



STATE OF ILLINOIS

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

**OFFICE OF
INSPECTOR GENERAL**

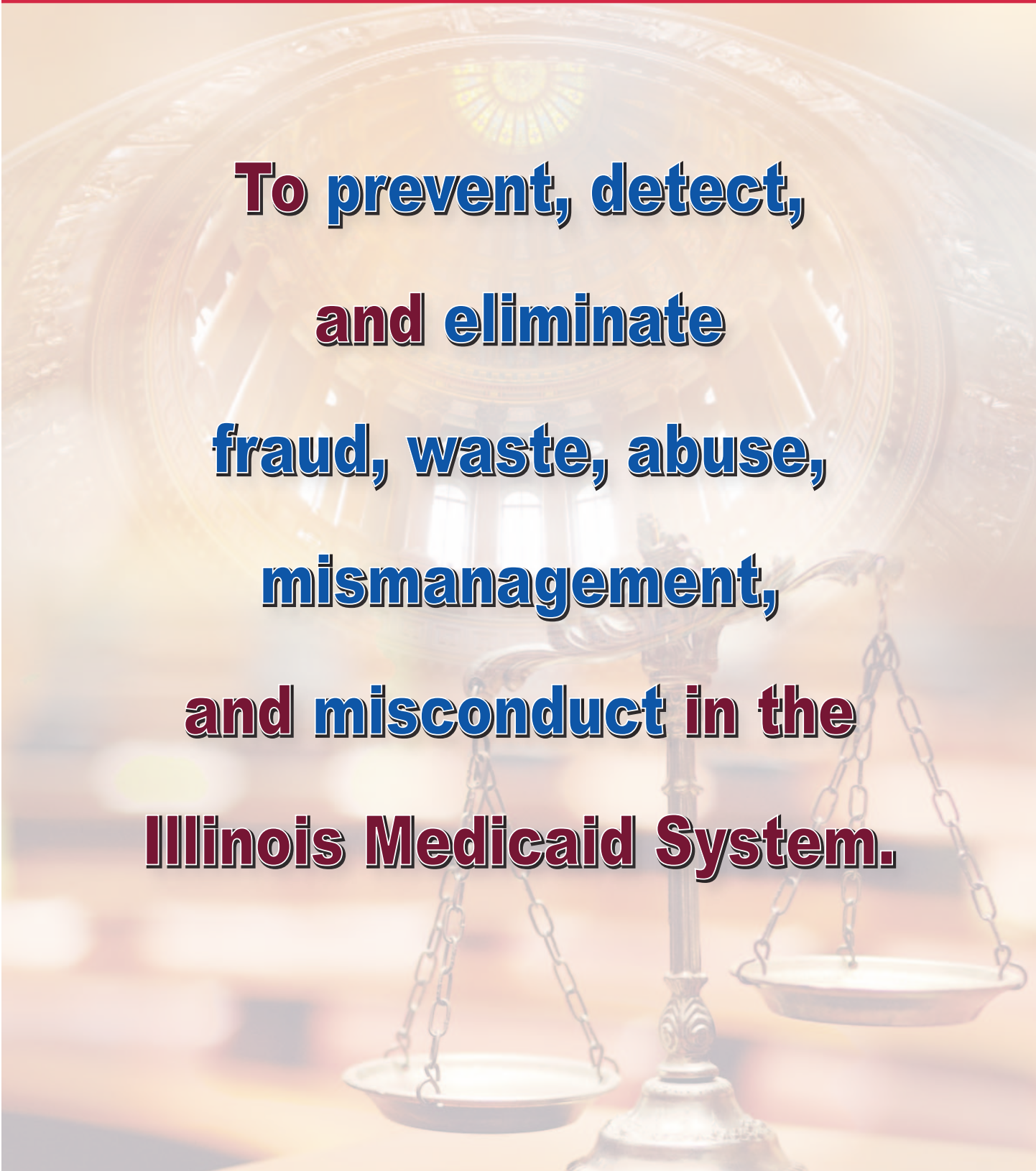
ANNUAL REPORT

FISCAL YEAR 2020



JB Pritzker, Governor
Patrick Conlon, Acting 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

I am pleased to submit the Inspector General's annual report for the Fiscal Year 2020 to Governor JB Pritzker, 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 in programs within the Illinois Medical Assistance Program (also known as Medicaid). 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 (PI) to ensure that taxpayer dollars are not wasted.

The OIG realized \$172.9 million in operational cost savings for the taxpayers of Illinois. This resulted in a return on investment (ROI) of \$6.70 for every \$1 spent. For FY20, the COVID-19 public health emergency caused OIG to refocus efforts and strategize to ensure PI duties were still being performed amidst the pandemic. A strong focus continues to be the Long Term Care-Asset Discovery Investigations Unit (LTC-ADI), which reported a total savings of \$125.4 million. Additional areas of focus are the PI aspects of managed care and the expansion of the Recovery Audit Contractor (RAC) operations to additional provider types.

The OIG is charged with PI for the Illinois Medical Assistance 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.

The OIG has experienced success despite the lack of available resources as well as transitioning to alternative work schedules and locations during the COVID-19 public health emergency. Given the March declaration of the COVID-19 public health emergency, OIG and our external partners ceased operations of audits of providers. The ROI statistic above is reflective of the effects of the pandemic yet is absolute proof that the efforts of the OIG are maximizing value to the taxpayers of Illinois, further justifying the need for OIG expansion. While the OIG ended FY20 with 154 onboard staff, the OIG has reached the pinnacle of ROI which that level of staffing can produce. This forces the OIG to continually reprioritize operations, hiring and system development; while

managing growing backlogs. This situation prevents the OIG from enhancing our current capabilities and being proactive with topics and trends in modern healthcare.

The OIG is continuing to identify ways to boost efficiency and cost savings for taxpayers, including developing a triage process for referrals, working collaboratively with HFS Bureau of Managed Care (BMC) to further enhance PI contract language in the HealthChoice Illinois (HCI) contract, and collaborating with law enforcement and managed care special investigations units. OIG is continually moving forward with efforts and strategies to ensure safekeeping of taxpayer dollars while ensuring that recipients are provided the best quality services under the Medicaid Program. The OIG staff is dedicated to safeguarding the fiscal integrity of the Illinois Medical Assistance Program, as well as ensuring the safety and well-being of the recipients. In FY21, 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,

A handwritten signature in black ink that reads "Patrick B. Conlon". The signature is written in a cursive, flowing style.

Patrick B. Conlon
Acting Inspector General

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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, 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 CMS and the US Department of Justice (DOJ). The OIG is also a participating member of: Healthcare Fraud Prevention Partnership (HFPP) and National Health Care Anti-Fraud Association (NHCAA).

OIG Staff Trainings at the NAC/MII FY20

Specialized Skills and Techniques in Medicaid Fraud Detection

Program Integrity Partnership in Managed Care Symposium

Provider Auditing Fundamentals Program

Emerging Trends in Medicaid Symposium—Beneficiary Eligibility and Fraud

Program Integrity Fundamentals Seminar

MII – Investigative Skills Planning Group

Coding for Non-Coders

HCPPro's Evaluation and Management Boot Camp

Medicaid Provider Enrollment Seminar

HCPPro's Certified Coder Boot Camp—Original Version

Trends in Medicaid Symposium: PARIS Data Intensive

Program Integrity Directors' Symposium

Investigative Skills I—The Basics and Beyond
Basic Skills and Techniques in Medicaid Fraud Detection

Collaboration and Training with External Organizations and Partners

NCHAA Webinar: Healthcare Fraud Schemes Related to COVID-19 – April 2020

HFPP Regional Information Sharing Session – April 2020

IAMHP Webinar for FQHC Billing – May 2020

HFPP Data Analytics Webinar - May 2020

NHCAA National Information Sharing Session (Fraud topics/schemes) – June 2020

2020 NETS Webinar – June 2020

IAMHP and OIG - WebEx training for Waiver, MCOs, law enforcement counterparts – June 2020

FY20 Financial Highlights

Dollars Recovered

Provider Audits:	\$17,874,582
Global Settlements:	\$2,570,529
Restitution:	\$95,863
Total:	\$20,540,974

Questioned Costs

Provider Audits:	\$15,547,050
Recipients:	\$7,082,622
Restitution:	\$684,939
Total:	\$23,314,611

Funds Put to Better Use

LTC-ADI:	\$125,418,153
Client Program Overpayments:	\$204,098
Provider Sanctions:	\$2,519,640
Recipient Restriction Program:	\$131,953
SNAP:	\$779,592
Total:	\$129,053,436

**Overpayments Identified and
Questioned Costs:
\$23.3 Million**

**Settlements and Restitution:
\$2.7 Million**

**Funds Put to Better Use:
\$129.1 Million**

**Audits:
\$17.9 Million**

**Total Dollars Questioned and
Put to Better Use:
\$152.4 Million**

**Total Dollars Recovered:
\$20.5 Million**

\$172.9 Million Cost Savings
ROI for the Taxpayers of Illinois = \$6.70 for every \$1 spent

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 recovery 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.

FY20 Successes

Fraud Detection Operations: ROI for LTC-ADI reaches \$1 billion

Since the program's inception in 2004, the total return of investment for the Long-Term Care-Asset Discovery Investigations (LTC-ADI) unit totals \$1 billion. This program began as a Quality Control pilot program and has grown into a major cost savings for the taxpayers of Illinois.

Litigation Activity: \$132K Settlement Secured with Hospital Provider

A global settlement agreement was executed by and between the Department of Healthcare and Family Services, Office of Inspector General and the hospital for \$132,453.97 in lieu of an administrative recoupment action seeking to recover an aggregate amount of \$189,219.96. The settlement encompasses Recovery Audit Contractor (RAC) audit findings for nine individual inpatient service claims billed by and paid to the Hospital and five individual inpatient service claims billed by and paid to the Hospital. The claims were determined in a complex RAC review to be non-compliant with the Department's utilization review criteria.

Fraud Detection Operations: Over \$353K in Assets Discovered During Asset Discovery Investigations

The Illinois Department of Human Services Bureau of Hearings (DHS-BAH) upheld the OIG's decision to impose a penalty period for an applicant who made transfers for less than fair market value. After review of the application, HFS-OIG determined that applicant had paid caregivers for up to 19 hours per day during a period where she was a resident of a long-term care facility. Caregiving expenses alone totaled between \$3,000 to \$5,000 per month. Appellant argued that fair market value was received for the services provided and that additional caregivers were necessary for appellant to be comfortable in the facility. Appellant was unable to show any medical need for the caregivers. In the final administrative decision, BAH found that the additional caregivers were not shown to be necessary and as the applicant was already receiving long term care services, the payment of the caregiving services was also unnecessary. Accordingly, appellant failed to overcome the presumption that the transfers were made for less than fair market value. The amount of the penalty upheld was \$353,838.

