity (BMI) would conduct the onsite readiness review. During on-site visits, the business' location and existence is confirmed; information provided on the enrollment application, including ownership information, is verified; and the business' ability to service Medicaid clients is assessed.

Fingerprint-based background checks are generally completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the High-risk provider category. High-risk provider types are determined by federal CMS and may be added to by the individual states, based upon their systems' needs. Federal CMS currently lists Durable Medical Equipment (DME) providers and Home Health Agencies (HHA) as High-risk providers. Illinois has added Non-Emergency Medical Transportation (NEMT) providers to its high-risk category. High-risk providers also include providers who have prior OIG sanctions or owe a debt to the Department.[6]

[6] Pursuant to provisions of federal regulations 42 CFR §455.100 Subpart B—Disclosure of Information by Providers and Fiscal Agents and §455.400 Subpart E—Provider Screening and Enrollment.

Enrollment may be denied by OIG for various reasons:

- an incomplete enrollment package;
- a non-operational business;
- the inability to contact the applicant;
- a requested withdrawal by the applicant;
- applying for the wrong type of services;
- the applicant's non-compliance with fingerprinting or documentation requirements;
- the failure to establish ownership of vehicles;
- fraud detected from another site affiliated with the applicant;
- an applicant's participation in the Medicaid Program using another provider's number; and
- providing false information to the Department.

Per the Affordable Care Act (ACA), HFS, as the State Medicaid Agency, must revalidate the enrollment of all providers regardless of provider type at least every 5 years. Revalidations are conducted as full screenings and are appropriate to the risk level as described above in the NPV process. If providers are non-compliant with requests for additional documentation during the revalidation process, the OIG may take action; including, but not limited to, payment suspensions and terminations.

The MRA section underwent a restructuring in FY18 to reorganize and streamline duties within the OIG to establish efficiency. One key component of this restructuring was to return the provider credentialing, document collection, and vetting of any sanctions for New Providers and Provider Revalidation applications back to HFS Provider Enrollment Services (PES). Previously, the OIG had been assisting PES with the credentialing and document collection for High-risk providers during the transition period from the paper-based enrollment process to the cloud based Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system. This created a distinct burden on the OIG, as there is only one OIG staff member dedicated to the process. As of the end of FY18, PES has resumed the responsibility of credentialing, collecting documentation, and vetting any enrollment applications before sending them to the OIG. This revised business model will greatly cut down on usage of OIG administrative time and resources and will allow the OIG to focus solely on Program Integrity functions of reviewing applicants for sanctions and criminal backgrounds.[7]

Rapid Results:

Provider enrollment responsibilities, documentation collection, had been re-assigned from Provider Enrollment Services to HFS-OIG in 2014, delaying the monitoring and investigation process within HFS-OIG. Prior to the implementation of IMPACT, PES held the responsibility for these duties. The shift of work load back to PES will save worker hours within the OIG, and will improve the process of monitoring and investigating providers and provider sanctions during enrollment and re-enrollment.

As the restructuring occurred for the MRA Section, more attention can be focused on proactive research projects to aid in highlighting risk areas for the Department, as well as highlighting areas for improved efficiency. At the time of printing, one such risk-based research essay has been completed and presented to Department Management. This essay and future essays will be presented in the FY19 Annual Report.

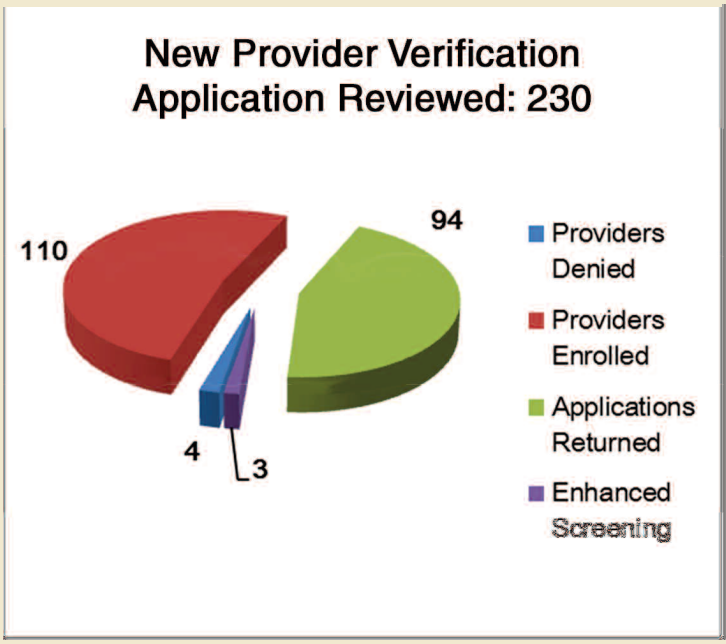
As the OIG Liaison with the Managed Care Organizations (MCO), the MRA unit is working closely with the MCOs to facilitate improved communication and increased information sharing. Additionally, MRA has begun working closely with the HFS Bureau of Managed Care (BMC) to address and identify areas of concern in regards to Program Integrity for the Department. The OIG holds monthly case review meetings, which are attended by representatives from the MCOs, Illinois State Police-Medicaid Fraud Control Unit (ISP-

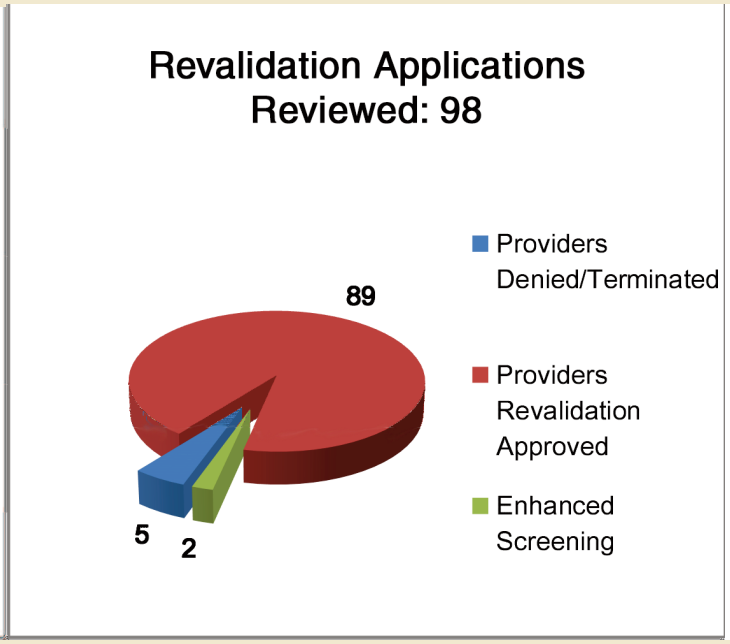
[7] This is also a Rapid Results case for OIG.

Administration

MFCU), and the OIG Units who review and analyze fraud, waste and abuse cases. These case review meetings bring together a variety of key players in the program integrity arena, and bridge the gap between MCOs, law enforcement and the Department. In these meeting, MCOs present trends, schemes and specific allegations of fraud for all partners involved to review and discuss. Some of these allegations and cases discussed can be further reviewed for any potential criminal, civil or administrative actions.

The OIG also meets quarterly with the MCOs and BMC as a group to review any concerns and questions, also to update on any departmental or policy issues or to highlight specific investigations which may have a large recovery or that may have commonality across different payers or books of business. Additionally, given the restructuring of MRA resources in FY18, new processes and reporting methods have been implemented and will be highlighted in FY19.





The total number of applications reviewed includes NPV or revalidation applications, which were either closed through administrative action or due to applications being withdrawn by the Medicaid providers themselves.

MRA also works to ensure that all OIG staff (and respective law enforcement partners) have access to and are trained on OIG programs, policies and procedures.

Examples:

IMPACT training

A collaborative, hands-on training session was held for all OIG staff and The Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU) staff. Two sessions were held to accommodate Chicago staff and Springfield staff. A total of 82 staff attended the sessions. The sessions were provided in conjunction with HFS Provider Enrollment Services (PES). In both training sessions, staff were taught how to search and retrieve necessary provider enrollment information from the IMPACT database, which will allow them to perform their work duties more efficiently. Participants were shown a PowerPoint presentation informing them about the history of IMPACT, as well as its functions and capabilities as it relates to their respective positions. This training received high reviews from attendees, and has allowed staff to personally research and obtain documents and information without the need of seeking assistance from other Department staff. One comment from the evaluations read "Excellent job! The most helpful IMPACT training received to date!"

MCO/OIG/MFCU cross training

To further develop the relationships and lines of communication between the MCOs, ISP-MFCU and itself, HFS-OIG hosted an inaugural collaborative cross-training session on May 29, 2018. A total of 98 participants in several locations attended this session via video conference, including individuals in Springfield, Joliet, and Chicago. At this event, representatives from each MCO presented an overview of their respective program integrity processes. The training included presentations from HFS-OIG, BMC, and ISP-MFCU, among others. This was the first cross-training session of its kind, and due to its success, HFS-OIG is planning to continue to hold these training events annually and include additional partners and encourage more specific presentations on schemes and trends in fighting fraud, waste and abuse. To ensure that future trainings are successful, HFS-OIG surveyed the participants in the training. The feedback was overwhelmingly positive and included comments such as:

"The opportunity to learn from each of the entities and receive contact information for future reference."

"Great collaboration between OIG/Law Enforcement and MCO."

"The entire presentation/training was very useful."

"This was a good starting point for future meetings with all entities involved."

Administration

Fraud Abuse Executive (FAE)

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

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

The FAE also identifies key departmental staff members and other governmental staff members to work with state and federal law enforcement entities to provide specific information regarding policy and programs. These staff may be asked to provide witness testimony at criminal and civil proceedings, as it relates to the Illinois Medicaid Program.

The FAE monitors all actively pursued law enforcement cases, and upon completion, will coordinate internal administrative actions as necessary. Administrative actions could include

Highlights

External referrals: 57
Global Settlement Agreements: 14
Referrals to MFCU: 31
Data requests from law enforcement:
  93 FFS, 17 MCO
Information requests from
  law enforcement: 160
Personal Assistant / Waiver providers:
  Referred to DHS and Aging: 523
  Referred to MFCU: 29
  Referred to BAL for termination: 28

Audit reviews, Peer Reviews and payment suspensions, as well as possible termination from the Illinois Medicaid program. The FAE is the liaison between law enforcement and OIG and ensures that providers are administratively sanctioned if any criminal or civil case results in conviction. After legal processes result in convictions of providers, the FAE works in conjunction with the Office of Counsel to the Inspector General (OCIG) to administratively terminate these providers from the Medicaid Program.

The OIG is statutorily required to suspend payments to Medicaid vendors when OIG determines a credible allegation of fraud exists[8]. The FAE works in conjunction with OCIG on the implementation of payment suspensions pursuant to 42 C.F.R. 455.23 as well as the enhanced payment suspension capabilities authorized by the SMART Act (PA 97-0689). Ending in FY18, the OIG is withholding payments from providers with credible evidence or allegations of fraud, totaling over $7 million dollars.[9] One specific case in FY18 involved suspending payments to a Medicaid vendor where,

[8] 42 CFR 455.23 Suspension of payments in cases of fraud.

[9] This dollar amount does not include MCO payment information but does include monies held by sister agencies.

upon investigation by the OIG and law enforcement, it was determined that a credible allegation of fraud existed. In working with law enforcement, the OIG began withholding payments to the provider and, as of this report print date, the total dollar amount being withheld for this provider alone is over $3 million dollars.

Personal Assistants and waiver providers are one category of providers which the OIG and law enforcement take action upon regularly, both at a state level and nationally. In FY18, the FAE referred 28 PA cases to OCIG for termination. As noted in the MPIS section of this annual report, this provider type is notorious for fraud schemes. In FY18, the FAE and Inspector General Hart worked tirelessly on a tremendous backlog of PA cases, which were the result of many administrative issues, one being lack of OIG staffing. The FAE established a protocol for vetting and researching the backlogged PA cases and through cooperation and assistance between DHS and ISP-MFCU, OIG was able to reduce the backlog by over 700 cases.[10] New processes have been put in place to triage and address the review of PA referrals, ensuring that they are processed timely and effectively.

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

[10] This number is reflected in the total reported above, 523 cases being returned to DHS and Aging.

Bureau of Fraud Science and Technology

Section

2

Bureau of Fraud Science and Technology

Fraud Science Team/Technology Management Unit

The Bureau of Fraud Science and Technology (BFST) is responsible for the introduction, development, maintenance, and training of staff on new technologies. BFST utilizes sophisticated computer technology to analyze, detect, and prevent fraud, waste and abuse by providers and recipients. BFST oversees the maintenance and enhancement of the Dynamic Network Analysis (DNA) Predictive Modeling System, a Center for Medicare & Medicaid Services (CMS) "Best Practice" put into production in September 2011; and Case Administrative System Enquiry (CASE), a highly sophisticated case tracking, and document management system developed specifically for OIG. BFST responds to referrals from within and outside the Department. The areas within BFST include the Provider and Recipient Analysis Section (PRAS), Recipient Restriction Program (RRP), Fraud Science Team (FST) and the Technology Management Unit (TMU).