FY20 OIG Case Highlights

Provider enrollment and revalidation applications reviewed: 343

OIG referrals to MFCU: 13

Global Settlement Agreements executed: 7

Medicaid Providers terminated, denied, suspended and excluded: 13

Audits completed: 284

Provider audit dollars recovered: \$17.87 million

Litigation Activity: \$134K Recovery Ordered and Provider Terminated due to Fraudulent Billing Findings

A Final Administrative Decision was issued by the HFS Director, who adopted an administrative law judge's recommended decision to award a recoupment recovery of \$134,562.36 based upon a desk audit of provider Specialty Services & Linda and Joseph Roudez d/b/a Specialty Services. Additionally, the providers' eligibility to participate in the Illinois Medical Assistance Program was terminated and Linda and Joseph Roudez were barred from further participation in the Program. The Department's audit covered dates of service starting in May 1, 2009 through December 31, 2013 and determined that transportation company received overpayments in the amount of \$134,562.36 due to improper billing of loaded mileage, duplicate billing, and billing for transportation during an inpatient stay. After failing to request a hearing in writing, or to appear at the scheduled administrative hearing, the ALJ granted HFS OIG's motion for default and the recommended decision was later affirmed by the HFS Director.

Virtual Collaborative Training Opportunities: Waiver Fraud and Webinar Trainings

During the COVID-19 public health emergency, OIG had to adjust to a new work environment, ensuring work product continued, while also taking advantage of additional online learning options. OIG worked collaboratively with Illinois Association of Medicaid Health Plans (IAMHP) to present and to train the MCOs on fraud, waste and abuse (FWA) in the waiver agencies programs. In addition, OIG's audit partner HMS has been holding webinar trainings for our Recovery Audit Contractor (RAC), and HFS has been hosting webinar trainings for HFS staff on Enterprise Resource Planning -

FY20 Successes

Systems, Applications, and Products (ERP – SAP) for the new accounting system. OIG also held multiple inhouse webinar trainings for OIG staff to ensure efficiencies in remote working and computer programs.

Typically, OIG holds an annual in person training with our collaborate partners on Program Integrity related topics. This year the training was held virtually. The goal of this IAMHP collaborative training was to educate all involved parties on the workings of sister-agency waiver programs and ultimately how FWA is investigated and prosecuted. As waiver fraud cases can be investigated through a variety of venues, both criminally or civilly, all involved parties need to be aware of the legal process. Given the shift to managed care, the investigators and prosecutors working these cases also must understand how MCOs fit into the functioning of waiver programs. All parties must understand the payment structures of the programs to know how to effectively investigate FWA in these programs. Finally, the MCOs must understand their component in the FWA investigation process. Presenters included staff from DHS-DRS, DHS-DD, IDOA as well as ISP-MFCU, AG-MFCU and HHS-OIG.

Fraud Detection Operations: Over \$78K in Assets Discovered During Asset Discovery Investigation

The Illinois Department of Human Services Bureau of Hearings (DHS-BAH) upheld the OIG's decision to impose a penalty period. After review of the application, HFS-OIG determined that applicant made large cash withdrawals near nursing home admission and the application for medical assistance. Appellant was unable to provide any documentary evidence to show the purpose of the withdrawals, other than a signed statement from applicant's spouse stating some of the funds were used for gambling and others were used for vacation. OIG was unable to verify any history of large gambling expenses. However, it did verify that applicant and spouse used a debit card frequently for purchases in Illinois during the time of the alleged vacations. In the final administrative decision, DHS-BAH found that appellant had failed to meet its burden to rebut the presumption that transfers were made for less than fair market value and upheld the penalty period of \$78,881.

Fraud Investigation: \$12K SNAP Benefits Fraud Case Resulted in Successful Prosecution Benefits Fraud Conviction

A client eligibility referral was received and investigated by the OIG which alleged that a SNAP recipient failed to report her husband's employment income on her benefits application. The case was subsequently successfully litigated through the State's Attorney's office which confirmed the allegation and findings. The client pled guilty to State Benefits Fraud, (Class 3 Felony), on December 03, 2019 and was sentenced to a conditional discharge of 24 months, and restitution to the State of Illinois in the amount of \$12,023.

Fraud Investigation: \$17K SNAP Benefits Fraud Case Resulted in Successful Prosecution and Benefits Fraud Conviction

A client eligibility referral was received by the OIG alleging that a SNAP recipient failed to report her husband's self-employment income from farming. After investigation by OIG and referral to the State's Attorney's office, the case was successfully litigated. The client pled guilty to State Benefits Fraud, (Class 3 Felony), on December 12, 2019 and was sentenced to 24 months' probation, 200 hours of community service, and restitution to the State of Illinois in the amount of \$17,130.

Litigation Activity: Over \$11K Settlement Reached with Transportation Provider

On February 25, 2019, a Notice for Right to Hearing Department Action to Recover was filed pursuant to a self-audit for \$21,396 for the dates of services from January 1, 2012 through December 31, 2013. The provider made an offer to settle for \$11,785. A Settlement Agreement was executed by Vendor and Director and the Notice was withdrawn.

FY20 Successes

Litigation Activity: Settlement Reached With Physician for Over \$68K in Fraudulent Billing Findings.

A settlement agreement was executed by and between the Department of Healthcare and Family Services, Office of the Inspector General and a Physician for \$68,509 in lieu of an administrative termination and recoupment action seeking to recover \$137,017. The settlement encompasses claims pursuant to a field audit with a hard dollar of \$46,489 and extrapolation from the service period of June 1, 2008 through May 31, 2010. Many of the claims found discrepant were based on incorrect medical coding and billing under the incorrect provider NPI number.

Litigation Activity: Over \$980K Recovered from a Transportation Provider

The Department has recovered an overpayment amount of \$890,775, as well as terminated and barred the provider and business owner from the Medical Assistance Program. The discrepancies in this matter were based upon a review of the provider's transportation records. During the review, the Department determined that there had been overpayment due to billing for 1163 missing records. The Department further determined that there had been overpayment due to billing for 488 instances of transportation during inpatient stays.

Fraud Investigation: \$40K in Overpayments Identified

An eligibility investigation was completed that alleged a client was married to her "landlord," who had been receiving monthly CHA housing vouchers (rental payments) for the client since 2005. The allegation was founded, and it was recommended an overpayment be processed by DHS. DHS returned two SNAP overpayments in the amounts of \$40,215 for the period of November 2010 through November 2018 and \$853 for the period of January 2019 through July 2019. Due to the multi-agency fraud, the Cook County State's Attorney accepted this case for prosecution.

Litigation Action: Personal Assistant Terminated Due to Felony Convictions and Fraudulent Billing Findings

A Final Administrative Decision was issued by the HFS Director which adopted an Administrative Law Judge's recommended decision to terminate Provider Assistant ("PA") Mitchell Dampier. HFS-OIG filed a Notice seeking to terminate the provider who had been convicted of felony offenses in the State of Illinois. The provider also made a materially false statement on his IMPACT Individual Provider Enrollment Form by indicating that he had never had a criminal conviction when he, in fact, had at least one. Additionally, provider was determined to have improperly billed the State of Illinois for services rendered to a Medicaid recipient during hours when the customer was in a hospital or long-term care facility. After failing to appear or request a hearing, the ALJ granted HFS-OIG's motion for default and the recommended decision was later affirmed by the HFS Director.

Litigation Activity: Physician Terminated for Improper Prescribing

A Final Administrative Decision was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate S. David Demorest, MD. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the Provider based on the Illinois Department of Financial and Professional Regulation's suspension of the provider's medical license because the provider improperly prescribed narcotics. HFS-OIG proceeded to file an immediate suspension and a termination action. After the Provider Vendor failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate the Vendor from the Illinois Medical Assistance Program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation and terminated the provider.

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. 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 (PI) issues. *Our mission is to fight fraud, waste and abuse, but it also charges us with being good stewards of taxpayer dollars and ensuring the quality of care provided to Illinois recipients. OIG works diligently towards stronger PI in hopes of being a role model for Illinois' Medicaid Program and program integrity units around the nation.*

Managed Care: Program Integrity Concerns

The OIG continues to work with HFS-Bureau of Managed Care (BMC) staff to discuss workable solutions to program integrity (PI) and data integrity (DI) issues. OIG continues to work on closing any gap between OIG and HFS mission statements; specifically, in the effective use of the Medicaid dollar. To that end, OIG continues to push the issue of effective collection and use of claims data, documenting the needed services provided to the enrollees we serve.

These are some of the specific areas of concern that the OIG believes will improve accountability and better align program objectives with anticipated results:

- Require managed care plan submission of denied service claims to HFS
- Require managed care plan submission of any service claim adjustment to HFS
- Transparency of service claim data with managed care plans and subcontractors
- Require managed care plans comply with contractual network enrollment to ensure that providers are in network, thereby only allowing provider payments to network providers.

Our mission is to fight fraud, waste and abuse, but it also charges us with being good stewards of taxpayer dollars and ensuring the quality of care provided to Illinois recipients.

There are several MCO issues affecting the OIG's mandate. First and foremost is the absence of an inter-agency agreement outlining roles and responsibilities between BMC and the OIG. Per CMS CPI's audit findings, BMC is responsible for programmatic oversight, delegates program integrity related to functions related to the OIG for all FWA activities. Based upon CPI's audit recommendation for an inter-agency agreement between the departments, the OIG started the process by drafting our roles and responsibilities.

The OIG provided contractual language to clarify its role in PI over MCOs, while working collaboratively with the Department and the plans on identifying the ways to fight fraud, waste and abuse and to save taxpayer monies. The contractual changes to strengthen PI were added, however no recoveries provision was included, which poses a concern regarding PI and data integrity, especially as managed care takes dominance in the Illinois Medical Assistance Program.

The OIG has noted a lack of compliance by the MCOs to HFS policies and the MCO contract, specifically as it relates to the withholding of monies for providers who are under official department payment suspensions. The OIG had documented and presented these findings to HFS, showing the MCOs are paying providers, when the department would otherwise not (and has advised the plans to not pay). From a nationwide perspective, nonconformity for PI between HFS and MCO creates an incongruence that stifles proactive PI enforcement and hinders the efficient operation of PI in general.