BFST initiatives center around the OIG's mission to insure program integrity, while evaluating data integrity. BFST is upgrading the case investigative tool used across the OIG with the intent of extending usage options to entities outside of the OIG that have similar programmatic responsibilities.

Highlights

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

Technology Management Unit (TMU) is responsible for all computer related transactions within OIG, coordinating with the Department of Innovation & Technology (DoIT) on network access, as well as hardware and software requests. Database design and development, web development, computer training, and technical support are also essential functions provided by TMU. Functions completed by TMU are central to the success of the various units within the OIG.

TMU coordinated resolution of 4,225 OIG Help Desk inquiries during FY18. Another function of TMU is to complete data requests from federal, state, and local law enforcement agencies; 102 data requests were completed, of which many will result in dollars being returned to the state from court decisions and settlements. TMU staff also assisted with any issues related to complete replacement of all OIG printers. OIG's CASE system was migrated to DoIT's Shared Web Services. TMU also assisted with ongoing testing and implementation of new features and software related to the Enterprise Data Warehouse (EDW). Progress also continued on the State's Enterprise Resource Program (ERP) project, with TMU staff providing consultation on supporting system transitional issues, and across platform system integration concerns. Despite ongoing vacant positions and staff shortages, TMU has continued to deliver a high-level of technical consultation, programming and support services to the OIG.

Bureau of Fraud Science and Technology

Dynamic Network Analysis (DNA) Framework Development Initiative

The Bureau of Fraud Science & Technology (BFST) oversees maintenance and enhancement of the Dynamic Network Analysis (DNA) Framework. Under BFST's direction, the DNA development team continuously strives to adopt federal and state policy and regulation changes, provide creative data analytics on various mission-critical subjects, and add new routines to the DNA system. With the deployment of further features and modules, the DNA system has become one of the primary investigative and analytic tools for OIG. In FY18, the creation of more than 13,000 reports and jobs included provider profiles, recipient profiles, provider claim details, and recipient claim details. These reports and jobs provide comprehensive data analytics for auditors and investigators to use when researching potential fraudulent providers and recipients in their efforts to combat Medicaid fraud, waste, and abuse. The following modules or analyses are additions to the DNA system and are utilized to enhance the efforts of auditors and investigators.

Opioid Analysis

In recent years, the opioid epidemic has become a public health concern nationwide. The U.S. Department of Health & Human Services Office of the Inspector General (HHS-OIG) released a Toolkit to calculate opioid levels and identify patients at risk of opioid misuse or overdose. BFST incorporated the federal methodology and revised current routines to synchronize with federal guidelines and standards. The analysis of recipient opioid level and identification of recipients at risk of opioid misuse or overdose used an extraction of pharmacy claims data from the most recent five years. To allocate recipients into different opioid risk categories, such as Medium, High, or Extreme-risk, the morphine milligram equivalents (MME) per-day and the maximum of any 90-day average MME were calculated and applied. Other indicators, such as doctor-shopping, recipient death, cancer history information, and opioid antidote consumption, are included in the analysis. Based on opioid prescription volumes and frequencies, the identification of corresponding physicians helps auditors and investigators have a more complete picture of the opioid crisis.

The OIG is currently integrating algorithms to calculate patients' average daily morphine milligram equivalent (MME) dosages, which converts various prescription opioids and strengths into one standard value. MME values can be used to analyze prescription drug data and identify patients who may be misusing or abusing prescription opioids, placing them at increased risk for adverse or fatal events. This allows the OIG to identify recipients in need of additional case management (such as a Lock-In Program) or other follow-up. It also identifies practitioners who may be putting Medicaid recipients at risk by overprescribing these dangerous drugs. In an attempt to address the opioid epidemic, the State of Illinois passed legislation requiring prescribers to check the prescription monitoring program (PMP) prior to prescribing opiates. This law became effective January 1, 2018.

Executive Summary

Executive Summary Reports show pre-summarized information by selected topics, which provide a statewide overview to executive users. Under the Health Choice Summary section, monthly and yearly comparisons between MCO payments and FFS payments display the most recent five years. The comparisons are available for both county and statewide level by provider types, or by service category. Similarly, users can compare different health plans based on payment information for the Medicare-Medicaid Alignment Initiative (MMAI) program.

Provider Peer Comparison

Added to the DNA system in FY18 is the Provider Peer Comparison routine. Users of this routine can compare a provider's service and payment patterns, and use specified procedure codes for peer analysis. Descriptive statistics from this module indicate if a

provider falls outside the peer group norm for the same provider type and geographic region. Investigators are better able to quickly narrow down potential fraudulent providers through the use of this module.

Medicaid Verification

Often, OIG investigators are required to check if an individual is simultaneously a recipient of the Medicaid program and a provider or payee. Implementation of the new Medicaid Verification module assists in this process. Extraction of an individual's relevant information from the Medicaid program occurs by inputting recipient or provider IDs, full or partial names, and NPI. The system then searches the entire Medicaid system to determine if the individual is either a Medicaid recipient, provider, or both.

Audit Verification

A frequent challenge for OIG auditors is ensuring that previously audited claims from a desk audit, field audit, RAC audit, or provider self-disclosure are excluded from the new audit universe. When performed manually, this can be a time-consuming task. The Audit Verification database records all demographic information of previously audited providers and corresponding audit universes. Built into the DNA system, this innovative database eliminates the error-prone manual-checking process that determines whether there is a need for a new audit task based on historical data. In addition, the system guarantees the correct carve-out process and helps users retrieve audit data more easily if any questions should arise during future litigation.

Peer Review Inquiry Report

The DNA development team is collaborating with the Bureau of Medicaid Integrity (BMI) Peer Review unit to convert routine work into automated peer review reports in the DNA, which will significantly increase effectiveness and accuracy of results. Peer Review Reports are planned to increase from approximately 11 to 24 reports. These reports are provider-specific and will be utilized by staff who can use them to review prescribing patterns, procedure code use, and interrelated relationships between providers. Multiple reports populate an "all" feature or allow the user to populate specific interests such as procedure codes or diagnosis codes for a desired time frame. Additionally, generating reports for specific provider groupings, such as physicians, dentists, long-term care facilities, and nurse practitioners, will soon be possible.

Provider and Recipient Inquiries

The resulting layout for both Provider Inquiries and Recipient Inquiries switched from table to drop-down view. This change allows users to see the trends in payment, recipient and services, and top-ten paid procedure codes for each provider more easily. The change also enables a quick toggle function for different claim types, including drug, inpatient, Non Institutional Providers (NIPS), and outpatient for each recipient.

Investigative Case Management Initiative

An investigative CASE system is necessary to track the daily investigative activities, task completion and retaining supporting documentation in various media. The current CASE system supports approximately 90 Staff working on 3,000 to 5,000 current case investigation activities, and is the repository for over 360,000 cases. Entities external to OIG performing these tasks include the Illinois State Police, Attorney General's Office, as well as other state agencies.

Xanalys Investigation Management (XIM) is an investigative case software being procured to replace the current CASE system. The new XIM software will work seamlessly with OIG's Dynamic Network Analysis (DNA) system. The DNA system provides all OIG staff with "real-time" data analytics, link analysis, visualization analysis, and various other data metrics and research functionality. The DNA system runs on a SAS Enterprise Technology, acquired in 2008, and works directly with the HFS data warehouse, as well as other data sources.

Bureau of Fraud Science and Technology

Provider and Recipient Analysis Section (PRAS)

Within the Provider and Recipient Analysis Section (PRAS) of BFST is the Provider Analysis Unit (PAU) and the Recipient Analysis Unit (RAU). PAU is the triage unit for incoming Medicaid provider referrals and for monitoring medium and high risk provider-types one year prior to full enrollment (180-365 monitoring program). The Unit is comprised of five registered nurses and a nurse manager. Through the relationship with HFS-OIG and the NAC/MII, OIG staff is able to obtain valuable and prestigious educational training which adds value to the OIG. For example, two nurse analysts have become Certified Professional Coders and one is pursuing a Certified Program Integrity Professional (CPIP) certification in FY19 through the NAC/MII collaboration.[1]

Provider Analysis Unit

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

180/365

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

Highlights in FY18:

113 provider referrals received - of these:
- 76 medical providers analyzed
- 63 cases presented to Narrative Review Committee; 9 providers sent Narcotic Letter of Concern; 13 cases closed with no further action warranted as allegations were unsubstantiated

180/365 day monitoring program:

Non-Emergency Transportation, DME, Lab providers

169 providers monitored and analyzed - of these:
- 150 were enrolled
- 19 were disenrolled

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

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

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

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

Bureau of Fraud Science and Technology

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

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

Actions recommended by this committee may include:

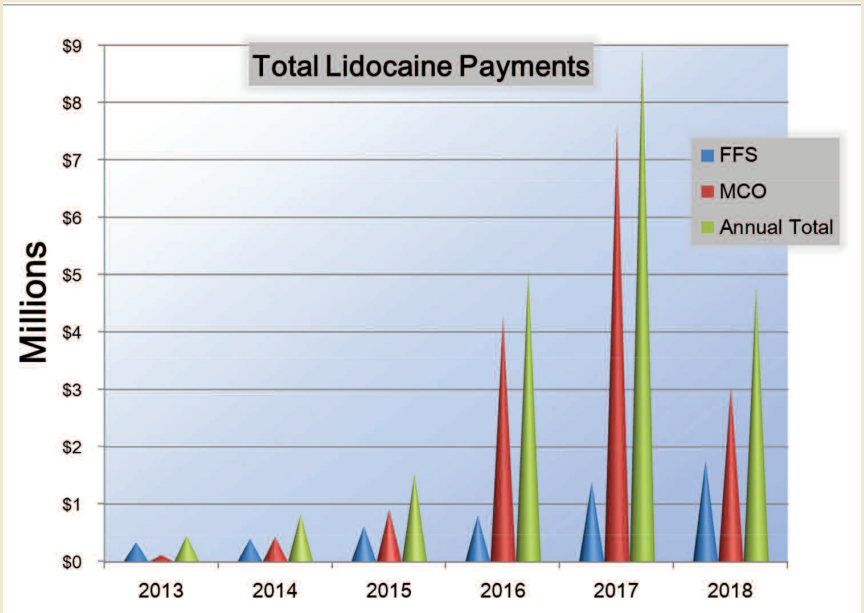
- Sending a letter of concern to the provider
- referral for an audit
- referral for a focused Peer Review
- referral to law enforcement for any suspected criminal violations
- imposition of a payment suspension
- recommendation for denial/disenrollment or additional monitoring of Moderate/High risk providers (180/365) recommendation to HFS administration for a policy change as evidenced to the following scenario:

A referral was received from another State alleging potential fraud of expensive topical anesthetic prescriptions. PAU nurse analysts identified there was little, if any, medical necessity to support the use, quantity and duration of the expensive prescriptions reviewed, suggesting that the product may or may not have been dispensed to recipients, signifying potential false billing practices. This case was referred to appropriate entities and is presently under investigation.

PAU's clinical review of this pharmacy revealed a significant spike in statewide prescribing of 5% Lidocaine and other expensive topical anesthetics. As a result, PAU performed data analysis on the specific therapeutic class of this drug, and identified additional providers with questionable prescribing practices. These providers are currently being investigated for potential fraud, waste and abuse.

Below is a snapshot showing the substantial increase in payments for specific therapeutic class for topical anesthetics since 2013:

A cost analysis completed by the HFS pharmacy unit revealed 5% Lidocaine costs the Department $6 per gram, while 4% Lidocaine costs $1 per gram. Due to the tenacity of the PAU nurse analysts and the substantive quality of their investigation and findings, OIG-PAU and HFS's pharmacy unit collaborated to enact a change in Department policy. In April of 2018, quantity limits were placed on 5% Lidocaine. In addition, a prior approval requirement was put in place for additional quantities of the prescription. HFS' pharmacy unit was also able to negotiate a better price for the medication, adding additional cost savings to the State of Illinois. This was submitted as a Rapid Results Project in FY18 and HFS-OIG will have total cost savings to be reported in FY19.