Medicaid Program Integrity Spotlight

IMPACT System: Program Integrity Concerns

IMPACT (Illinois Medicaid Program Advanced Cloud Technology) is a federally required provider and billing agent enrollment and revalidation portal. Inconsistency between MMIS and IMPACT enrollment systems result in payment and credentialing discrepancies for the MCOs. Also, the MCO plan(s) network providers are not always entered in IMPACT. Failure to enroll effects the OIG audit functions, criminal background checks, and verification of the federal and state exclusion list. Atypical providers enrollment information is not accurate. A specific example: Several home health agencies have multiple service locations yet are only enrolled and bill with one provider ID. This prevents investigators and auditor from knowing from which location the services were rendered, which can render criminal and civil investigations ineffective.

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

The OIG worked continually with DHS, HFS and the labor union to negotiate the manner and means of the performance of background checks to establish procedures for Division of Rehabilitation Services-Home Services Program (DRS-HSP or HSP) enrollment. This Collective Bargaining Agreement was completed in the fall of 2019.

As these personal care service programs are known nationally for fraud, waste, and abuse, the OIG will continue to work collaboratively with DHS to guarantee access to care for those that need services so that they can remain in their homes, while preventing the abuse of the system through fraudulent means. The need or desire for Medicaid recipients to consent and receive home care from individual providers with a criminal history will result in fewer cases being filed, with only a limited number of grounds or crimes being used to terminate or deny enrollment.



Administration

SECTION



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. The Administration Section also acts as a liaison with our fraud, waste and abuse partners by providing increased communication, information exchange and investigative support.

Administration staff support 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 (MRA).

Fiscal Management

The duties of the Fiscal Management Unit include overseeing all fiscal matters, including general collections, bad debt recovery, procurement, selected personnel timekeeping 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.

The 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, Provider settlements 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 FY20, General Collections monitored, on average \$67 million in open receivables, established \$38 million in new receivables, and collected \$18 million.

A new Enterprise Resource Planning (ERP) system was implemented in FY20 that replaced the previous Public Aid Accounting System (PAAS). Fiscal Management staff have attended all necessary training and have worked very closely with the Bureau of Fiscal Operations staff and the ERP-SAP Vendors to ensure that all OIG receivables, procurement, contracts and invoice processing is accurate and efficient.

FY20 Fiscal Highlights

Open Receivables: \$67 million

New Receivables: \$38 million

Collected: \$18 million

Fiscal Management has continued the use of the 15-day demand letter that goes out to Medicaid Providers who owe money to HFS and have not worked out a payment plan to make payments on the debt that is owed to the Department. The collection letters and 15-day demand letters inform the providers on how much is in arrears to the Department. The letters also inform providers if they do not contact the Collections unit within the 15 days to pay the debt owed in full or to make payment arrangements, OIG can terminate and/or debar them from participation in the Medicaid Program. If the provider does not make payments or make payment arrangements, then the provider and owner information is referred to the OIG-Office of Counsel to the Inspector General (OCIG) for termination/debarment proceedings. In addition, the Fiscal Management staff have worked closely with OCIG to implement an affidavit process whereby if the provider does not cooperate with the collection process, then the affidavit assists OCIG in their administrative hearing processes for settlement, termination and/or barrment from the Medicaid Program.

Fiscal Management is responsible for procuring and monitoring of all contracts, interagency agreements, and vouchering for OIG. OIG secures procurement and continually monitors approximately 50 contracts and 13 interagency agreements per year. OIG also contracts with external entities to provide consultation services in a variety of capacities, such as Medical and Statistical Consultants, CPA and other Auditing transcription and court-reporting services.

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 to determine if the provider is actively enrolled in the Medicaid Program.

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

Administration

If the provider is actively enrolled, OCIG imposes a payment suspension to hold any future payments 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), which allows the IOC to intercept any other state monies that may become payable to that provider and redirect the monies to 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 collection efforts are unsuccessful after 90 days, 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 Illinois Attorney General (AG) for Collection Action

If property ownership and/or employment are established, a collection action is requested through the IL AG's Office. The AG's efforts may include wage garnishment, if individual's wages are sufficient to satisfy the amount owed to the Department and/or liens on personal property.² A Collection Action Referral is prepared in accordance with the guidelines set forth by the AG'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 AG's Office is successful in obtaining funds from the provider and/or owner, these funds are collected by the AG's Office and routed to OIG and applied to the debt.

Referrals to the Illinois Attorney General for Bad Debt Write-Off

When all collection efforts have been exhausted, a request is submitted to the AG'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 AG's Office for processing. If the AG deems the debt uncollectible, the previously established receivable is reduced by the amount certified as uncollectible and written off.³

The 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, the OIG has worked extensively on building a strong working relationship with the AG 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 AG, the OIG has had increased success rates of overpayment fund recovery.

² 735 ILCS 5/12-801 et seq.

³ The state receives their FFP portion at the time the receivable is written off.

Administration

Management, Research and Analysis (MRA)

Management, Research and Analysis (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 the OIG. MRA is also responsible for evaluating program policies and procedures relating to Medicaid fraud, and serves as the OIG liaison with Agency staff to facilitate attainment of project or study goals on monthly statistical reports for all OIG bureaus. The MRA Manager is the liaison with the Managed Care Organizations (MCOs) and oversees the Fraud, Waste and Abuse Executive (FAE).

The MRA section in FY20 suffered the loss of two key staff which greatly hindered the productivity of the Unit. No risk-based essays were written, however two are already in production for FY21 based on identified risks to the Department and overall integrity of the Illinois Medicaid Program.

The COVID-19 public health emergency did not have any real effect on the functioning of this Unit. Technology has allowed for continuity of information sharing, and if anything, has increased the communication by allowing for more opportunities of webinars and teleconferences in place of in-person meetings. FY20 saw an increase in OIG's participation in national collaborative teleconferences. The OIG participates regularly in meetings with other states to learn best practices for Program and Data integrity (PI and DI) for the Medicaid program as well as issues and concerns for FWA in managed care programs.

As the OIG liaison, the MRA section works closely with the MCOs to facilitate improved communication and increased information sharing between them and the Department. Additionally, MRA staff work closely with the HFS-Bureau of Managed Care (BMC) to address and identify areas of concern regarding PI for the Department. OIG holds monthly case review meetings,

which are attended by representatives from the MCOs, Illinois State Police-Medicaid Fraud Control Unit (ISP-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 PI arena, and bridge the gap between MCOs, law enforcement and the Department. In these meetings, 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.

OIG previously met quarterly with the MCOs and HFS-BMC as a group to review any concerns and questions, and to provide updates on any departmental or policy issues. In FY19, the meetings were scheduled monthly instead of quarterly in order to increase communication and this continued into FY20. This allows the Department, as well as our law enforcement counterparts, to openly discuss specific topics and investigations which may be of an urgent or ongoing nature and which may have commonality across different payers or books of business. Additionally, new processes and reporting methods have been implemented and are being tracked and monitored which allows for greater interaction and information sharing between the MCOs and the Department.

Continuing in FY20 was the monthly correspondence between OIG and the MCOs, to act as a check-and-balance and ensure the plans are aware of any cases under payment suspensions and any cases under any criminal or civil investigation. This new communication has been well received.

As noted in the Medicaid Program Integrity Spotlight section (MPIS), in FY19, the OIG submitted contract changes to amend the current managed care contract for a robust PI presence. The contractual changes included a recovery or "clawback" provision which would allow for the State Medicaid Agency (HFS) to recover misspent funds. This language was not included in the contract amendment, which poses concern regarding PI/DI, especially as managed care takes dominance in the provision of Medicaid care in Illinois. Through data analysis, the OIG is continually finding areas of concern regarding PI and is continuing to address these with the MCOs and with the Department Administration.

Administration

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. In FY20, OIG worked in collaboration with Illinois Association of Medicaid Health Plans (IAMHP) to present a 2-day collaborative webinar cross training session in June 2020. The session trained attendees on fraud in Medicaid Waiver programs and included speakers from OIG, ISP-MFCU, AG-MFCU, HHS-OIG and the sister agencies (DHS and Department of Aging).

The COVID-19 public health emergency has allowed for more opportunities of webinars and teleconferences in place of in-person meetings. Collaboration between sister agencies as well as national FWA counterparts like National Health Care Anti-Fraud Association (NHCAA) and the Healthcare Fraud Prevention Partnership (HFPP) have provided many educational opportunities. Being members of these organizations has opened the door to many free educational tools and resources for auditors, investigators and data analytics staff at OIG.

Fraud Abuse Executive (FAE)

The Fraud Abuse Executive (FAE) is the primary liaison with state and federal law enforcement entities, as well as other governmental 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 (ISP-MFCU). The FAE evaluates and transmits fraud, waste and abuse referrals to MFCU, as well as other governmental agencies, depending upon the allegation.

The COVID-19 public health emergency did not have any real effect on the functioning of this Unit. Technology has allowed for continuity of information sharing, and if anything, has increased the communication by allowing for more opportunities of webinars and teleconferences in place of in-person meetings.

The OIG supports other law enforcement counterparts such as key entities within the US federal government: Department of Health and Human Services Office of Inspector General (HHSOIG), CMS, Federal Bureau of Investigations (FBI), U.S. Department of Justice (USDOJ), U.S. Attorney's Offices, and the 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 together 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.

Highlights

External referrals: 68

Global Settlement Agreements: 7

Referrals to MFCU: 13

Data requests from law enforcement: 88

MCO Information and data requests: 28

Referred to BAL for termination: 52

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, coordinates internal administrative actions as necessary. Administrative actions include 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 the OIG and ensures that providers are administratively sanctioned if any criminal or civil cases result in convictions. After legal processes result in convictions of providers, the FAE works in conjunction with OCIG to administratively terminate these providers from the Illinois Medicaid Program.

Administration

The OIG is statutorily required to suspend payments to Medicaid providers when the OIG determines a credible allegation of fraud exists. 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 FY20, the OIG is withholding payments from providers with credible evidence or allegations of fraud, totaling over \$3.8 million dollars.⁴ OIG also works in collaboration with the Managed Care Organizations (MCO) on ensuring compliance with OIG issues program integrity actions.

Personal Assistants and waiver provider fraud is one category of providers which the OIG and law enforcement act upon regularly, both at a state and national level. In FY20, the OIG worked directly with DHS–DORS to change the enrollment process to more appropriately apply PI principles to the program. Through collaboration and in utilizing the SEIU negotiated

Collective Bargaining Agreement (CBA), OIG and DHS–DORS have worked together to establish a more efficient process to reviewing PA fraud allegations and potential non-eligible providers.

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 the 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 and HHS-OIG and the DEA. These referrals can result from the OIG provider committee reviews, audits, review cases or Provider Analysis Unit (PAU) cases, in which provider education, licensing concerns or billing concerns have been identified and need to be addressed within another jurisdiction.



⁴ This dollar amount does not include MCO payment information or monies held by sister agencies and represents all Fee for Service (FFS) held payments as of 09/25/20.

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 case tracking, and document management system developed specifically for the OIG. BFST also manages healthcare 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).

All BFST initiatives center around the OIG mission to ensure program integrity, while evaluating data integrity. The case investigative tool is being upgraded for additional functionality using newer technology and extending usage options to entities outside of the OIG that have similar programmatic responsibilities.

FY20 FST/TMU Highlights

The **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) and Teradata SQL, 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 the OIG's operational and decision-making processes.

The **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 key to the success of the various units within OIG.

TMU coordinated resolution of 4,210 OIG Help Desk inquiries on FY20. Another function of TMU is to complete data requests from Federal, State, & Local Law Enforcement Agencies. 104 data requests were completed, many of which will result in dollars being returned to the State through court decisions and settlements. TMU assisted with ongoing testing and implementation of new features and software related to the Enterprise Data Warehouse (EDW) and the upcoming CORE claiming system. Staff continued testing on the State's Enterprise Resource Program (ERP) project which went live on 1/1/2020. CASE reports were migrated into DoIT's Shared Services and now all of CASE is hosted in Shared Services. With the COVID-19 public health emergency, TMU staff quickly adjusted to supporting staff who were working remotely. 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.

Dynamic Network Analysis (DNA) Framework Enhancement

In FY20, more than 11,000 jobs were submitted to the Dynamic Network Analysis (DNA) Framework system that the Bureau of Fraud Science & Technology (BFST) tasks a development team to oversee maintenance and enhancement. Of these jobs, the most frequently used reports were the recipient profile, recipient claim details, WARP report, marriage divorce report, and provider profile report. To address changes to state policies and regulations, the DNA development team must continuously revise existing programs of and develop new functionalities for the system to meet the needs of users. These revisions and developments to the system allows the BFST to better address the changing nature of waste, abuse, and fraud in the Medicaid Program. Under BFST's direction and guidance, a list of enhancement

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and development priorities was laid out for FY20. The list included an early warning enhancement, procedure code outlier model development, audit tracking enrichment, sampling automation, and provider impact profile development.

Early Warning Enhancement

Currently, various statistical models support detection of potential Medicaid fraud and abuse from different angles. For instance, the outlier model lists all atypical providers with extremely high payments, number of services, or number of recipients for a limited span time. The transportation during in-patient routine aids detection of all fraudulent transportation services while recipients have an in-patient hospital stay. The Time Dependent Billing routine (TDB), calculates the aggregate time to render all billed procedure codes based on corresponding service time from the CMS guideline, which can help identify all providers who overwhelmingly bill for procedures in limited span of time.

Unlike these passive models or routines that allow a one-dimensional view, the early warning system is an active model ranking all providers under their provider types by multi-dimensional views. The model combines different scores from other models and generates a comprehensive rank for all providers. The advantage of the early warning system is that it allows the user to scan all providers and pro-actively identify any potential fraudulent targets.

Procedure Code Outlier Model Development

Although payment, services, and recipients are the most common variables used in statistical models, when used to render a volume of services that exceeds hundreds of recipients, caveats exist in detecting abnormal billing patterns of practitioners. As a result, it's highly possible that the traces of problematic claims are buried among those voluminous services. To address this, the DNA team developed the procedure code outlier model. The payment and the number of recipients are grouped by all rendered procedure codes for a given provider and, simultaneously, the billing pattern of procedure codes of the provider in question is compared against his/her peers under similar circumstances. This approach more easily locates suspicious providers with unusual billing behaviors. It also allows further review of the providers with highly concentrated payments for a limited number of a procedure codes. Distribution of procedure codes across the state is available from this model.

Audit Tracking Enrichment

Built into the DNA system, universe creation and audit verification modules streamline the auditing processes. The verification database stores all demographic information of previously audited providers and corresponding audit universes. In addition, the accepted self-disclosure claims are loaded into the database. The DNA team designed and implemented the interface to search audit records by a range of variables that include Case ID, Audit ID, and Provider ID. Users can check if a provider was audited in the past and retrieve statistical information that includes sampling unit, sampling method, and sample seed.

Sampling Automation

After identifying providers with possible abusive and/or fraudulent activities, further investigation of detailed provider claims is needed. However, these providers normally have a large number of claims that make reviewing every claim detail improbable and inefficient. The simple random sampling process is desirable for auditors to concentrate on the sampled records for finding any errors. Different sampling units are used based on the variation of provider types to ensure the sample is representative of the whole claim universe.

In the past, sampling creation was a manual process that involved lengthy email communications, manual database integrity verification, and manual data processing. The automation of the simple random sampling process was necessary to not only improve the timeconsuming communication issue, but also to reduce the error-prone manual process.

The DNA team built this function by providing a concise form that works with automation programs running behind scenes. Users create a new sampling job that handles the most common cases and download the result from the job manager. An alert is sent to the DNA team in case if an endless loop occurs; in some extreme cases this occurs due to data irregularity. The DNA application provides additional automation tools for the team and automatically collects logs to facilitate manual intervention. Gradually these rare cases are incorporated into the model as part of the training process to make the model more robust and stable.

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Statistical Validation on Recoupment Calculation

Interpretation and extrapolation becomes a necessary step to estimate the recoupment amount in line with claim universe size, universe dollar amount, sample size, sample dollar amount, and confidence bound estimate of recoupment amount once auditors complete reviewing records of the Provider Claim Details (PCD) and identify error findings.

Auditors can upload their findings to the Statistical Verification module and an automated workflow is triggered to perform a systematic statistical formulas validation and calculation of confidence bound, sum of square on paid and discrepancy amounts, and estimate of recoupment amount in consideration of different sampling scenarios. Finally, a set of packaged reports, including provider summary report, recoupment worksheet, and audit schedules, are downloadable from the job manager.

Provider Impact Profile Development

Illinois Medicaid Program Advanced Cloud Technology (IMPACT) was a multi-agency effort to replace Illinois' old Medicaid Management Information System (MMIS) to meet federal requirements in the Affordable Care Act. The provider enrollment component was built a few years ago and more information related to providers is now collected compared to the legacy system. For instance, the vehicle identification number (VIN) for transportation providers, subspecialty and taxonomy for individual practitioners, and owner information are now collected. A plethora of information is needed to conduct provider analysis for investigators and auditors. Nevertheless, it's not efficient to extract the comprehensive data points for a given provider. Resultant of this, the DNA team developed the provider IMPACT profile as a one-stop shop to organize and present relevant information

available from both IMPACT and the legacy systems, increasing efficiency and productivity. The user only needs to fill in either the legacy Provider ID, Impact ID, or national provider identifier (NPI), and the report is ready in a few minutes. The DNA team continues revising this profile making the information more accurate and reliable.

Opioid Analysis Addition to DNA

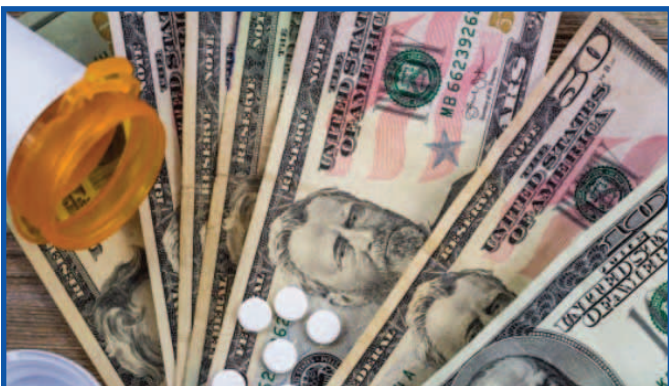
Last year the DNA development team adopted an opioid calculation toolkit from the Office of the Inspector General of the U.S. Department of Health & Human Services and validated the outcome of morphine milligram equivalents (MME). In FY20, to meet the needs from different user types, an opioid monitoring dashboard was added to the executive summary module. Additionally, the customized opioid usage report and opioid inquiry modules were made available for general users.

The opioid dashboard module helps users visualize the usage trend of opioid related drugs for the past five years by MME levels. Management users can choose either the overall statistics or a specific opioid, displaying payment, services, recipients from both FFS and MCO, and the number of involved pharmacies.

The opioid usage report predefines report types by prescriber, recipient, or both prescriber and recipient. The additional selection criteria changes according to selected report type. The report summarizes opioid usage by prescribers, recipients, and drug type, providing different measures identifying patients at risk of opioid misuse or overdose. The indicators of opioid usage days by MME levels and average MME, over a certain period, are only available in the opioid usage report.

Covid-19 Service & Payment Monitoring

On January 31, 2020, the Secretary of the U.S. Department of Health and Human Services (HHS) declared a public health emergency in response to COVID-19. The Illinois Department of Healthcare and Family Services quickly implemented and released relevant regulations and policies to address the growing COVID-19 public health emergency. Accordingly, the DNA development team performed data analytics on COVID-19 related diagnosis and procedures, summarizing number of services, recipients, and provider charged amounts, as well as payment by Fee-For-Service and Managed Care Organization types. The breakdown by each MCO



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organization gives management users an overall picture on COVID-19 expenditures, whereas the analysis of hospitals, nursing facilities, independent labs, home health agencies, and individual practitioners provide detailed information to evaluate if waste, abuse, or fraudulent activities occurred. A similar algorithm is applied to the service area of tele-health, teledentistry, E-visit, and virtual check-in to detect occurrences of abnormality during this pandemic. As the situation of coronavirus evolves rapidly, the DNA team frequently updates routines to adopt new rules and regulations to identify potential providers for audit and investigation.

User Interface Improvement

The DNA team developed a card to present query results and job details to provide context-aware drill-down menus based on the contents. Previously, the drill-down could provide one level deep results in the form of tables and charts for the same card. This year, additional capacity was added to the card to enable multi-step queries. As a result, the card is not limited to the same screen, allowing continuous data navigation from page to page. This feature was first applied to the provider and procedure code menus, allowing navigation from a provider to the rendered procedure codes. This also allows the same functionality while reviewing a specific procedure code as the user explores providers serviced in the procedure code.