*** MCO payment amounts are currently being re-validated by administration and IT staff and are unable to be 100% validated at this time.**

Bureau of Fraud Science and Technology

Recipient Analysis Unit (RAU)

The purpose of the Recipient Restriction Program (RRP) is to identify, detect and prevent abuse of medical and pharmaceutical benefits, based on set parameters in federal and state regulations, as well as HFS policy. RRP uses the DNA Predictive Analytic model and profile-reporting system for data that identifies overutilization of services by enrolled recipients. Other referral sources include tips regarding potential recipient fraud or abuse from the OIG website, Medicaid Fraud Hotline and calls to the RRP hotline. When recipients utilize multiple prescribing providers and multiple pharmacies, they are at a significant risk for adverse and potential life threatening situations. The RRP is designed to promote recipient safety through care coordination, often referred to as a Lock-In Program. Specific indicators will trigger Lock-In Program intervention, and also, in the case of a fee-for-service recipient, a single primary care provider. The OIG has established protocols for the identification, restriction, monitoring and periodic evaluation of recipients suspected of abusing pharmacy benefits or over-utilizing covered medical services. Additionally, one RAU analyst is dedicated part-time to evaluating recipients who have been identified through data analytics or by referrals, as being prescribed the "Holy Trinity" or a "Vegas Cocktail".[2] In FY18, this analyst reviewed 701 recipients.

Top Accomplishments in FY18:

- 2,835 cases reviewed - 701 of these were Vegas Cocktail cases
- 378 recipients restricted in FFS
- 816 restrictions recommended to MCOs
- 2,030 total number of FFS restrictions as of 6/30/18
- Total cost avoidance for RRP: $2,209,495

Given the transition to Managed Care, OIG provides assistance to MCO partners in developing and implementing their Lock-In Programs. Using HFS guidelines, most MCOs implemented a pharmacy Lock-In Program; others implemented both primary care provider and pharmacy Lock-In Programs.

[2] "Vegas Cocktail", aka "Holy Trinity" is a dangerous recreational drug combination consisting of 3 drugs taken together to induce extreme euphoria. The combination can cause respiratory depression and death.

Bureau of Internal Affairs

Section

3

Bureau of Internal Affairs

*The **Bureau of Internal Affairs** (BIA) investigates misconduct of State employees and contractors, while also monitoring the safety of employees and visitors in Department buildings. BIA is charged with security oversight of HFS, which involves conducting assessments on threats received from employees, non-custodial parents, clients and civilians.*

BIA ensures compliance with State regulations as it pertains to new employee hiring by obtaining and researching the criminal history information of all applicants. These background checks are required for all Staff who needs access to proprietary data sources.

The Bureau is responsible for monitoring employee Internet traffic and the use of State resources. By utilizing a variety of investigative methods, BIA identifies fraudulent staff activity and security vulnerabilities. BIA conducts forensic examinations of Department Personal Computers (PCs) when an investigation warrants this action.

The Bureau prepares investigative reports and shares the findings with the agency's division administrators, the Bureau of Labor Relations, and with state and federal authorities if necessary. Once an investigation is completed and the report is published, the Division Administrator or the Bureau of Labor Relations are required to report any action taken back to the Bureau within 30 days.

Investigations conducted by the Bureau can include inquiries into public aid fraud, criminal code offenses, contract violations, and criminal and non-criminal work-rule violations. Internal investigations often reveal violations of work rules or criminal statutes. A single investigation may cite multiple violations, and involve multiple employees or vendors. Resolutions may include resignation, dismissal, suspension, or reprimanding.

Highlights

Investigations

Total Staff: 10

Open/Active cases: 32[1]

Total cases opened: 492

Total completed cases: 520

Average Case Processing Time:

Background Investigations – 2.98 Days

General Investigations – 69.29 Days

Investigation Outcomes

BIA received an anonymous complaint on May 24, 2016, alleging that a Human Resource Specialist was utilizing HFS computer equipment for personal school work during work hours. The employee admitted to, and Agency forensic imaging confirmed, that the employee forwarded a large number of non-work related materials (e-mails, pictures and documents) from the employee's home e-mail to the work computer, and additionally printed personal e-mails during the workday. The employee acknowledged that the actions were in violation of Department policy and subsequently received a 30 day suspension on July 28, 2017.

On August 18, 2017, while performing maintenance on computers used by the BIA, it was discovered that an Information Systems Analyst I had accessed computers used by the Internal Affairs Chief and Staff. Forensic examination of the employee's computer indicated that the employee had also accessed the computers of the Administrator of Healthcare and Family Services, the Division of Personnel and Administrative Services, and the personal drive of a Division of Child Support Services employee. The investigation determined that the Information Systems Analyst violated multiple HFS Employee Handbook policies.[2] This

[1] Total represents 26 Record Keeping Cases and 6 Active Investigations.

[2] (EH) 605.1Section 605.1a #21 – Misuse of Computer Systems and Employee Handbook Section 605.1a #3 –Inappropriate Behavior.

employee held a sensitive position, having nearly unlimited access to the HFS computer system. The employee used their position to access unauthorized folders, which were not part of official duties and could not provide an explanation as to why they were accessed. The Information Systems Analyst I was discharged on April 6, 2018.

BIA received a complaint on April 23, 2018, alleging that a Public Service Administrator (PSA) was frequently tardy, used extended lunch periods, and had falsified time and attendance records. The investigation determined that the employee violated multiple HFS Employee Handbook policies: failing to report to work at the regularly scheduled work hours on 29 separate instances, extended lunch periods on 11 instances without taking appropriate authorized Available Benefit Time, allowing a subordinate to falsify Employee Daily Time Logs, and failing to address the employee when they did not report to work on time.[3] The Public Service Administrator received a 14-day suspension on August 20, 2018.

BIA conducted an Internet use review and determined a Medical Assistance Consultant III (MAC) appeared to have excessive, non-work related internet usage. Through the employee's own admission and forensic evidence, the investigation determined that the employee violated multiple Employee Handbook policies when the employee used the Department's equipment and resources for strictly personal reasons.[4] The employee admitted to using Agency resources to make purchases on shopping websites and to access their personal e-mail and banking accounts. The Medical Assistance Consultant III received a 1-day suspension on March 5, 2018.

BIA received a complaint on June 21, 2017, which alleged an Office Coordinator in the Division of Child Support Services displayed inappropriate behavior for the workplace when being counseled by the employee's supervisor. The investigation determined that the Office Coordinator was discourteous to the supervisor and inappropriate for the work place by using profane language when being counseled by the supervisor, displaying frustration by pounding on their supervisor's desk, and continued slamming file drawers while exiting the work area. The Bureau of Internal Affairs received another complaint on August 14, 2017, that the same Office Coordinator was discourteous to an SPSA and a Security Officer in the Division of Child Support Services. The investigation resulted in the Office Coordinator being discharged on May 7, 2018, as a result of multiple Employee Handbook violations.[5]

On April 18, 2018, during routine monitoring of the HFS computer system it was discovered that a Human Service Case Worker was utilizing Department equipment and resources for managing an ESPN fantasy baseball team, visiting the University of Illinois' website, and sending personal e-mail messages. The forensic examination located 423 personal e-mail messages that were sent by the employee. Upon admission by the employee that they used Department equipment to monitor and make updates to an ESPN Fantasy Baseball Team, the employee received a 5-day suspension on August 21, 2018.[6]

An anonymous complaint was received by BIA on April 7, 2018, alleging that a Child Support Specialist Trainee was abusing the State of Illinois e-mail system. During the investigation, the forensic

[3] (EH) 605.1 #2 Repeated and Excessive Tardiness or Absenteeism and/or Violation of the Affirmative Attendance Policy, (EH) 605.1 #5 Unsatisfactory Work Performance or Neglect in the Performance of Duties, and (EH) 120.5 Signing In and Out.

[4] (EH) 605.1 and 635, #21 Misuse of Computer Systems and Internet Security.

[5] (EH) 605.1 #2 Repeated and Excessive Tardiness or Absenteeism and/or Violation of the Affirmative Attendance Policy, (EH) 605.1 #5 Unsatisfactory Work Performance or Neglect in the Performance of Duties, and (EH) 120.5 Signing In and Out.

[6] (EH) 605, Personal Conduct , 605.1, #1 Violation of Work Rules, (EH) 605.1, #3, Inappropriate Behavior or Discourteous Treatment to Others, (EH-605.1), Personal Conduct/Violation of Work Rules.

examination located 528 non-State of Illinois related e-mail messages located in the employee's sent folder. For using the State of Illinois internet for personal reasons, the Child Support Specialist Trainee received a 7-day suspension. [7]

On May 25, 2017, BIA received a complaint alleging that a Public Service Administrator (PSA) had sexually harassed an employee both on and off the work site. Upon questioning, the PSA denied having a personal relationship with the co-worker with the intention to mislead and deceive investigators. Upon further questioning by BIA, the PSA admitted to having a relationship with the co-worker and coworker's husband. The PSA's intentional false statements constituted a failure to cooperate with an IA investigation, and therefore the PSA received an oral reprimand on September 21, 2018.[8]

BIA received a complaint on March 13, 2017, alleging that an Office Associate was utilizing State resources for personal use. The employee was allegedly sending job applications to other state agencies through Certified Mail, at the Department's expense. Upon questioning, the employee admitted to sending applications and bid forms approximately three times via Certified Mail at the Department's expense. The Office Associate received an oral reprimand on November 15, 2017.[9]

In FY18, BIA completed a total of 520 Department employee and contractor investigations. Of this total, 443 of these investigations were employee background checks. During routine criminal background checks on new and transferring employees, BIA confirmed that five employees did not report all convictions on the State of Illinois Self Disclosure of Criminal History form (CMS 284B). Each of the five employees received a 1-day suspension. In addition, three additional applicants were not offered employment because they were not truthful on their CMS 284 A&B when they applied to the Department.

[7] (EH) 605, Personal Conduct , 605.1, #1 Violation of Work Rules. (EH) 605.1, #3, Inappropriate Behavior or Discourteous Treatment to Others. Employee Handbook (EH-605.1), Personal Conduct/Violation of Work Rules.

[8] (EH) 605.1, #1Violation of Work Rules & #3 Inappropriate Behavior or Discourteous Treatment of Others.

[9] (EH) 625.1-Use of Office Equipment; 610.1-Conflict of Interest & Governor's Executive Order #4-Conduct Unbecoming a State Employee.

Bureau of Investigations

Section

4

Bureau of Investigations

Investigations, SNAP Fraud Unit, WARP

The Bureau of Investigations (BOI) investigates allegations of suspected fraud, waste and abuse against the Medicaid system by both recipients and providers. The BOI may pursue criminal prosecution and administrative sanctions against any recipient and provider under the OIG's jurisdiction[1] for Child Care Fraud, Eligibility Fraud, and Provider Fraud.

Bureau of Investigations Highlights

Identified Overpayment: $7.7 million
Completed Cases: 824 (of these 615 were founded, 209 were unfounded)
Referred for Prosecution with the State's Attorney: 12
Open/Active cases: 3,364
Onsite Visits: 109
Child Care Overpayment: $85,583
Total Staff: 27

Investigations

During the process of investigating allegations of provider and recipient fraud, the Bureau works hand-in-hand with state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. The Bureau is also responsible for processing criminal background fingerprint results for all High-risk providers enrolling as Medicaid providers. BOI investigators are also charged with conducting on-site inspections of High-risk providers. Investigators conduct on-site reviews of transportation and Durable Medical Equipment (DME) providers. The main goal of these reviews is to ensure that the provider exists, that their location of business is valid, and that all paperwork to conduct business in Illinois has been properly filed with the appropriate entities.

In FY18, the BOI identified $15.2 million in potential Medicaid recoveries due to total ineligibility. Unfortunately, there is no current process to collect these monies.

Child Care Fraud

Investigations are conducted when recipients or providers are suspected of misrepresentation of facts regarding their eligibility for the Child Care Program. Recipient fraud can occur for a variety of reasons: earnings from providing child care are not reported as income, child care needs are misrepresented, or child care payments are stolen or diverted. Provider fraud occurs when claims are made for child care not provided or for care provided at inappropriate rates. The results of these OIG investigations are provided to DHS's Bureau of Child Care and Development (BCCD). In cases where an overpayment has been identified, it is referred to DHS's Bureau of Collections (BOC). Once BOC establishes the debt, they refer it to the Illinois Office of the Comptroller for involuntary withholding. Additionally, should the debt become delinquent, it is referred to a private collector. Cases involving large overpayments or aggravated circumstances of fraud cases are sometimes referred for criminal prosecution to a State's Attorney or a U.S. attorney, or to the DHS's BOC for possible civil litigation.

Investigation Outcomes

An investigation was completed for a child care case that alleged that the client received child care payments in her mother's name, but reported that she resided with her children's father who had a means of income. The investigation revealed that the client resided with her children's father while he was gainfully employed, but failed to report it. The investigation could not substantiate that the client

[1] 305 ILCS 5/12-13.1 Inspector General: In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct, the Inspector General shall oversee the Department of Healthcare and Family Services' and the Department on Aging's integrity functions.

was receiving child care payments in her mother's name. An estimated child care recipient overpayment totaled $9,972 from December 2011 through May 2016.

An Investigation was completed for a child care recipient case, which alleged that a client falsely reported the identity of her child care provider to the Department of Human Services from April 2014 through March 2017. During this time period, the provider, who is the client's father, was incarcerated. The investigation revealed the client submitted numerous signed redeterminations and certifications for child care with the incarcerated provider's name listed. An estimated child care overpayment was totaled at $17,465 for the child care services provided.

Medical Card Fraud

Investigations are conducted when recipients or providers are suspected of misuse or misrepresentations concerning medical programs. Recipient fraud occurs when recipients are suspected of misusing their medical cards or when medical cards are used improperly without their knowledge. Examples of recipient fraud include: loaning a medical card to an ineligible person, visiting multiple doctors during a short time period for the same condition, obtaining fraudulent prescriptions, selling prescription drugs or supplies for personal gain, or using emergency room services inappropriately. Founded cases are referred to the Recipient Restriction Program.

Investigation Outcomes

An investigation completed for client eligibility case alleged the client came to the United States illegally and had a child, which they signed up for Medicaid before returning home to Syria. The investigation revealed that the client flew to the United States on September 10, 2014 and left the country on February 21, 2015. The client had a child in the U.S. while on a travel visa, which was issued for one month only, to visit family. Before leaving the U.S. via O'Hare International Airport, the client admitted in an outbound interview to Immigration and Customs Enforcement that she failed to report her pregnancy to U.S. Officials when obtaining the U.S. Travel Visa and that Medicaid paid for the birth of her child. The client also admitted that she was a Treasury Officer in Iraq and her husband was an IT manager for an oil company. The client's Medicaid payments totaled $9,335. Immigration and Customs Enforcement denied a second Travel Visa request from the couple in December 2016, due to the concealment of her pregnancy from U.S. Officials in 2014.

Provider Fraud

Provider fraud occurs when claims are submitted for services not provided or for services provided at inappropriate rates. Depending upon the results of the investigation, the case may be referred internally to the Provider Analysis Unit (PAU) for further review.

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

Bureau of Investigations

SNAP Fraud Unit

Within the BOI, the SNAP Fraud Unit works diligently to ensure the integrity of the federal Supplemental Nutrition Assistance Program (SNAP). Recipients who intentionally violate SNAP rules and regulations are disqualified from the program for a period of 12 months for the first offense, 24 months for the second offense, permanently for the third offense, and 10 years for receiving duplicate assistance and/or Trafficking. Cost avoidance on SNAP cases is calculated based on the average amount of food stamp standards during the overpayment period multiplied by the length of the disqualification period.

Bureau of Investigations – SNAP Highlights

Referrals received: 701
Case reviewed completed: 1,482
Identified Overpayment: $1.8 million
Cost avoidance: $2.0 million
Disqualification Hearings Held: 849
Disqualifications: 787
Open/Active cases: 2,168
Total Staff: 3
Administrative Hearing Decisions Rendered: 453, 451 of these decisions, or 99.6%, were found in favor of the OIG.

Investigation Outcomes

A referral was received from a Family Community Resource Center (FCRC) requesting BOI to investigate a recipient who refused to comply with the Division of Child Support Enforcement when the non-custodial parent was earning over $5,000 per month and the recipient reported zero income for herself. The investigation revealed the recipient failed to report her spouse, the children's father and the non-custodial parent, had been in the home and they had both been gainfully employed. As a result of the recipient knowingly hiding the true household composition and total household income, a total SNAP overpayment of $20,121 was identified.[2] The investigation was completed in March 2018, was processed by DHS Bureau of Collections (BOC) in April 2018, and is currently being recouped.

Upon review of a recipient eligibility referral received by OIG, a BOI investigation determined that the recipient did not report the presence of the responsible relative, the father of recipient's children, living in the home. The responsible relative had resided in the home since 2010 and had income earned from self-employment. A SNAP overpayment was estimated at $44,553 from January 2011 through May 2018. This case was referred to BOC. This case may be considered for criminal prosecution.

A referral was received alleging a recipient resided with the father of her children and provided altered pay stubs to the FCRC in order to qualify for benefits. A BOI investigation confirmed that the recipient also failed to report she was married and confirmed the pay stubs submitted to the local office were altered. The recipient knowingly failed to report true household income which resulted in a SNAP overpayment totaling $23,515 from January 2011 through December 2017.[3] The investigation was completed in November 2017, processed by the FCRC in January 2018, and is currently being recouped by the BOC.

Another example of a household composition case investigated by BOI revealed that a recipient failed to report that her children's father had lived in the assistance unit with her and their children since November 2011. Additionally, it was found that the children's father had income from employment. The

[2] Overpayments were identified as follows: $4,715 for the period of 06/13-11/13, and $15,406 for the period of 02/16-03/18 totaling $20,121.

[3] SNAP overpayments were identified as follows: $11,942 for the period of 01/11 - 10/14, and $7,354 for the period of 01/15 – 09/16, and $4,219 for the period of 01/17 – 12/17 totaling $23,515

investigation was completed in April 2018 and submitted to the FCRC. The FCRC calculated that for the period of November 2011 through March 2018, the recipient received an overpayment of $59,547 in SNAP benefits. This case was referred to BOC. This case may be considered for criminal prosecution.

One successful criminal prosecution case resulted from a referral in which a BOI investigation confirmed that a SNAP recipient failed to report her husband had earned income while residing with the recipient and their children from July 2012 to September 2014. The BOI investigator was able to place the husband in the household through his employment records, state income taxes, postal verifications, school verifications, and Illinois Secretary of State Records. The recipient's husband's own admission confirmed the findings. Per a sentencing order filed in Fulton County, Illinois on May 31, 2018, the recipient was charged with a Class A misdemeanor for theft. The Judge also imposed $11,000 in restitution, and sentenced the recipient to two years of probation and 60 days in the Fulton County Jail.

The Welfare Abuse Recovery Program (WARP)

Within BOI, WARP serves as the central fraud intake unit for the entire OIG. WARP processes fraud and abuse referrals received directly from local DHS offices, alleging potential fraud by recipients and providers. Referrals are also received by the general public via a hotline[4], an online intake referral form, as well as direct referrals from state and federal agencies and law enforcement entities.

WARP conducts thorough research on suspected fraud referrals by accessing multiple databases from a variety of sources including, but not limited to, DHS, Secretary of State, Illinois State Police (ISP), DPH vital records, employment and unemployment history. WARP takes multiple steps in gathering, reviewing, and analyzing information regarding the referral and processes the referral in the OIG's case tracking system. WARP ultimately determines how and where to route cases, based on the findings. Cases can be closed out due to lack of merit or information, or sent to BOI investigators for further review and investigation. Cases can also be sent to FCRC for additional follow up, or sent to BOC to establish a dollar amount and time frame for an overpayment. When BOC receives a referral, they respond to the OIG with the appropriate overpayment amount.

Warp Highlights

Referrals received: 22,438

Staff: 5 and 2 Graduate Public Service Interns (GPSI)

In FY18, WARP received a total of 22,438 allegations of potential fraud, waste and abuse. These inquiries were received through phone calls, internet, mail, and e-mail. Of these, 360 cases were reviewed and a total of $940,229 in SNAP and TANF overpayments were established.

Given the volume of fraud referrals received, the backlog of pending investigations into allegations of fraud remains large. All allegations of fraud against recipients are set up by WARP, researched and vetted through a variety of proprietary State and Federal databases, and routed to the Bureau of Investigations Supervisor, to assign to Investigators. Based on staff vetting and research, some referrals can be completed without an interview or field visit, based on current case information and electronic verification. Through a CMS Rapid Results project

[4] 1-844-ILFRAUD/ 1-844-453-7283 and https://www.illinois.gov/hfs/oig/pages/reportfraud.aspx

an Executive I position was established for WARP. This position will expedite the process, eliminate unnecessary and unfounded referrals routed to BOI investigators and will save time and funding that otherwise would have been spent on additional investigative staff and/or overtime. Once this position is filled, the new procedure for researching and vetting incoming fraud allegations will be streamlined and more efficient.

Recipient Program Overpayments	
Recipient Program	Total Overpayments Established
BOC Local Office SNAP	$908,876
BOC Local Office TANF	$31,353
Total:	$940,229

Bureau of Medicaid Integrity

Section

5

Bureau of Medicaid Integrity

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

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

Audit

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

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

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

- **Desk Audits** involve audit findings based mostly on the use of data analytics and algorithms that electronically analyze specific billing and reimbursement data. The OIG verifies the data outcomes using applicable law, regulations, and policy.

Highlights

Audits Initiated: 856

Audits Completed: 1,170

Re-Audits: 4

Total Overpayments Collected: $13.5 million

- **Field Audits** require a manual review of medical or other documentation by auditors. Field Audits also use data analytics, but require a more thorough verification process by qualified professionals.
- **In-House Field Audits** are mirrors to the same processes and procedures as a desk audit other than the fact that the auditor or team of auditor(s) conducts an on-site visit prior to the audit being commenced.
- **Self-Audits** involve audit findings based upon external and/or internal referrals or by internal OIG data analytics. Self-Audits require the provider to review all audit documents and schedules to determine agreement and/or disagreement with potential overpayment findings. A reconciliation process is implemented until all audit findings are validated and finalized.
- **Self-Disclosure Reviews** involve the identification of irregularity in the billing practices of a provider. In appropriate circumstances, the OIG requires a provider to conduct its own investigation and overpayment self-disclosure. The OIG will verify the overpayment amounts through data analytics and professional review. The Self-Disclosure Protocol Notice can be found at the following link: http://www.illinois.gov/hfs/oig/Documents/ProviderSelfDisclosureProtocol.pdf.
- **Audit Sampling and Extrapolation** may involve the use of sampling and extrapolation. Using statistical principles, the OIG selects a valid sample of the claims during the audit period in

question and audits the provider's records for only those claims. The OIG then calculates an overpayment amount by extrapolating the findings of the sample to the overall universe.

External Contract Vendor Auditors

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

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

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

In FY18, The Bureau's **Audit Section and the External Audit vendors** conducted a total of 1,170 audits on Medicaid providers to ensure compliance with the Department policies. The Audit Section reviews various records and documentation, including patient records, billing documentation and financial records. Deficiencies noted because of these audits may result in the recoupment of any identified overpayments. The OIG collects the overpayment in full or via installment payments received from the provider. In FY18, the total amount of Overpayments collected was **$13.5 million** which is comprised over overpayments identified in FY18 and installment payments received from prior year audits.

FY18 Audit Initiatives

- **Audit Package Implementation**

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

- **Electronic Health Record (EHR) Audits**

  The State of Illinois Department of Healthcare and Family Services is to comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act). HFS-OIG is mandated to implement an annual Electronic Health Information Technology Auditing Plan to ensure that all Eligible Professionals (EPs) and Eligible Hospitals (EHs); successfully demonstrate meaningful use of certified EHR technology. The OIG performs audits of a random sample of all EP/EH providers to ensure that providers who have attested to the adoption, implementation, or upgrade (AIU) of certified EHR technology have the adequate documentation to support the AIU efforts and to ensure that appropriate federal incentive payments for EHR implementation have been made to these provider(s). In FY18, the OIG performed 75 audits of EHR eligible professionals for AIU certification. All provider(s) during this audit period attested and were certified as meeting federal AIU requirements.

  In FY19, the OIG will continue efforts to audit EHR providers for AIU requirements in addition to beginning efforts to audit eligible

professionals and eligible hospitals for Meaningful Use (MU) requirements. The OIG is planning on conducting audits on at least 10% of all EP and EH providers and 100% of providers who are determined to be High-risk providers (as determined by risk scores defined in the HFS-OIG EHR Audit Plan).

- **Hospital Global Billing Payments**

  In FY18, the OIG performed 112 audits to identify and potentially recover **$800,000** in overpayments made by the Department to hospitals who billed the professional component of a laboratory or X-ray service in addition to a physician billing the professional component for the same recipient on the same date of service with the same procedure code. Hospitals, as a part of this initiative, have made successful efforts to fix their internal billing systems to ensure that these global billings do not occur in the future. The OIG is also working with these hospitals in receiving global billing self-disclosures to remedy this duplicate payment situation.

  Importantly, beyond recovering overpayments, the Global Billing Initiative established a positive and transparent process that allows the hospitals to review their own internal billing processes. Further, as a result of the self-audit, several hospitals implemented changes to their internal billing processes to prevent overpayments from occurring in the future. As a result, the Global Billing Initiative process has resulted in an estimated cost-avoidance amount of approximately $500,000 for FY18.