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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). PAU is comprised of five nurses and a nurse manager. The RAU and monitoring program include three full time analysts.

Provider Analysis Unit

Due to the COVID-19 public health emergency, All PRAS staff began working remotely approximately 3 weeks after the public health emergency was declared. Staff worked diligently to create a “home office” enabling them to continue their work for OIG. Some even purchased their own equipment and have remained diligent in their work product.

PAU nurse analysts provide clinical expertise for OIG investigations into researching aberrant 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 identify billing outliers. Billing trends, payment amounts, business interrelationships and pharmaceutical prescribing patterns are all reviewed and compared to similar providers, within the same specialty.

After review of each provider, the findings are presented at the OIG’s Narrative Review Committee (NRC). NRC is comprised of Acting Inspector General Patrick Conlon, managers of PRAS, Peer Unit, Audit Unit and OCIG and 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 the NRC 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 suspected criminal violations
- referral to other federal or state agencies, depending on violation

FY20 PRAS Highlights:

- 467 provider referrals received
 - Of these, 200 cases were closed due to no FWA identified in the referral.
- 143 medical providers analyzed
 - 49 cases presented to Narrative Review Committee
 - 94 cases closed with no further action warranted as allegations were unsubstantiated

180/365 day monitoring program:

Non-Emergency Transportation, DME, Lab providers

- 282 providers monitored and analyzed
 - 79 enrolled as participating providers
 - 22 disenrolled
 - 2 terminated by the Provider Review Committee for non-compliance
 - 179 cases currently being monitored during their 365-day monitoring process.

- recommendation for denial/disenrollment or additional monitoring of moderate/high risk providers (180/365)
- recommendation to HFS administration for a policy change as evidenced by the following scenario:

The OIG PAU has increased the use of and reliance on data analytics to identify provider and recipient fraud. Referrals of fraud are also received from the OIG fraud hotline, other agencies, and various law enforcement entities. 467 provider fraud referrals were received in FY20. Potential fraud, waste or abuse was identified in 267 of those cases and those were created for further investigation. The PAU nurse investigators provide clinical expertise while performing indepth analysis of billing records to determine if claims and services are appropriate compared to similar providers within the same specialty. The Narrative Review Committee (NRC) reviewed 49 of the PAU cases, many of which were forwarded for internal review such as Peer Review or Audit, while other cases are referred to external units such as the Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU), the IDFPR and/or the DEA for more in-depth investigations. Many of this year’s PAU cases involved prescribing patterns for narcotic or controlled drugs. If prescribing concerns were substantiated by the analyst, these providers may have received an educational letter of concern from the OIG outlining prescribing guidelines for various medications or some may have been referred to ISP-MFCU, the Drug Enforcement

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Agency (DEA) and IDFP and/or payment suspended while the investigations continued. Dental providers were also a common provider-type reviewed by the nurse investigators due to allegations of unlicensed, unqualified persons performing services, upcoding simple extractions to surgical extractions or for billing for services not rendered.

Behavioral Health and Telemedicine claims have significantly increased since the COVID-19 public health emergency. Nationally these types of providers have been flagged for potential fraud, waste and abuse. Therefore, the OIG will be focusing closely on these provider types moving forward to determine if any fraudulent activities were noted for the Illinois Medicaid Program during the public health emergency.

Through the relationship with HFS-OIG and the National Advocacy Council/Medicaid Integrity Institute (NAC/MII), OIG staff obtains valuable and prestigious educational training which adds value to the OIG investigations. In FY20, two PAU nurses attended the MII for training, and later passed national certification tests, becoming Certified Program Integrity Professional. (CPIP). CPIP is a prestigious certification held by very few Medicaid analysts across the country. The intense training includes fundamental courses and examinations exploring common and emerging healthcare fraud schemes and trains students on investigative techniques, evidence gathering, and preparation of cases for prosecution.



180/365 Conditional Enrollment

New Provider Verification (NPV) involves pre-enrollment monitoring or “365-day conditional enrollment” of non-emergency medical 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.

Non-emergency medical transportation (NEMT) providers, as well as laboratories and durable medical equipment providers, are considered medium or high-risk provider types. Upon initial enrollment and for one year afterwards, the OIG monitors billing patterns for each of these provider types to detect potential billing abnormalities or fraudulent activities. Claims are analyzed at about 180 days post enrollment at which time the analyst contacts the provider to offer guidance and answer questions they may have, and then again just prior to the end of 365-day monitoring period. If no concerns are identified during the review the provider becomes a fully enrolled Medicaid provider. If problems are identified, the provider may be granted a conditional enrollment extension or may be disenrolled, depending on issues identified.

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 provider billing patterns to determine or detect any potential billing abnormalities or aberrant behaviors. The analyst will often contact providers to validate findings 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. These the findings are presented at the OIG's Provider Review Committee. This committee is comprised of the Inspector General, managers of PRAS, Peer, and OCIG and includes representatives from Provider Enrollment Services. 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.

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Recipient Analysis Unit (RAU)

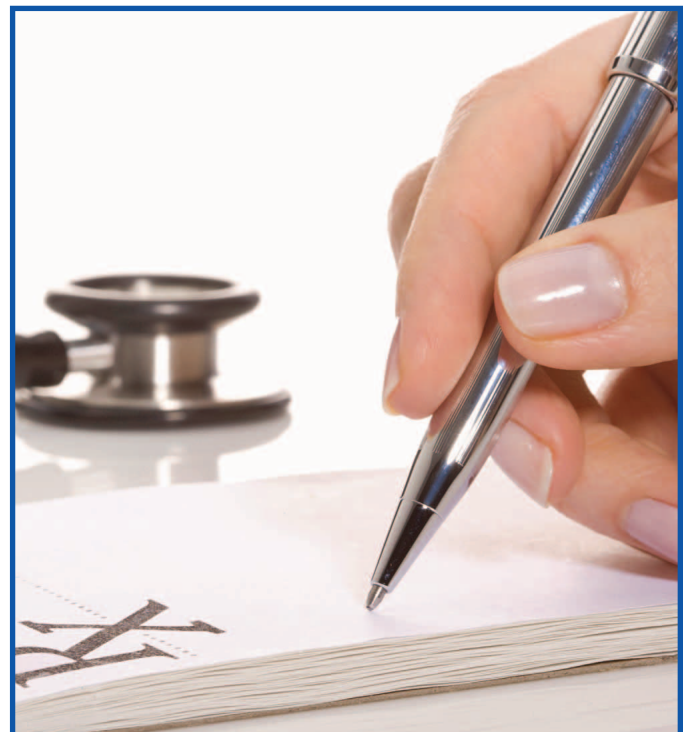
The purpose of the Recipient Restriction Program (RRP) is to identify, detect and prevent abuse of medical and pharmaceutical benefits, based on set parameters in federal and state regulations, as well as HFS policy. RRP uses the DNA Predictive Analytic model and profile-reporting system for data that 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” or restriction program. Specific indicators will trigger restriction program intervention, warranting assignment to a single primary care provider in both FFS and MCO plans. 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. Previously, one RAU analyst was dedicated part-time to evaluating recipients who have been identified through data analytics or by referrals, as being prescribed the “Vegas Cocktail”.⁶ However, in in FY20, two full time analysts evaluated all cases for narcotic and controlled drug overuse and/or abuse, inducing the Vegas Cocktail.

The OIG continues to provide ongoing support and guidance to our MCO partners in their development of restriction programs.

FY20 RAU Highlights:

- 3,006 cases reviewed
 - 2,888 computer generated selection cases
 - 118 individual recipient fraud referrals received from other units or external sources
- 260 cases recommended for restriction/lock-in
 - 46 new recipients restricted in FFS
 - 214 new restrictions recommended to MCOs
- 1,597 Total number of FFS restrictions as of 06/30/20
- 2,746 Total Medicaid recipients reviewed but not restricted (FFS and MCO)
 - 273 due to recipient's eligibility cancelled
 - 6 due to recipient death
 - 52 due to recipient restriction released (in compliance)
 - 2,415 due to no restrictions warranted (appropriate utilization)
- Total cost avoidance for RRP: \$131,953⁵



⁵ Due to patient restriction logic being re-evaluated and receiving updates during the year, the number of reviews not resulting in restrictions was inflated. This logic will be reviewed in the upcoming year for more efficient and effective use of staff resources.

⁶ Vegas Cocktail is a combination of concurrent opiates, benzodiazepines and muscle relaxant prescriptions being dispensed to the same individual.

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 controlling access of HFS facilities, and monitoring the safety of employees and visitors in Department buildings. BIA's monitoring includes security oversight of HFS, which involves conducting threat assessments received against state employees, Department assets, and Department buildings.

BIA continues to monitor employee Internet traffic and usage of State resources by utilizing a variety of investigative methods to identify inappropriate staff activity, including the misuse of State resources and time. BIA also has the capability to run computer forensic examinations on HFS computers when an investigation warrants such action.

BIA saw a variety of changes and adjustments that came with the COVID-19 public health emergency. As BIA navigated what their work and obligations were, BIA was at the forefront of locking down HFS facilities, making sure

FY20 BIA Highlights:

Total Staff: 12

Open/Active Cases: 11⁷

Total Cases Opened: 648

Total Completed Cases: 637

- **Substantiated cases: 72**

Average Case Processing Time:

- **Background Investigations: 11 Days**

- **General Investigations: 155 Days⁸**

HFS had safe working environments for staff to return, and ensured employees could access HFS facilities after months of inactivity. BIA continued to work with the Illinois Emergency Management Agency (IEMA) and the State Emergency Operations Center (SEOC) to gain personal protective equipment (PPE) for HFS staff, discuss emergency plans, and pass along guidance from daily briefings.



⁷ Open cases as of July 1, 2020 (start of FY21).

⁸ During Fiscal Year 2020 BIA closed two cases that have been on hold pending criminal outcomes. The two criminal cases averaged 958 days per case. BIA's average case processing time without the delayed criminal cases was 106.36 days.

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During FY20, BIA had a 20.81% increase in the number of background cases that were opened compared to FY19. BIA saw an increase of total cases opened by 15.71% from FY19 (560 cases opened) to FY20 (648 cases opened). In addition to an increase in cases opened and closed, BIA's substantiated cases rose 125.00% from FY19 (32) to FY20 (72).

BIA Investigative Reports are completed and shared with the agency's Division Administrators, the Bureau of Labor Relations, and when necessary, State and Federal authorities. Once an investigation is complete and the report is published, the Division Administrator or Labor Relations are required to report back any action taken within 30 days to BIA.

BIA Initiatives

This year, along with conducting our standard background checks, BIA developed new procedures for background checks to ensure HFS was compliant with Internal Revenue Service (IRS) Publication 1075 (Pub. 1075) standards. IRS Pub. 1075 states that any Federal, State, or local authority who receives or reviews federal tax information (FTI) must have adequate safeguards in place to protect taxpayer confidentiality. BIA was tasked with organizing the fingerprinting of all current staff that have access to FTI, reviewing those results, and ensuring that only the employees who meet the Pub. 1075 standard remain in those positions. The fingerprint and review processes are also followed for potential new hires.

BIA also provided two staff members as liaisons on the "Return to Work" committee, which discussed and implemented guidelines to help employees return to work in the safest and most efficient way. BIA established a new mailbox for staff to report concerns and ask questions pertaining to the workplace and the COVID-19 public health emergency. Employees can send those emails to the mailbox named HFS.Info.CoronaVirus@illinois.gov.

FY 20 Investigative Significant Cases

BIA Investigation Yields Resignation from Multiple Violations

In April 2019, BIA received a complaint alleging that a Human Resource Specialist violated HFS policy by utilizing an assigned computer for personal use. BIA completed a forensic analysis of the employee's assigned computer,

email account, and submitted HFS e-2053 leave requests. BIA identified that the employee frequently violated the HFS computer use policy by shopping for personal items online. BIA also discovered that the employee violated several other HFS policies by altering/forging hiring file documents, submitting various false e-2053 leave requests for purported military leave with pay, sharing confidential Human Resource information, and other violations. During the interview the employee admitted to wrongdoing and opted to resign.

Internal Fraud Detection Operations: HFS Employee Resigns After Taking Advantage of Position

In August 2019, an Office Associate, who was also an HFS bureau timekeeper, resigned in lieu of discharge, following a substantiated investigation. BIA investigators reviewed emails and text messages from the employee calling off for work, the employee's HFS e-2053 leave request history, timekeeping records, and the employee's computer usage, finding that the employee failed to submit HFS e-2053 leave requests after calling off work on 36 days in an eight-month period. The employee was also required to repay \$3,000.

Time Abuse Results in a Three-Day Suspension

In November 2019, a complaint was received alleging that an Administrative Assistant II violated HFS policy by abusing time and falsifying timesheets. BIA investigated and determined that on ten consecutive workdays, the employee arrived after the start time indicated on submitted HFS 163 timesheets without submitting any HFS e-2053 leave requests covering the time missed. Further investigation completed by BIA revealed that the employee used an assigned State of Illinois computer to frequent non-work-related websites. The employee was interviewed and admitted to the misconduct, ultimately received a three-day suspension without pay.

Information Systems Analyst II Retires During Investigation

In November 2019, a complaint was received about an Information System Analyst II using a personal USB storage device on a State of Illinois computer. BIA subsequently imaged and analyzed the employee's computer, identifying that several different USB storage devices had been used by the employee while accessing the computer, that the

Bureau of Internal Affairs

employee's computer contained numerous link files, 415 non-state related .MP3 audio files containing podcasts, and several personal documents. During the employee's interview, he admitted to violating policy. The investigation did not identify the transferring any sensitive State of Illinois data onto USB storage devices. The employee retired from State employment prior to the conclusion of this investigation.

Internal Fraud Detection Operations: Employee Receives 29- Day Suspension for Conduct Unbecoming/Sexual Harassment

In August 2019, BIA was contacted about a complaint of inappropriate and unwelcomed behavior, some of which was sexual in nature, by a Child Support Specialist I. BIA obtained video imagery and still photos of the alleged incident. During the investigation BIA identified several other employees who reported that they were similarly harassed by the same employee. BIA also identified that the employee had previously been suspended for inappropriate conduct related to sexual harassment. BIA obtained written statements and interviewed the individuals who made allegations. During the subject interview, the employee

admitted to being familiar with laws and policies related to sexual harassment but denied the allegations and any wrongdoing. Though some of the claims made by the employees lacked additional evidence, the overwhelming amount of coincidences along with video and picture images of the initial complaint resulted in a sustained finding. The employee was suspended 29 days.

BIA Digs Deeper and Finds Deceit

In November 2019, BIA was informed that a Public Aid Investigator was arrested related to a domestic violence altercation. During the course of the investigation, BIA reviewed documents related to the arrest, as well as, the employee's personnel file. During an interview the employee answered questions about the arrest and separation from a previous employer. BIA investigators pursued the circumstances surrounding the former employment and identified major discrepancies between the employee's statements and documentation obtained from the previous employer. As a result of the BIA investigation the employee resigned from HFS prior to the conclusion of the investigation.



Bureau of Investigations

SECTION

4



Bureau of Investigations

Investigations, SNAP Fraud, NPV, WARP

The Bureau of Investigations (BOI) investigates allegations of suspected fraud, waste and abuse by recipients and providers against Department programs including SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families), Child Care Program, and general eligibility for Medicaid benefits. The BOI may pursue criminal prosecution or administrative sanctions against any recipient or provider. The Bureau is comprised of four units: Investigations, SNAP Fraud, New Provider Verification (NPV) and Welfare Abuse Recovery Program (WARP).

Investigations

During the process of investigating allegations of provider and recipient fraud, the Bureau works together with state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies.

Eligibility Fraud

The OIG conducts investigations when recipients are suspected of misrepresenting their eligibility for public assistance. Investigation results are provided to Department of Human Services' (DHS) Bureau of Collections to calculate the recoupment of overpayments. In cases with large overpayments or aggravated circumstances, the OIG prepares cases for criminal prosecution and presents them to a state's attorney or a U.S. Attorney. Eligibility factors include non-reported earnings, other income, household composition, residence and duplicate benefits. Cases that are considered for criminal prosecution but fail to meet prosecutorial merit are administratively closed and returned to DHS for collection activity.

Significant Eligibility Cases

An eligibility investigation found that a SNAP recipient did not report to DHS that the responsible relative continued to live in the home even after she reported him no longer in the assistance unit. The results of the investigation have been submitted to the DHS local office with an estimated SNAP overpayment established of \$43,205 for the period of January 2013 to September 2019.

A BOI eligibility investigation uncovered that a SNAP recipient did not report to DHS that two people living in the assistance unit had unreported income. The results of the investigation have been submitted to the DHS locate office with an estimated SNAP overpayment established of \$54,074 for the period of January 2015 to August 2019.

FY20 Investigations Highlights

Total Staff: 24

Identified Overpayments: \$5.7 million

Client Eligibility Completed Cases: 599 (of these 407 were founded and 192 were unfounded)

Referred for Prosecution with the State's Attorney: 20 Open/Active Cases: 2,053

Personal Assistant Cases Completed: 114

Onsite Visits Completed: 125

Child Care Program Cases Completed: 4

Child Care Program Identified Overpayments: \$146,533

An eligibility investigation found that a SNAP recipient did not report her son was no longer living in the assistance unit. It was determined the child was living in the responsible relative's home. The results of the investigation have been submitted to the DHS locate office with an estimated SNAP overpayment of \$66,300 for the period of January 2012 to January 2020.

A client eligibility investigation was completed that revealed a SNAP recipient did not report to DHS that a responsible relative, the father of the SNAP recipient's children, was residing in the assistance unit with unreported income from employment and unemployment insurance benefits. The results of the investigation were submitted to the DHS local office, which calculated a SNAP overpayment of \$36,177 for the period of August 2014 through May 2020.

An eligibility investigation was completed for a client eligibility case that alleged a recipient was falsely reporting her children as part of her household to the Department of Human Services. The investigation revealed the recipient falsely reported three of her children were residing in her household from May 2015 through December 2019. The recipient falsely reported another child was a member of her household from May 2015 through August 2017 and October through December 2019. The children were placed outside of the recipient's household with court documents, school verifications, Secretary of State Records and a third-party interview. The recipient failed to submit custody verification for the children. An estimated SNAP overpayment totaled at \$40,256 for the period of May 2015 through December 2019.

An eligibility investigation was completed for client eligibility case that alleged the public assistance recipient and the

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father of her children were living together after their separation, and the recipient did not report living with the father of her children or his income on the public assistance case. Caseworker notes on 6/10/2015 reflect the recipient reported the father of her children no longer lived in her household. The investigation found that the recipient lived with the father of her children from 2014 to 2019. The investigation found that the recipient and the father of her children and are the parents of four children per KIDS Parentage Inquiry. The investigation found the recipient and the father of her children both reported residing at the same address on their income tax returns from 2015 through 2018. The investigation found the recipient and the father of her children both reported residing at the same address on their driver's license registrations and vehicle registrations from 2017 through 2019. The investigation found the father of the children last reported residing at the same address as the recipient to his employers and to the Unemployment Office in 2018 and 2019. Post Office records reflect the recipient and the father of her children last received mail at the same address. The investigation found that the recipient failed to report her living with the father of her children and his income on her assistance case. Based on the information included, the allegation is founded, and it is recommended an overpayment be processed by DHS. An estimated SNAP overpayment totaled at \$40,038 for the period of July of 2015 through October of 2019.

An investigation was completed for a client eligibility case that alleged the recipient failed to report child support payment, social security benefits, income for employment at her parent's company, the father of two of her children resided in her home and she received monies from child care payments made to her sibling for watching her children. The investigation revealed the recipient did admit to having access to the childcare monies paid to her brother for supposedly caring for her children, the Responsible Relative/father of two of her children was in the home and he was employed by her father. An estimated SNAP overpayment totaled \$44,179.00 for the period of May 2012 through January 2020. This case will be presented to the Cook County State's Attorney after the Bureau of Collections completes their overpayment process.

Child Care Program Fraud

Investigations are conducted when recipients or providers are suspected of misrepresenting their eligibility for the Child Care Program. Recipient fraud can occur for a variety of reasons: earnings from providing childcare are not reported

as income, childcare needs are misrepresented, or childcare payments are stolen or diverted. Provider fraud occurs when claims are made for childcare not provided or for care billed at inappropriate rates. The results of these BOI investigations are provided to DHS' Bureau of Child Care and Development (BCCD). In cases where an overpayment has been identified, it is also referred to DHS' Bureau of Collections (BOC). Once BOC establishes the debt, the case is referred to the Illinois Office of the Comptroller for involuntary withholding. Should the debt become delinquent, cases are then referred to a private debt collector. Cases involving large overpayments or aggravated circumstances of fraud cases are often referred for criminal prosecution to a State's Attorney or a U.S. Attorney, or to the DHS' BOC for possible civil litigation.