- **Prevent Payment for Deceased Recipients**

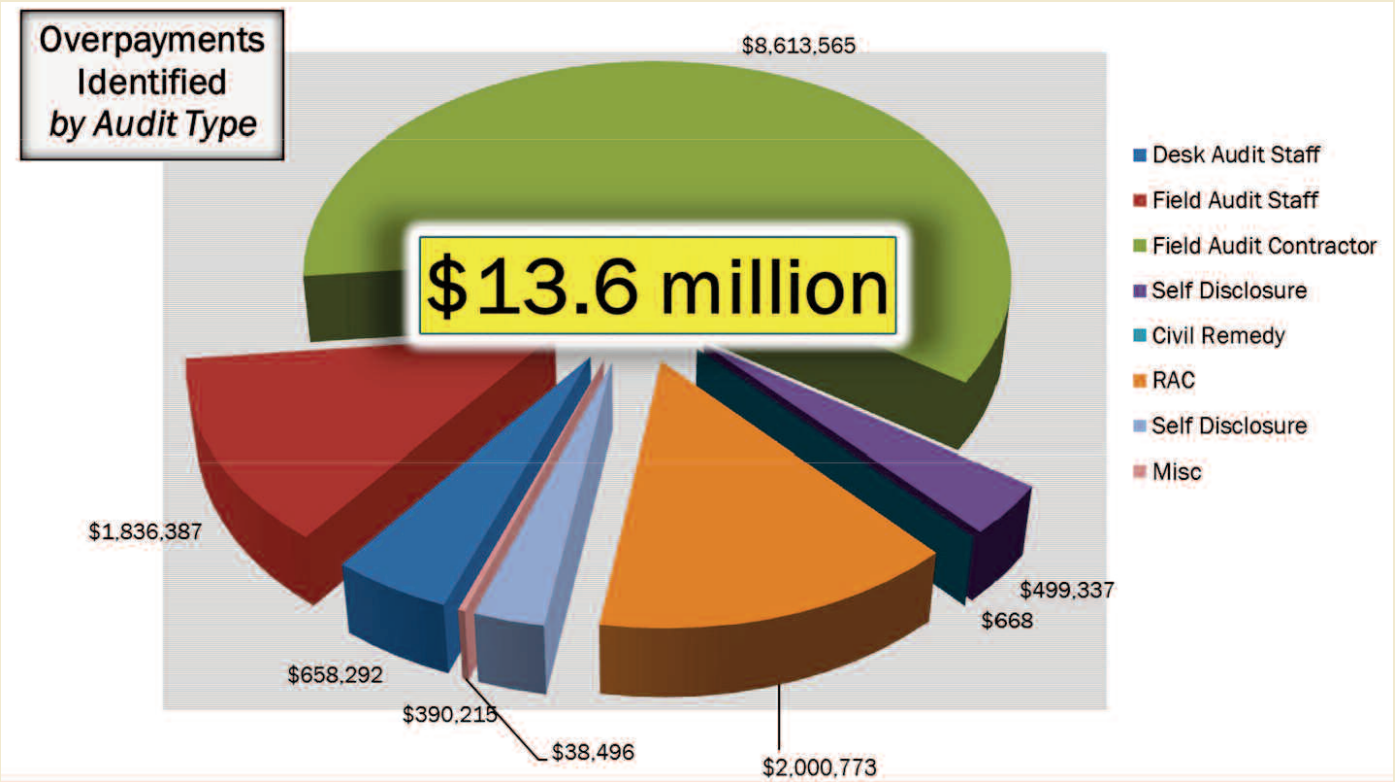
  In FY18, the OIG continued initiatives focused on areas of identified Program vulnerabilities. This includes preventing payments and recovering overpayments made for deceased recipients. In FY18, the OIG performed 62 audits to identify and recover **$63,000** in overpayments made by the Department for deceased Medicaid recipients.

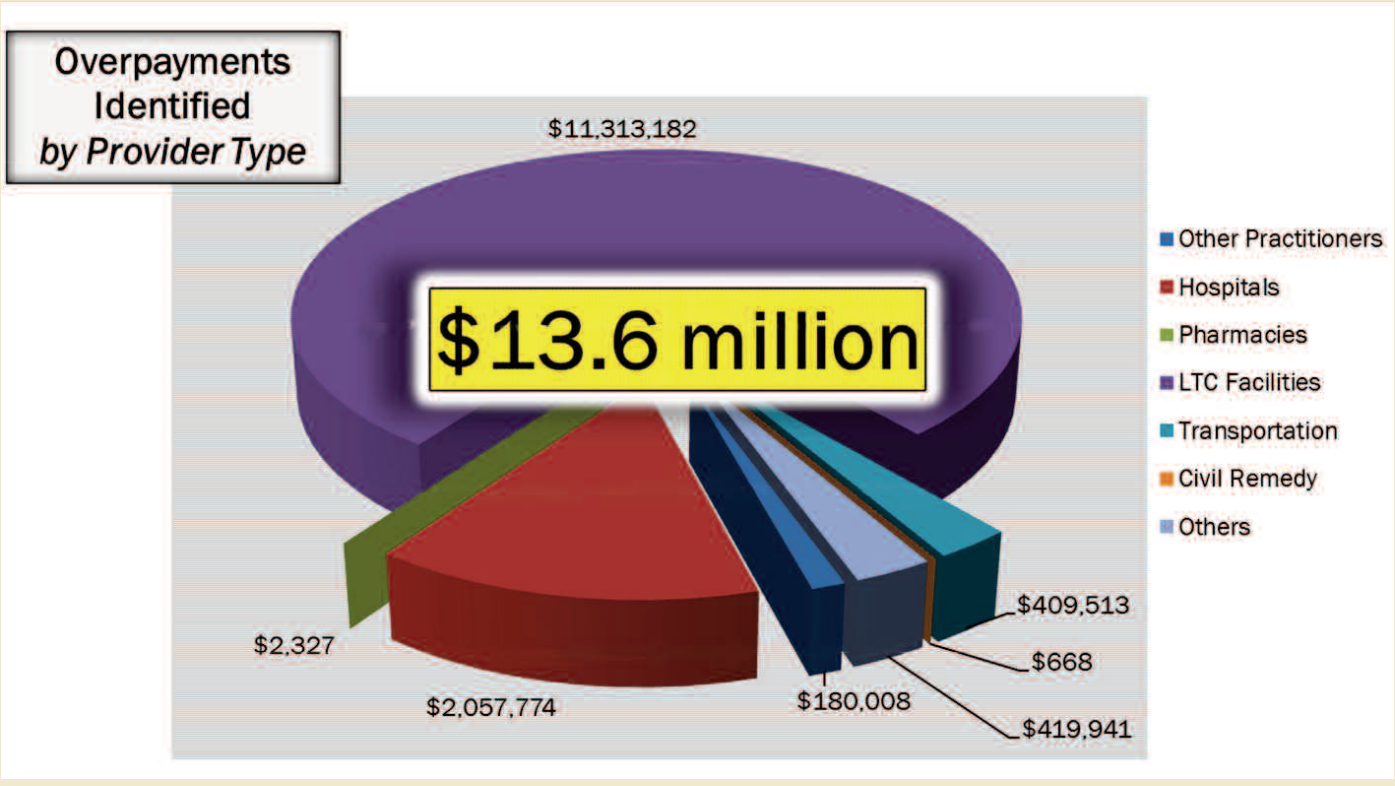
  Further, the OIG conducts outreach to provide education on healthcare fraud laws and Department regulations pertaining to the improper billing for payments for deceased recipients. When appropriate and when the audit provides evidence of improper conduct by a provider, the OIG has invoked its authority to sanction providers through payment suspensions and terminations from participation in the Medicaid Program. Importantly, as part of the OIG evaluation of these cases, OIG identifies instances of credible allegations of fraud and appropriately refers the cases to law enforcement partners for further criminal investigation.

- **Transportation Audits**

  In FY18, the OIG performed **254 audits** to identify and recover **$167,307** in overpayments made by the Department for transportation providers who billed for services during an inpatient stay not covered by HFS policy, duplicate transportation billings and loaded mileage billings. Loaded mileage is where there is more than one recipient in the same vehicle at the same time/trip and the provider bills HFS for both recipients. According to HFS policy, the transportation provider can only bill for one recipient therefore the billings for the additional recipient is a loaded mileage overpayment. OIG continues to run this algorithm audit on a yearly basis and is currently working with transportation providers to ensure HFS policies are followed and these types of erroneous billings do not occur in future billings to the Department.

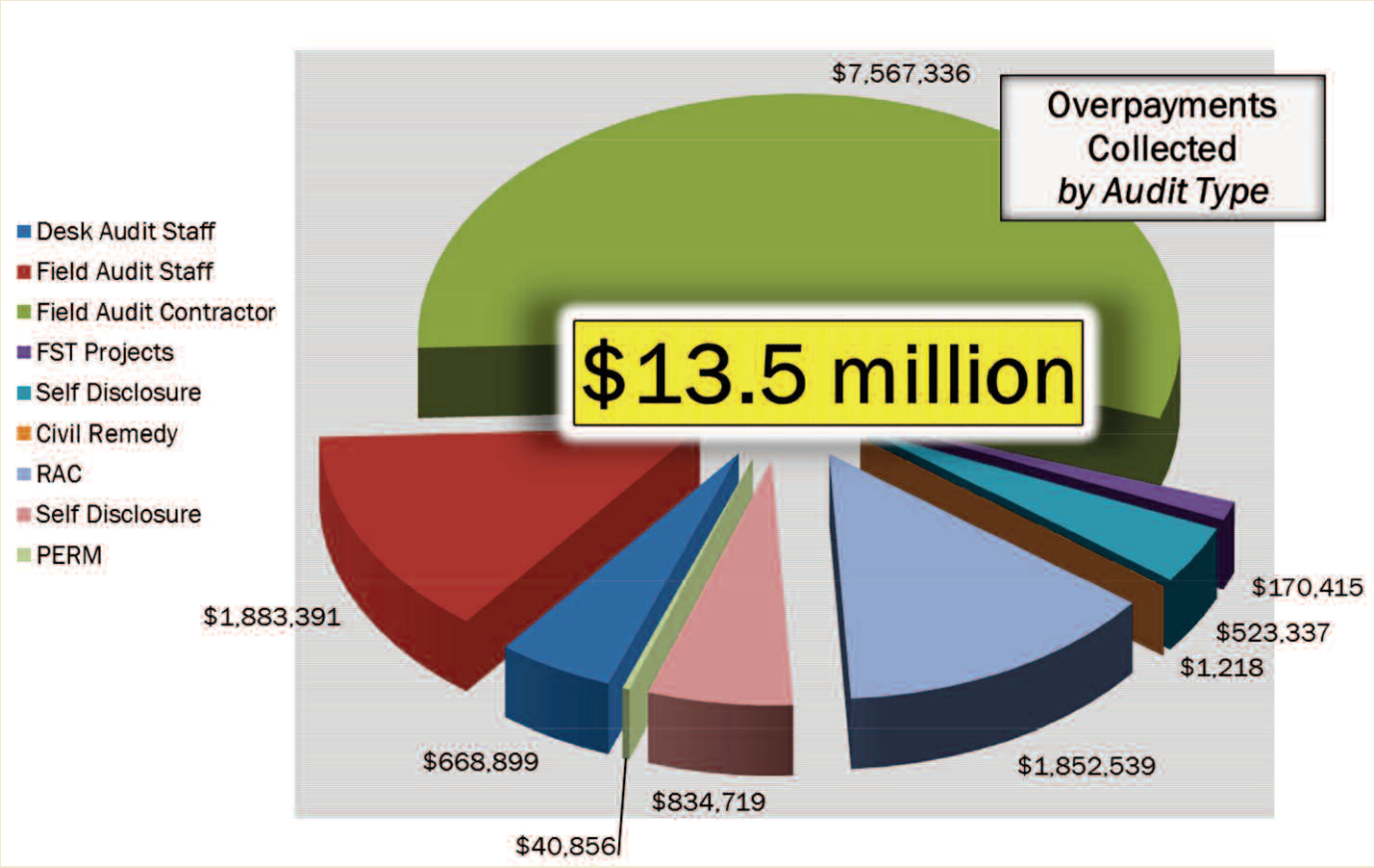
The following charts identify the number of audits and the amount of overpayments identified and collected in FY18 by provider type and by audit type.