Significant Child Care Program Cases

An investigation was completed for a childcare program fraud case, which revealed that a child care recipient lived with the father of her child. While living in the recipient's household, that father of the child had income from employment. The childcare recipient's failure to accurately report her household composition and income enabled her to fraudulently receive an estimated \$17,823 in child care benefits for the period of May 2018 through August 2019.

An investigation was completed for a child care case that alleged the recipient failed to include the Responsible Relative (RR)/father of her children on her child care applications and employment income and there were discrepancies for the recipient and her child care provider's (recipient's sibling) work schedules. The investigation revealed that the recipient's total household income which included child support and her kid's Responsible Relative's income exceeded the childcare standard eligibility. The estimated child care overpayment totaled \$99,376.03 for the period of January 2012 through October 2017. This will be presented to the Cook County State's Attorney after the Bureau of Child Care and Development completes their overpayment process.

New Provider Verification (NPV) On-Site Review

BOI investigators are charged with conducting on-site reviews of High-risk Medicaid 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

Bureau of Investigations

location of business is valid, and that all paperwork to conduct business in Illinois has been properly filed with the appropriate entities. This requirement is Federally mandated under 42 CFR § 455.450.

Medical Card Fraud

Investigations are conducted when recipients or providers are suspected of misuse or misrepresentations concerning use of medical benefits cards. 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 can 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 for further review.⁹

Personal Assistant (PA) Providers

The BOI's role is to review PAs who have criminal backgrounds which may preclude them from being Medicaid providers. The BOI conducts research on criminal history and determines if the providers have disqualifying criminal offenses. The Illinois 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 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.



⁹ During FY20, there were no Medical Card Fraud Investigations conducted.

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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 issued during the overpayment period multiplied by the length of the disqualification period.

Significant SNAP Fraud Unit Cases

During FY20, the SNAP Fraud Unit received completed and signed waivers for recipients who voluntarily withdraw from the program due to violations. One waiver was received for a recipient who received duplicate assistance. The overpayment was for \$2,573 but the cost avoidance calculation was \$23,040. The unit also received signed waivers for three cases that had overpayments of \$45,933; \$33,881; \$33,491 for two overpayments; \$33,088 and on one prosecution case that had an overpayment of \$38,589.

FY20 SNAP Fraud Highlights:

Total Staff: 2
Referrals Received: 1,381
Case Reviews Completed: 1,246
Identified Overpayment: \$1.4 million
Cost avoidance: \$777,288
Disqualification Hearings Held: 103
Disqualifications: 326
Open/Active cases: 78
Administrative Hearing Decisions Rendered: 51 (36 of these decisions were found in favor of the OIG)



New Provider Verification (NPV)

The New Provider Verification Unit has been working diligently to streamline and improve the efficiency of processing High and Moderate-Risk provider referrals from the HFS Provider Enrollment Services (PES) Unit. Monthly coordination meetings have greatly increased the clarification of duties and responsibilities between the units. Additionally, shifting the responsibility of document collection from the OIG to PES has improved timely review and processing of applications by the OIG. New policies, procedures and coordination of investigations ensure all parties maintain continuity of purpose. The Interagency Agreement (IAG) with the Department of Public Health (IDPH) to share on-site visit survey information will further reduce the burden of documentation gathering by OIG staff for High-risk Home Health Agencies. Additionally, the IAG eliminates the cost of travel and increases efficiency for an already understaffed unit.

FY20 NPV Highlights

Staff: 3
New Provider Verification Applications Reviewed: 360

- NPV Setup: 214
- Applications Denied: 9
- Application Withdrawn: 8
- Applications Denied: Criminal History: 13
- Enrolled: 95
- Applications Returned: 21

Provider Revalidation Applications Approved: 13
Provider Enrollment Services (PES) Modifications: 88

- Applications Withdrawn: 1
- Applications Approved: 77
- Applications Denied: 1
- Applications Returned: 9

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Modification Types:

Transportation Modifications:

Change of address; vehicles added; vehicles deleted; new drivers; change from service vehicle to Medicar vehicle.

Vehicles change: Proof of address change; vehicle registrations need address change, phone bill receipt with new address for verification.

Vehicle removed ensure provider has changed information in IMPACT and correct on CASE.

Add Vehicle: Documents would be vehicle registration; new plates or transfer of plates from vehicle that had been removed; proof of insurance on vehicles; city or municipal stickers needed for that location; if multiple vehicles are added and they only have a few drivers, need to contact provider and request list of all drivers, safety training, driver's license, SOS abstract; review all information to ensure no concerns on driving record and up to date on safety training, safety training is good for 3 years; ensure corporate ownership is in good standing.

DME:

Location change
License update
Owner/Manager change

Pharmacy:

Adding DME subspecialty

Home Health:

Location change
License update
Owner/Manager change

Physicians:

Reinstatement requests are sent as modifications.

Additional Modification Types:

Any modification submitted in IMPACT that gets an alleged "hit" in Lexis/Nexis, no matter the provider type, are sent to the NPV Unit; this is true especially for physicians. They are often sanctioned; usually updating a license, MCO, or billing provider.

Many modifications are group, Therapist, Physicians, dental, nurses, etc. The provider is adding a doctor to the group or changing address and it has an alleged "hit" on one of the providers. Then consent orders and criminal review is required, which is a time-consuming process as these providers are not required to be fingerprinted. There is no source to validate criminal record "hits" from different states in Lexis/Nexis.

The process of reviewing NPV cases includes reviewing and investigating fingerprint-based background checks, verifying licenses, insurances, corporate standings, and on-site visit results from BOI investigators.

Fingerprint-based background checks are completed on individuals with a 5 percent or greater ownership interest in a provider or supplier that falls under the High-risk provider category. Highrisk 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.

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Enrollment may be denied by the OIG for various reasons:

- an incomplete enrollment package;
- a non-operational business;
- the inability to contact the applicant;
- a requested application 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;
- 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 has implemented steps of action, including but not limited to payment suspensions and terminations.

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 from the public via a hotline, 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), Department of Public Health (DPH) vital records, Illinois Department of Employment Security (IDES) and the Division of Child Support Services (DCSS). WARP takes multiple steps in gathering, reviewing, and analyzing information regarding the referral and processes the referral in the OIG's CASE tracking system. Once cases are created and documentation is gathered, WARP routes cases appropriately, based on the findings.

Cases can be closed out due to lack of merit or information or sent to BOI for further investigation. Cases can also be sent to DHS' Family Community Resource Center (FCRC) for additional follow up or sent to the DHS-Bureau of Collections (BOC) to establish a dollar amount and time frame for a fraud overpayment. When DHS BOC receives a

FY20 WARP Highlights

Staff: 4

Referrals Received: 6,851

Desk Audit Referrals Reviewed: 74

Recipient Program Overpayments Established:

BOC Local Office SNAP:	\$187,542
BOC Local Office TANF:	\$16,555
Total:	\$204,097

referral, they respond to the OIG with the appropriate overpayment amount and timeframe of the overpayment referral, they respond to the OIG with the appropriate overpayment amount and timeframe of the overpayment.

In FY20, WARP received a total of 6,851 allegations of potential fraud, waste and abuse. These inquiries were received through phone calls, internet, mail, and e-mail. Of these, 74 cases were reviewed and a total of \$204,097 in SNAP and TANF overpayments were established as a result of a desk audit. These cases were completed by the WARP unit since the documentation received provided enough information to establish an overpayment.

All allegations of recipient fraud are set up by WARP and are

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researched and vetted through a variety of proprietary State and Federal databases. Some referrals can be completed without an interview or field visit, based on current case information, electronic verification, employment verification, school verification and court orders. Given the volume of fraud referrals received, the backlog of pending

investigations into allegations remains large. BOI lacks the investigative staff to keep up with the volume of received fraud referrals, conduct federally required on-site reviews and checks, as well as investigating fraud referrals for the sister agencies as required by statute.



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 quality control eligibility 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 Quality Control (QC).

Audits

The Audit Section of BMI conducts program integrity audits on all provider types enrolled as Medicaid providers and receive reimbursement from Healthcare and Family Services.

The Audit Section is also responsible for the oversight of the Certified Public Accountant 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, 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 several factors in determining the selection of providers for audit, including, but not limited to, data analysis; fraud and abuse trends; identified vulnerabilities of the Program; external complaints of potential fraud or improper billing; and a provider's category of risk.

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

- **Desk Audits** involve audit findings based mostly on the use of data analytics and algorithms that electronically analyze specific billing and reimbursement data. The OIG verifies the data outcomes using applicable law, regulations, and policy.
- **Field Audits** require a manual review of medical or other documentation by auditors. Field Audits also use data

FY20 Audit Highlights¹⁰

Total Audits Initiated: 204

Total Audits Completed: 3,612

Total Overpayments Collected: \$17.87 million

analytics but require a more thorough verification process by qualified professionals.

- **In-House Field Audits** mirror the same processes and procedures as a desk audit except 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.¹¹
- **Audit Sampling and Extrapolation** OIG audits may involve the use of sampling and extrapolation. Using statistical principles, the OIG selects a valid sample of the claims during the audit period in question and audits the provider's records for only those claims. The OIG then calculates an overpayment amount by extrapolating the findings of the sample to the overall universe.

External Contract Vendor Auditors

Certified Public Accountant (CPA) Audits

Three firms currently assist the BMI Audit unit in performing

¹⁰ Totals reflect in-house and external vendor contract audits. In-house and CPA initiated audits totaled 1,760, RAC initiated Audits totaled 3,444. In-house and CPA completed audits totaled 284, RAC completed audits was 3,328).

¹¹ <http://www.illinois.gov/hfs/oig/Documents/ProviderSelfDisclosureProtocol.pdf>.

Bureau of Medicaid Integrity

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

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

Universal Program Integrity Contractor (UPIC) Audits

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

Audit Section and the External Audit Vendors

In FY20, the Bureau's Audit Section and the External Audit vendors completed a total of 3,612 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 FY20, the total amount of Overpayments collected was \$17.87 million which is comprised over overpayments identified in FY20 and installment payments received from prior year audits.

FY20 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 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). The Illinois Department of Healthcare and Family Services (Office of Inspector General) 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 FY20, the OIG performed 25 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 FY21, 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 of at a minimum 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 FY20, the OIG performed 15 self-audits and recovered \$34,049 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. The 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

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of the self-audit, several hospitals implemented changes to their internal billing processes to prevent overpayments from occurring in the future.