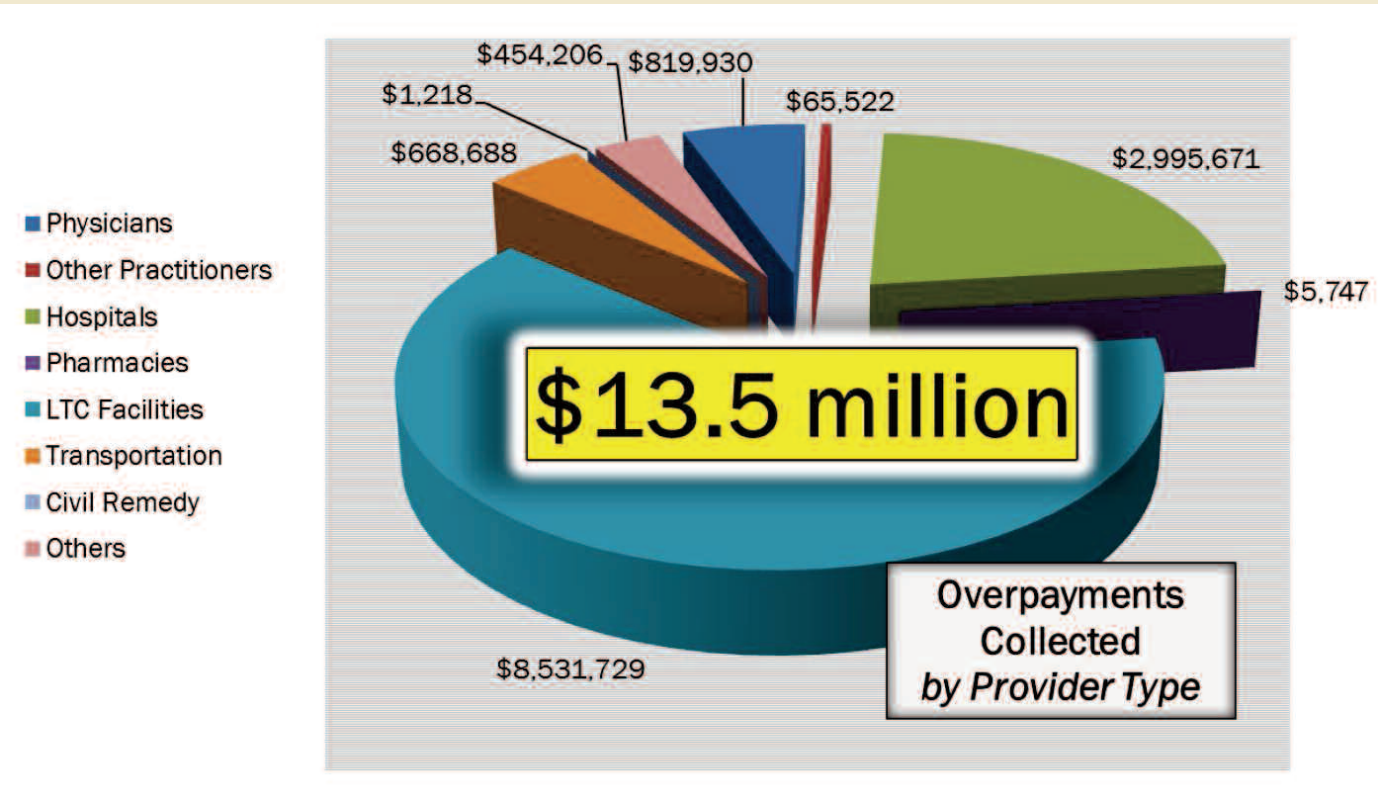




These figures include adjustments made to receivables when required.

Bureau of Medicaid Integrity





FY19 Audit Initiatives

In addition to the continuation of the FY18 audit initiatives, the following will be additional OIG audit initiatives for FY19:

- **Behavioral Health, Laboratories and Hospice Audits**

  The Audit Section will be working with the Universal Program Integrity Contractor (UPIC) to identify overpayments made to providers of Behavioral Health, Laboratories and Hospice services. These audits will be expansive field audits that will be conducted in a joint effort to combat fraud, waste and abuse within these provider types.

- **Durable Medical Equipment Audits**

  The Audit Section will be conducting audits on Durable Medical Equipment (DME) providers to identify issues of non-compliance with HFS policy and procedures. The audits will be focusing on services provided that are direct-shipped to the recipients, wheelchair/wheelchair supplies, diabetic supplies and other types of services.

- **Expansion of Long-Term Care Audits**

  The Audit Section, in conjunction with the CPA vendors and the RAC vendor, will be conducting financial audits on a wider population of LTC facilities across the State of Illinois.

- **MCO Contract Compliance Audits**

  The Audit Section will be working closely with the Managed Care Organizations' Special Investigative Units (SIUs) and the Bureau of Managed Care to perform Contract Compliance Audits. These audits will consist of identifying program integrity issues and discrepancies within the MCO contracts in regards to services being provided to the enrollees and what the deliverables are within each contract.

LTC-ADI

The Department is responsible for the Medicaid Long-Term Care (LTC) Program for approximately 55,000 eligible Illinois residents in over 738 nursing facilities. Illinois residents can apply to the LTC Program to have the State pay for their long-term nursing home services. Individuals are eligible for such assistance if they have less than $2,000 in resources and have not made unallowable transfers in the last five years.

While all states are required to perform asset transfer look-back reviews pursuant to the Deficit Reduction Act of 2005, Illinois is the only state in the nation with a dedicated Long Term Care-Asset Discovery Investigations (LTC-ADI) Unit of this size. This is also the only Unit to have a review look-back period of five years on asset reviews. As such, Inspector General Hart presents nationally about the successes of the Unit, its processes, and its cost savings to the tax payers of the state of Illinois. The unit is responsible for ensuring that

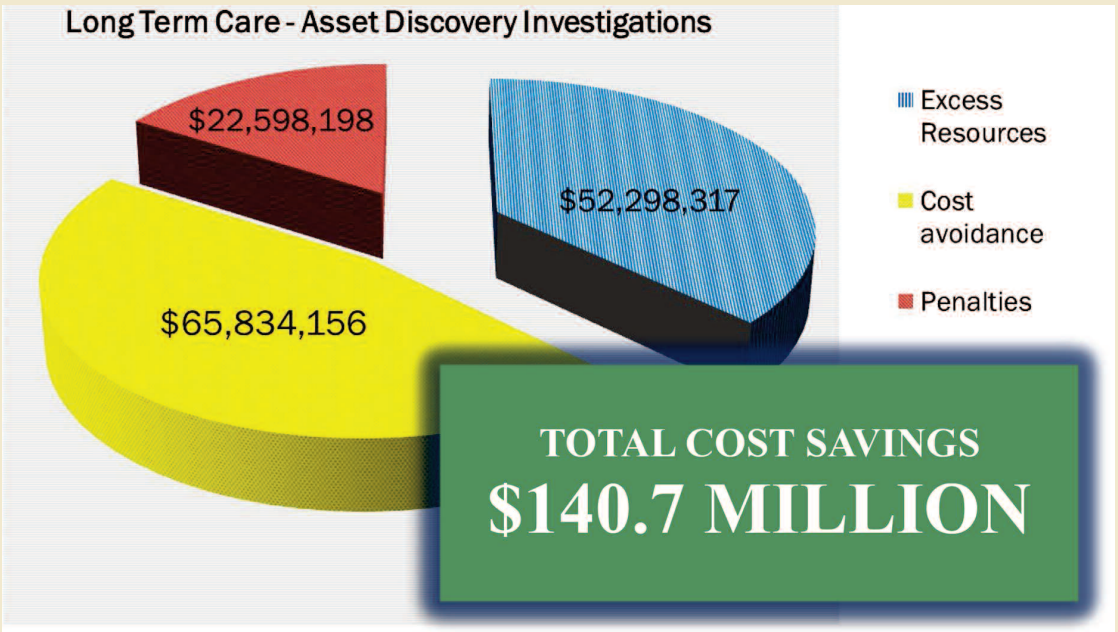
LTC-ADI Highlights

Applications processed: 2,407 applications
Total savings of $140,730,671
ROI of $42.80 for every $1 spent

Long Term Care (LTC) residents requesting coverage for LTC services are eligible and in compliance with federal and state regulations before they receive State assistance. The goal of the unit is to ensure that individuals applying for LTC services do not have excess resources or unallowable transfers of resources which would allow them to pay for their own nursing home care. By preventing improper conduct related to eligibility, the LTC-Asset Discovery Investigations Unit ensures program funds go to qualified applicants who have no other means to pay for their own care.

Applications are referred to the OIG from the DHS Family Community Resource Centers (FCRCs) as a result of meeting specific criteria. LTC-ADI

Bureau of Medicaid Integrity



Analysts (Analysts) complete reviews of financial records and applicant information up to five years from the date of the application for benefits. Directives are made and then provided back to the FCRCs to allow DHS to send out notices advising the applicants of their eligibility for the program.

What are excess resources?

Excess resources are any asset or resource that one has available to use as payment for the cost of their care, over and above the $2,000 allowed per statute. For example, if an individual has an investment account, it should be used to pay for their care; therefore this investment account would be an excess resource. If an individual does have excess resources, they will be required to spend down the value of the resources before the State of Illinois will pay for their care.

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

"I have to use my investment account to pay for my care?"

"I didn't think that the farm ground would have to be used for my care."

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

FY18 Case Examples of Excess Resources:

During this investigation, an Analyst found that the applicant applied for benefits with minimal information reported on the application. Upon thorough review of the application, the Analyst's investigation also uncovered two Charles Schwab investment accounts and a property held in the applicant's revocable trust. The assets held in the revocable trust are available to the applicant and the applicant will be required to spend down these excess resources, totaling $211,020 before the state will pay for long term care benefits.

In this case, an Analyst investigated an application for a 22 year old who had been involved in an accident which left him visually impaired. The applicant had received a settlement as a result of the accident and entrusted their mother with the funds. The applicant's mother used the funds to pay off her personal credit card bills, install a pool in her backyard, and remodel her house. These purchases were made after the applicant's mother admitted him to the LTC facility. The applicant's mother was penalized $97,032 for inappropriate spending of the applicant's funds, which should have been used to pay for her child's care.

During this investigation, an Analyst found that the applicant applied for benefits with minimal information reported on the application. Upon further review of the application and documents, the Analyst discovered that the applicant had made large monthly payments to an insurance company. When the Analyst received additional information, it was proven that the applicant had a life insurance policy with a face value of $650,000 and a cash value of $445,910. The Analyst also uncovered information showing that the applicant had a house available to them. In total, the amount of excess resources available to this applicant was $736,885.

During this case, an Analyst found that an applicant sold their house and put the funds into a Revocable Living Trust. The family thought this would protect the funds from having to be used to pay for their nursing home care. After legal review, it was determined that the assets in the revocable trust were available to the applicant. In addition, the analyst also uncovered interest income in the applicant's tax returns, payable from another bank not disclosed by the applicant. It was discovered that the applicant held a Certificate of Deposit (CD) and an Individual Retirement Account (IRA) with another bank. Before the Department will pay for benefits, the applicant will be required to spend down the $113,000 of resources that the applicant has available to use.

What is an unallowable transfer?

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

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

"...But the Internal Revenue Service (IRS) told me it was okay to gift $14,000."

"My mom can only keep $2,000, so I put the rest of her money in a 'special account.'"

"....But my mom really wanted me to have it."

"....But that is my inheritance."

FY18 Case Examples of Asset Concealment/ Unallowable Transfers:

During a review of an application for long-term care, an Analyst uncovered that an applicant sold their home and used the proceeds, $150,515, to purchase another home just prior to applying for LTC benefits. The applicant put the new property in the name of the applicant's son. A penalty was assessed for the transfer of assets. The case was appealed; however the Bureau of Administrative Hearings (BAH) upheld the Department's decision.

During a review, an Analyst uncovered documentation citing that the parents of an applicant created an irrevocable trust, containing 105 acres of farm ground and two homes. After legal review, it was determined that the applicant had access to the income and principal, therefore could afford to pay for their own long-term care. The total amount of assets determined available to the applicant totaled $1,191,000. The Department's decision was appealed by the applicant; BAH upheld the Department's decision.

Upon review of bank statements for an application, it became obvious to the Analyst that the applicant and the applicant's spouse were frequently gifting money to family members prior to filing the

application for LTC benefits. The applicant gifted $14,000 to each of the applicant's five children, and also made gifts to the applicant's grandchildren. Additionally, one of the children opened a business with loans given to them by the applicant. The total penalty applied for this case was $174,800.

Upon review of mortgage documents for an application, an Analyst determined that the applicant took out a reverse mortgage for $79,683 prior to their admission to the nursing home, and gave funds to applicant's daughter, who was also the power of attorney. In addition to this unallowable transfer, the Analyst uncovered that the daughter was writing substantial weekly checks to herself from the applicants account. The total penalty for this case was $110,682.

A review performed by an Analyst uncovered information showing that an applicant transferred money to her daughter several times a month for caregiving. Further inquiries performed by the Analyst discovered that there was no contract for this agreement and the applicant's daughter did not have any evidence to supply that the applicant's daughter cared for the applicant. Findings showed that in over just a few years, the applicant transferred $96,534 to her daughter. A penalty was accessed for the entire amount of the transfer.

Processes

The LTC-ADI Unit assumes responsibility for all appeals during the appeal process, as well as for all spend down and penalty issues that have been determined by the unit. New for FY18 was the hiring of legal counsel for the LTC-ADI Unit. This attorney coordinates and facilitates all pre-appeal conferences, and represents the OIG in litigation appeal cases involving spenddowns and penalties.

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

In the past year, the State has been sued by several nursing home corporations due to the lengthy delay in the application approval process. These lawsuits resulted in the Department of Human Services' expediting the application processes on their end. However, this change in process will eventually affect the LTC-ADI Unit, affecting the volume of applications received for review. LTC-ADI is proactively working on researching new and revised workflow methods to be prepared. The processing of the long term care benefits applications has been a "hot topic" for years; however, the process is cumbersome for both the applicants and the Analysts. Reviews are often lengthy and can extend for many months, as applicants have to spend time obtaining the necessary documentation before the Analysts can review the documents.

Senate Bill #2913 was passed by the General Assembly and signed into law on August 2, 2018, which streamlined processing of non-complex applications; however this did not affect the LTC-ADI Unit's processes.

Currently, the LTC-ADI Unit consists of 24 staff members, including: a manager, clerical staff, analysts, supervisors, and an attorney. The clerical staff research and obtain documents, such as applications or verifications of assets, from the Integrated Eligibility System (IES). Once the documents have been collected, they are provided to the Analysts for examination to determine if any resources are available to the applicant to spend towards their care and if any unallowable transfers of resources occurred in the prior five years. Often times, the Analysts must request additional information from the applicants, which can cause significant delay in the processing of the applications. The analysts are responsible for completing a directive for each case which will be sent to the DHS office for processing. Supervisors review the work of the analysts, train new staff, and

assist with the hearing process. The LTC-ADI's attorney is responsible for providing legal counsel on all legal issues such as trusts, wills, divorce, separation, spousal refusal, and spousal transfer.

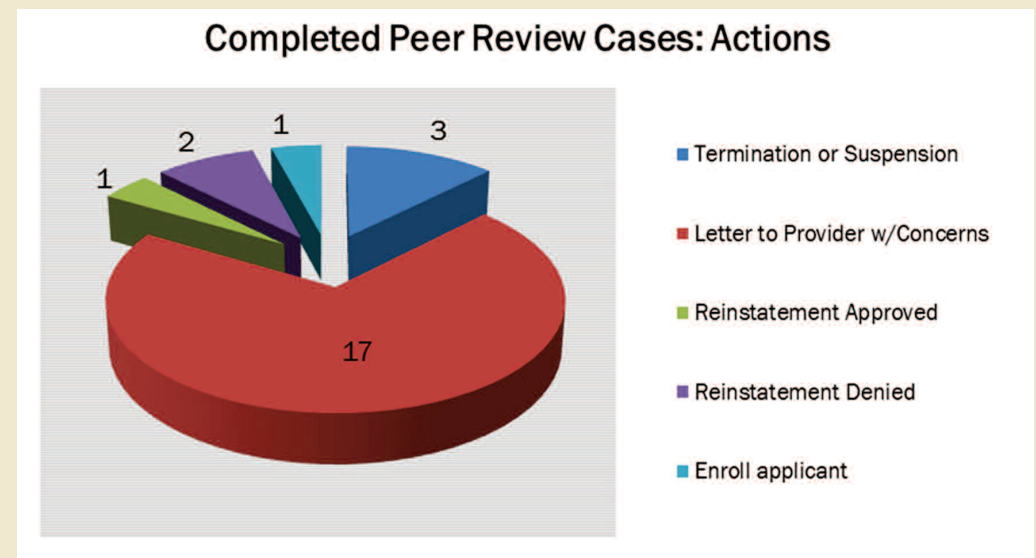
As stated above, the LTC-ADI Unit often faces legal issues in the public eye. The nature of the review process itself is lengthy. Any delays in the process of applicants providing resources and documentation to the Unit further exasperates the delay in processing of the applications. The application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

Peer Review

The Peer Review Section conducts quality of care reviews and monitors utilization of services rendered to Medicaid recipients from records submitted by a provider/applicant. Quality of care concerns are summarized in the categories of risk of harm, medically unnecessary care or care in excess of needs, and grossly inferior quality of care. Risk of harm is identified when there is a risk to the patient that outweighs the potential benefit of the service. Medically unnecessary care or care in excess of needs is identified when the care provided to the patient is not medically necessary and/or in excess of the patient's needs. Grossly inferior quality of care is identified when "flagrantly bad care" is provided to a patient. Peer Review conducts reviews of physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. Peer review cases can originate from hotline/complaints; referral from the Provider Analysis Unit, Recipient Restriction Unit, Audit Unit or other agencies such as the Illinois Department of Financial Professional Regulation, State Police, or Public Health. Some cases may also involve providers that have been reviewed previously and quality of care concerns were identified but were not serious enough to terminate the provider. The provider will be reviewed again to see if the concerns have been rectified. If a provider was terminated, suspended, or withdrew from the Program and submitted his/her enrollment application in IMPACT, a reinstatement case will be created and sent to Peer Review to conduct a quality of care review. If a potential provider submitted his/her application in IMPACT, but had a red flag

Peer Review Highlights

Peer Reviews Completed: 43
Cases in Review: 68
Cases Pending Assignment for Review: 89
Providers Terminated or Suspended Resulting from a Peer Review: 3



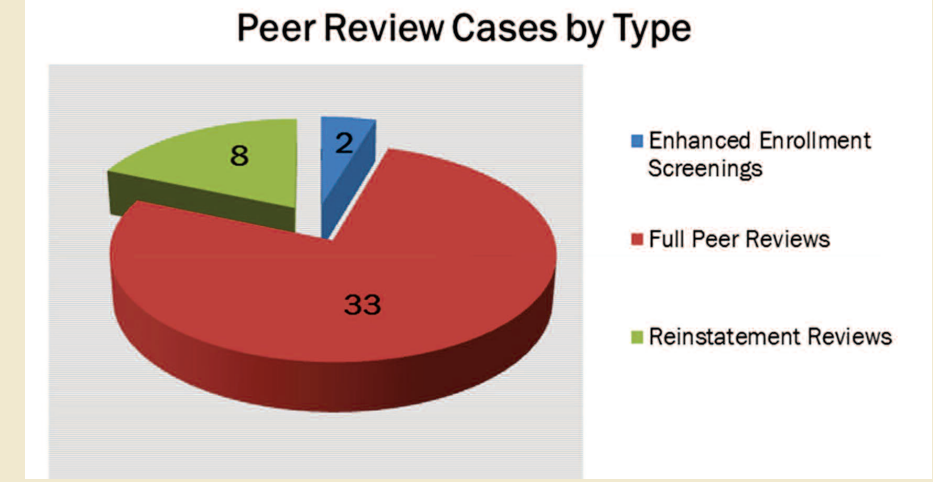
Bureau of Medicaid Integrity

such as a discipline on his/her license, an enhanced enrollment case will be created and sent to Peer Review to conduct a quality of care review.

The Peer Review staff reviewer may go to the provider's office to obtain the recipient records or may request the provider send the office records to the Department. A written report documenting the quality of care concerns and the recommendations is subsequently completed by the reviewer. Possible recommendations may include case closure with no concerns; case closure with minor deficiencies identified and sending a letter to the provider identifying these minor concerns; or a referral to a consultant for further review of potentially serious concerns. The consultant will review the office records and will submit a written report to the Department identifying quality of care concerns along with a recommendation to the Department. The consultant may recommend that a letter be sent to the provider outlining quality of care concerns and recommendations when minor concerns are identified. If the consultant has identified more serious quality of care concerns the Department will request that the provider attend a Medical Quality Review Committee (MQRC) meeting to discuss the care provided and attempt to clarify or discuss the concerns identified with the provider. The MQRC committee will consist of two to three departmental consultants of like specialty. If the provider is board certified, at least one committee member must be board certified in the same branch of medicine. The MQRC makes a recommendation to the Department prior to the conclusion of the meeting after the provider is dismissed. The committee may recommend that the provider be sent a letter identifying concerns that the provider should correct in his/her practice; suspension; corporate integrity agreement in lieu of termination; termination; denial of reinstatement; denial of enrollment; or referral to the Audit Section if potential compliance issues are suspected. In addition, a referral may be sent to the Department of Public Health and/or the Department of Financial and Professional Regulation for related regulatory actions.

Total Cases Open and Assigned	**68**
Full Peer Review	58
Modified Peer Review	2
Reinstatement Review	4
Enhanced Enrollment Review	4

Total Cases on Tickler or Needing Assigned	**89**
Full Peer Review	86
Modified Peer Review	2
Reinstatement Review	0
Enhanced Enrollment Review	1



QC (Quality Control)

Federally Mandated Reviews

Since the early 1980s, the State has been mandated by the Federal Centers for Medicare and Medicare Services (CMS), to conduct reviews of eligibility determinations as set forth in 42 CFR 431 Subpart P. At the onset of this mandate, the reviews were conducted by the Department of Public Aid (DPA) and consisted of all three federal programs – Aid to Families with Dependent Children (AFDC), Food Stamps and Medicaid. Currently HFS (formally DPA) conducts the Medicaid reviews (Medicaid Eligibility Quality Control – MEQC). DHS is responsible for the Supplemental Nutritional Assistance Program (SNAP) and AFDC quality control reviews.[1]

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

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

During FY18, QC performed the following activities:

- 250 MEQC eligibility reviews and 265 test cases to assess both the Manually Adjusted Gross Income (MAGI) budgeting process as well as the State's new Integrated Eligibility System (IES).
- 903 MEQC eligibility reviews of Medicare eligible recipients to ensure they were covered under the State's Aid to the Aged, Blind and Disabled (AABD) program and not incorrectly placed into the Affordable Care Act (ACA) population as federal matching funds are higher for the ACA program.
- 6,143 contacts to recipients to verify the receipt of services as mandated by 42 CFR 455.20 and 433.116.
- 11 PERM eligibility reviews for the review year (RY) 2019. QC continues to work with the CMS contractor to finish the review of the remaining 967 cases.
- Creation of the MEQC design for 2019 as required by CMS to determine what types of cases will be reviewed throughout 2019 and reported on by August 2020.

[1] The AFDC program changed to Temporary Assistance to Needy Families (TANF) in 1996.

The Office of Counsel to the Inspector General

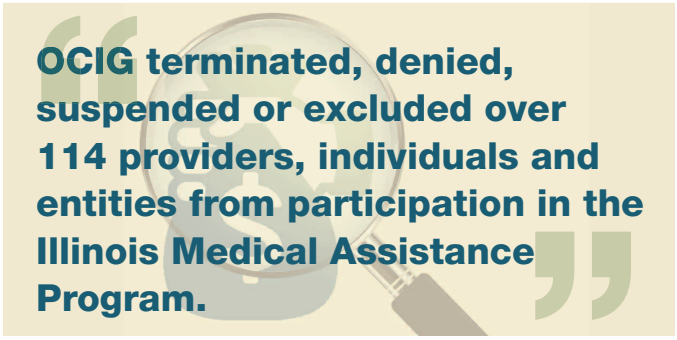
Section

6

The Office of Counsel to the Inspector General

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

OCIG drafts and monitors legislation and administrative rulemaking that impacts fraud, waste, abuse and the overall integrity of the Medical Assistance Program. OCIG is also responsible for the enforcement of provider sanctions, and



represents the Department in provider recovery actions; actions seeking the termination, suspension, or denial of a provider's Program eligibility; state income tax delinquency cases; civil remedies to recover unauthorized use of medical assistance; and legal determinations affecting recipient eligibility for the OIG's Long Term Care-Asset Discovery Investigations. Finally, OCIG assists with responses to Freedom of Information Act (FOIA) and subpoena requests.

Highlights

Hearings Initiated

Termination Cases: 132
Term/Recoup Cases: 49
Recoupment Cases: 121

Final Actions

Termination Cases: 110
Term/Recoup Cases: 36
Voluntary Withdrawals: 3
Recoupment Cases: 68
Barrment Cases: 3 [1]

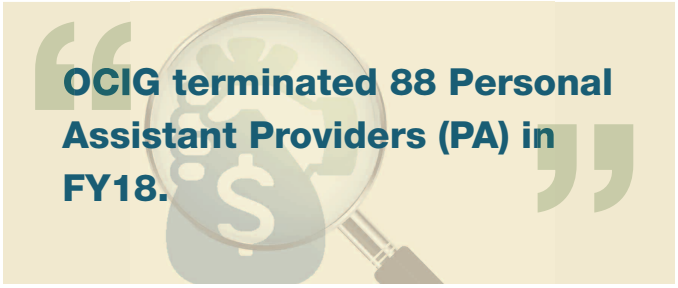
Reinstatement Actions

Denied Applications: 2
Reinstatement Cases: 5
Disenrollment Cases: 17

Voluntary Withdrawal Cases: 5
Payment Withholds: [2] 29

Total Medical Provider Sanction Dollars

Funds Put to Better Use: $1,515,719 [3]



[1] Includes federal exclusion cases.

[2] This number includes payment withholds imposed under all provisions under the jurisdiction of the OIG, including noncompliance with Department requests.

[3] Includes cost savings $434,697 and $1,081,022 rejected billings.

The Office of Counsel to the Inspector General

In FY18, OCIG terminated, denied, suspended or excluded over 114 providers, individuals and entities from participation in the Illinois Medical Assistance Program. Searchable exclusions lists are available on the OIG Website. Providers and owners who are terminated or debarred from the Program are restricted from participating in the Program and may not be employed by any entity receiving payment by a Federal or State health care program.

OCIG hires four new attorneys

In FY18, OIG bolstered its mission of preventing fraud, waste, and abuse by hiring four new attorneys. These attorneys each possess a wealth of knowledge and experience with administrative law. Three of the attorneys are operating from the Chicago office and assist with prosecuting medical provider cases. One attorney is operating in the Springfield office and assists with Long Term Care recipient eligibility issues and Freedom of Information Act (FOIA) requests. The addition of the new staff will greatly assist in processing backlogged cases, while also ensuring OIG remains in compliance with the due process rights of providers.

OCIG fights to keep convicts out of the Illinois Medical Assistance Program

A Final Administrative Decision (FAD) was issued, which adopted and upheld an administrative law judge's Recommended Decision to allow a Personal Assistant (PA), who had previously been criminally convicted of murder, to remain employed as part of the Illinois Medical Assistance Program. HFS-OIG filed Exceptions contending the Recommended Decision was incorrectly decided as a matter of law, a violation of the Illinois SMART ACT, and directly contrary to HFS-OIG's Program Integrity statutory mandate. The Recommended Decision improperly imposed an additional legal requirement on HFS-OIG to prove a "risk of harm" to the Personal Assistant and Medicaid Recipient relationship, despite the plain language of the applicable Illinois Administrative Code governing medical provider termination in such cases containing no such requirement. HFS-OIG maintains the FAD incorrectly adopted the Recommended Decision and that the provider should have been terminated.

Administrative issues hamper OCIG's ability to prosecute cases

The ability to file, schedule, and hear additional medical provider hearing cases is limited by the reduction in personnel, including attorneys, investigators, and staff members within the Office of the Inspector General. This is in addition to a reduction, as well as changes in Administrative Law Judge personnel and ancillary staff members assigned to hear and handle medical provider hearing cases. The ability to process the backlog of cases in a timely manner and schedule them for an administrative hearing is also constrained, in part, by the existence of a Bureau of Administrative Hearings Standing Order. This order limits the filing of all new cases to a maximum of 50 new cases per month. HFS-OIG is cooperatively working with the Bureau of Administrative Hearings to file and hear more cases.

FY18 Highlight Cases

Doctor terminated based on $2.9 million health care fraud scheme

Dr. Eguert Nagaj was terminated as a result of his criminal conviction for a $2.9 million health care fraud scheme. While the doctor lost his license to practice medicine because of his conviction, the doctor's termination from the Illinois Medical Assistance Program was effective from the date he was convicted.

OCIG obtains $31K judgment against transportation provider

Vee Transportation violated numerous Department policies, rules, and HFS Handbook provisions during a BMI Audit review. Violations related to the delivery of transportation services, including billing during an inpatient stay, loaded mileage, and multiple billings. The HFS Director's FAD affirmed an administrative law judge's recommended decision, which issued a default order against the provider and upheld the Department's right to an overpayment recovery of $31,129.

Acronyms

AABD	Aid to Aged Blind or Disabled
ACA	Affordable Health Care
AFDC	Aid to Families with Dependent Children
AG	Illinois Attorney General
AIU	Adoption, Implementation, or Upgrade
ALJ	Administrative Law Judge
BAH	Bureau of Administrative Hearings
BFST	Bureau of Fraud Science and Technology
BIA	Bureau of Internal Affairs
BMC	Bureau of Managed Care
BMI	Bureau of Medicaid Integrity
BOC	Bureau of Collections
BOI	Bureau of Investigation
CAP	Corrective Action Plan
CAS	Central Analysis Services
CASE	Case Administrative System Enquiry
CD	Certificate of Deposit
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Central Management Services
CPA	Certified Public Accountant
CPI	Center for Public Integrity
CPIP	Certified Program Integrity Professionals
DHS	Department of Human Services
DME	Durable Medical Equipment
DNA	Dynamic Network Analysis
DOIT	Department of Innovation and Technology
DOJ	Department Of Justice
DPA	Department of Public Aid
EDW	Enterprise Data Warehouse
EH	Eligible Hospital
EHR	Electronic Health Records
EP	Eligible Professional
FAD	Final Administrative Decision
FAE	Fraud Abuse Executive
FBI	Federal Bureau of Investigation
FCRC	Family Community Resource Centers
FFP	Federal Financial Participation
FFS	Fee for Service
FOIA	Freedom of Information Act
FQHC	Federal Qualified Health Center
FST	Fraud Science Team
FY	Fiscal Year
GPSI	Graduate Public Service Intern
EHR	Electronic Health Records
HFPP	Healthcare Fraud Prevention Partnership
HFS	Healthcare and Family Services
HHA	Home Health Agencies
HHS	Department of Health and Human Services
HITECH	Health Information Technology for Economic and Clinical Health
HSP	Home Services Program
ICF-MI	Intermediate Care Facility- Mental Illness
ICF-MR	Intermediate Care Facility- Mentally Retarded
IDFPR	Illinois Department of Financial and Professional Regulation
IDPH	Illinois Department of Public Health
IES	Integrated Eligibility System
ILCS	Illinois Compiled Statutes
IMPACT	Illinois Medicaid Program Advanced Cloud Technology
IOC	Illinois Office of the Comptroller
IP	Individual Provider aka Personal Assistant
IRA	Individual Retirement Account
IRS	Internal Revenue Service

Acronyms

ISP	Illinois State Police
LTC	Long Term Care
LTC-ADI	Long Term Care- Asset Discovery Investigations
MAC	Medical Assistance Consultant
MAGI	Manually Adjusted Gross Income
MCO	Managed Care Organization
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Control Unit
MMAI	Medicare-Medicaid Alignment Initiative
MME	Average daily morphine milligram equivalent dose
MMIS	Medicaid Management Information Systems
MPIS	Medicaid Program Integrity Spotlight
MQRC	Medical Quality Review Committee
MRA	Management, Research, and Analysis
MU	Meaningful Use
NAC/MII	National Advocacy Centers Medicaid Integrity Institute
NAMFCU	National Association of Medicaid Fraud Control Unit
NAMPI	National Association for Medicaid Program Integrity
NEMT	Non-Emergency Medical Transportation
NHCAA	National Healthcare Anti-Fraud Association
NPI	National provider Identifier
NPV	New Provider Verification
NRC	Narrative Review Committee
OCIG	Office of Counsel to the Inspector General
OIG	Office of Inspector General
PA	Personal Assistant
PAU	Provider Analysis Unit
PCS	Personal Care Services
PEER	Peer Review Unit of Bureau of Medicaid Integrity
PERM	Payment Error Rate Measurement
PES	Provider Enrollment Services
PI	Program Integrity
PMP	Prescription Monitoring Program
PRAS	Provider and Recipient Analysis Section
PSA	Public Service Administrator
QC	Quality Control reviews,
RAC	Recovery Audit Contractor
RAU	Recipient Analysis Unit
RIN	Recipient Identification Number
ROI	Return On Investment
RPY	Representative Payee
RRP	Recipient Restriction Program
RVP	Recipient Verification Procedure
SAS	Statistical Analysis System
SIU	Special Investigative Unit
SMART	Save Medicaid Access & Resources Together (Act)
SNAP	Supplemental Nutritional Assistance Program
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance to Needy Families
TMU	Technology Management Unit
UPIC	Universal Program Integrity Contractor
USDOJ	United States Department Of Justice
WARP	Welfare Abuse Recovery Program
XIM	Xanalys Investigation Management

OIG Statutory Mandate

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

- Audits of enrolled Medical Assistance Providers
- Monitoring of quality assurance programs
- Quality control measurements of any program administered by the Department
- Administrative actions against Medical providers or contractors
- Serve as primary liaison with law enforcement
- Report all sanctions taken against vendors, contractors, and medical providers
- Public assistance fraud investigations

In addition to the Medical Assistance Program Integrity components, the OIG has several other duties:

- Employee and contractor misconduct investigations
- Fraudulent and intentional misconduct investigations committed by clients
- Pursue hearings held against professional licenses of delinquent child support obligors
- Prepare an annual report detailing OIG's activities over the past year

Federal Mandates and Program Participation

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

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

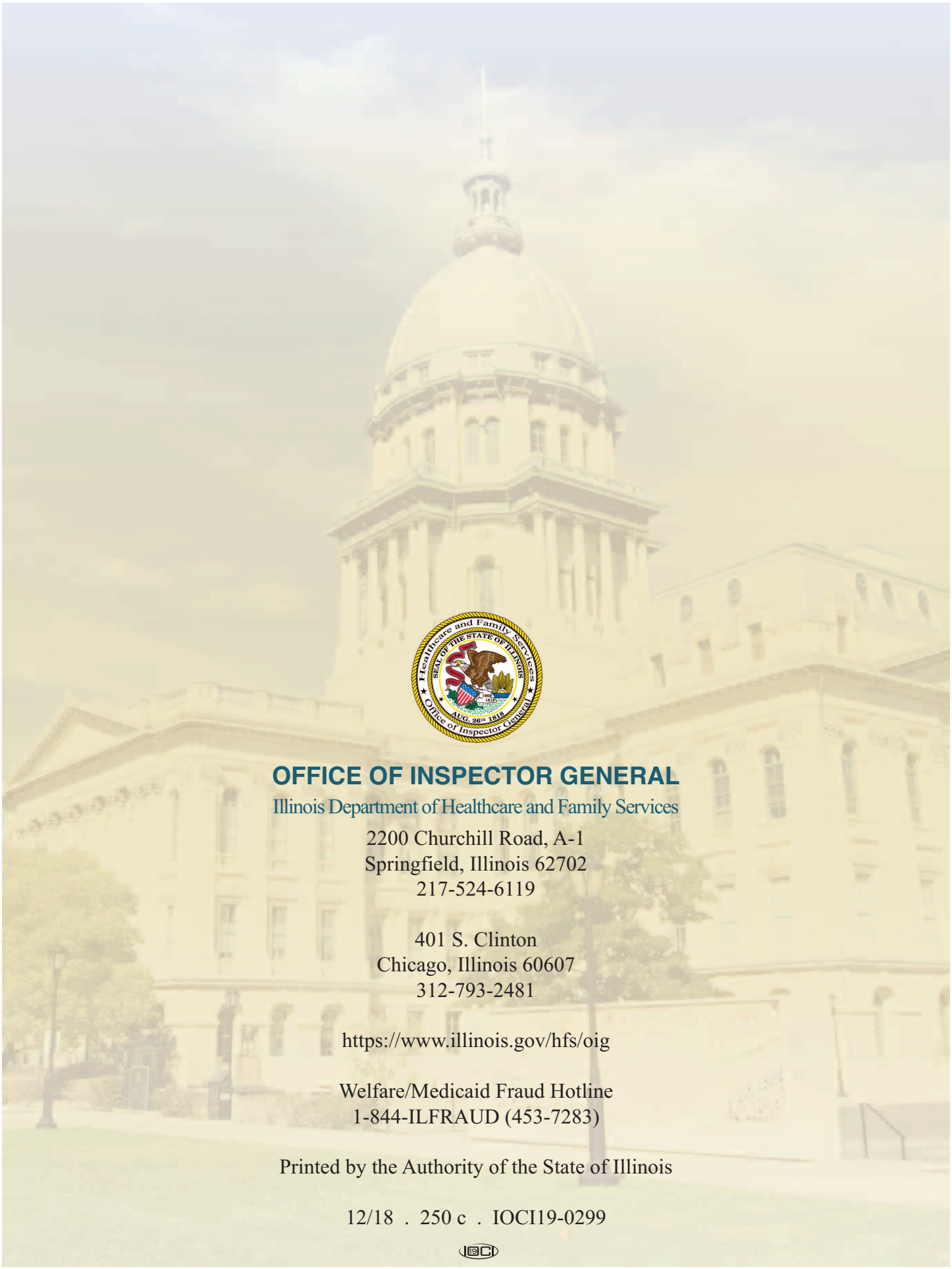
Appendix

Refill Too Soon

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

Aggregate Provider Billing/Payment Information

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed under the heading of 2018 Annual Report OIG's Website. The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably.



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