- **Prevent Payment for Deceased Recipients**

In FY20 the OIG continued initiatives focused on areas of identified Program vulnerabilities. This includes preventing payments and recovering overpayments made for deceased recipients. In FY20 the OIG completed the remaining 13 postmortem audits from FY19 and identified and recovered \$5,130 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, the OIG identifies instances of credible allegations of fraud and appropriately refers the cases to law enforcement partners for further criminal investigation.

- **Transportation Audits**

In FY20, the OIG performed 189 audits to identify and potentially recover \$336,165 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. The 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.

FY21 Audit Initiatives

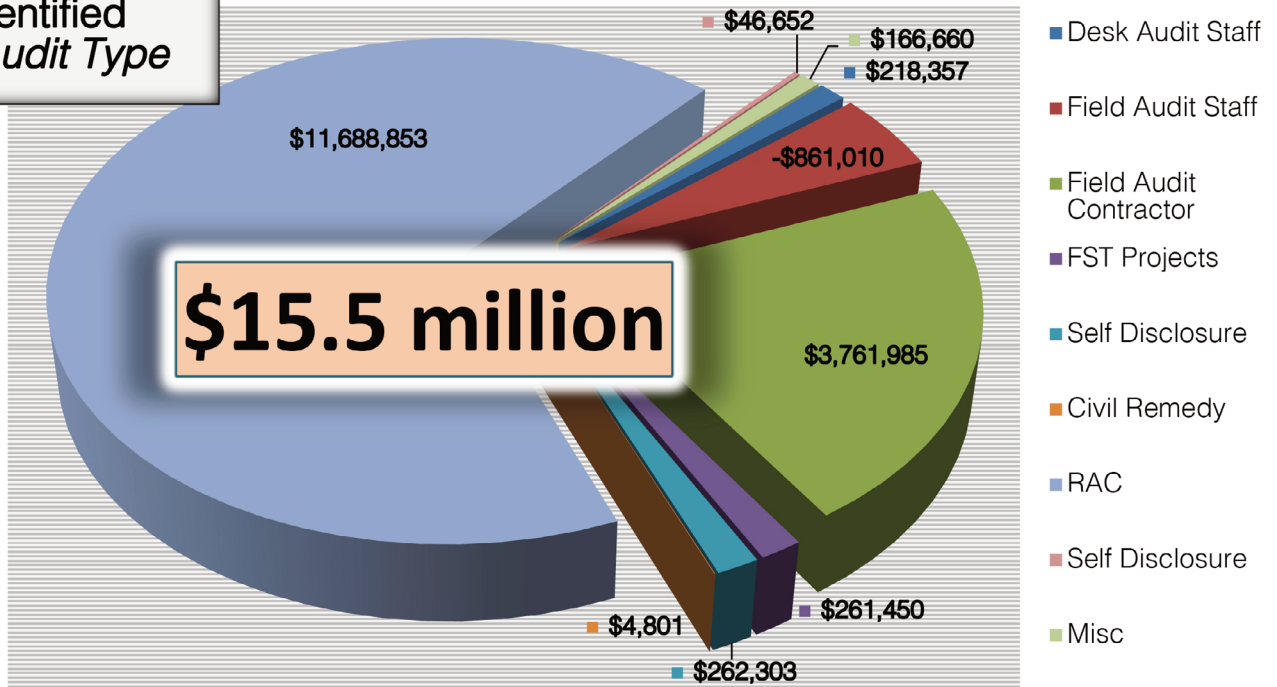
In addition to the continuation of the FY20 audit initiatives, the following will be additional OIG audit initiatives for FY21:

- **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 in 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 is 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 RAC vendor, will be conducting financial audits on 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 regarding services being provided to the enrollees and what the deliverables are within each contract.

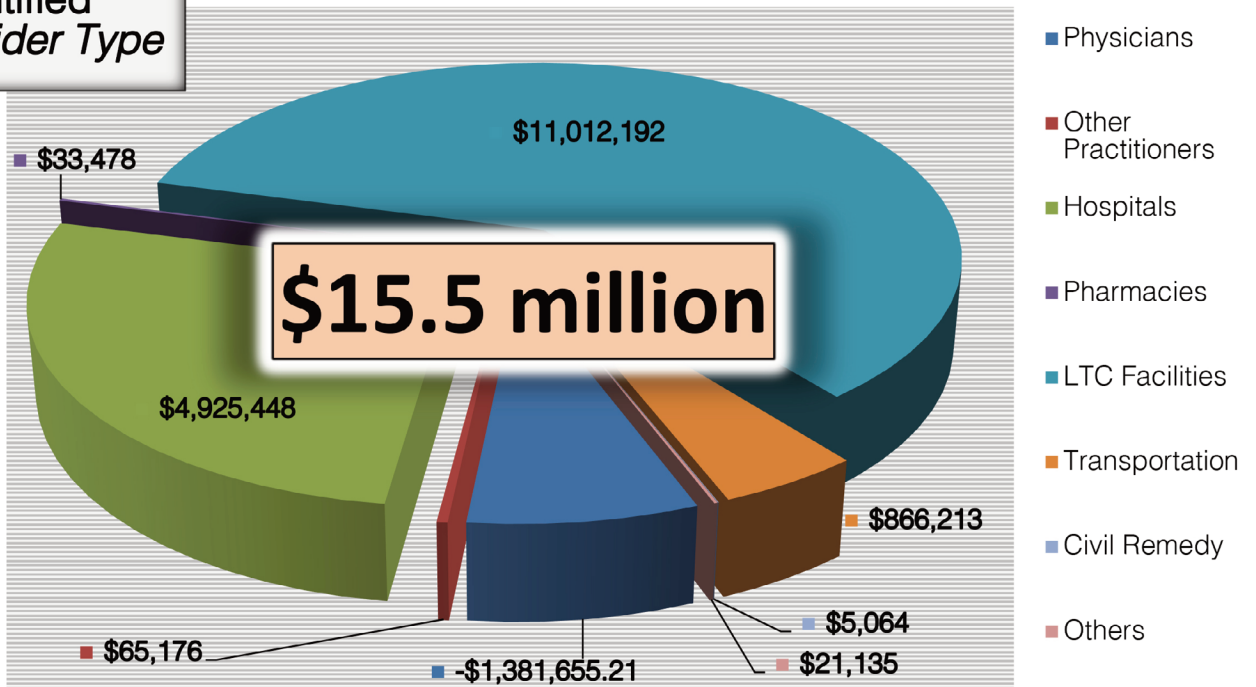
The following charts identify the number of audits and the number of overpayments identified and collected in FY20 broken down by both provider and audit type.

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Overpayments Identified by *Audit Type*

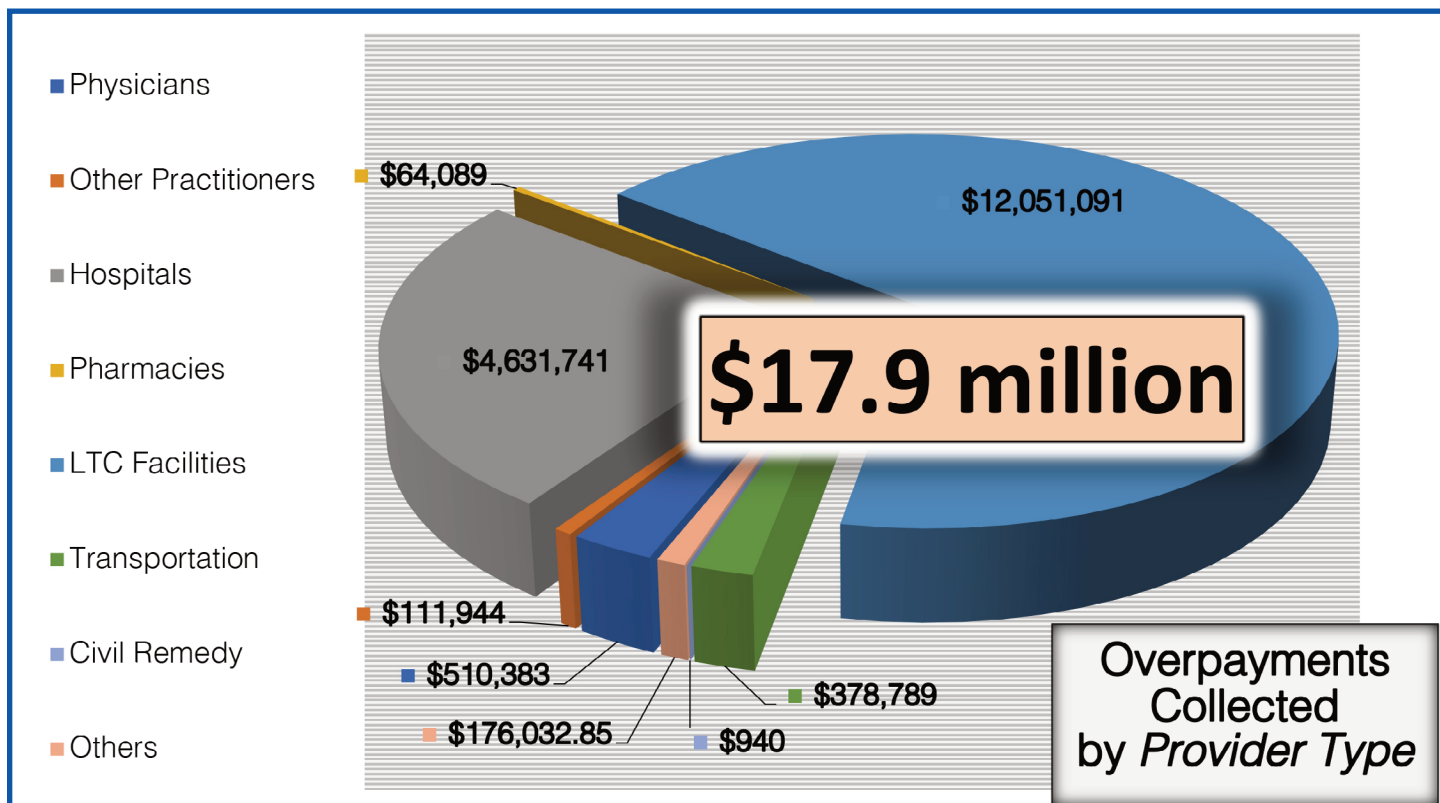
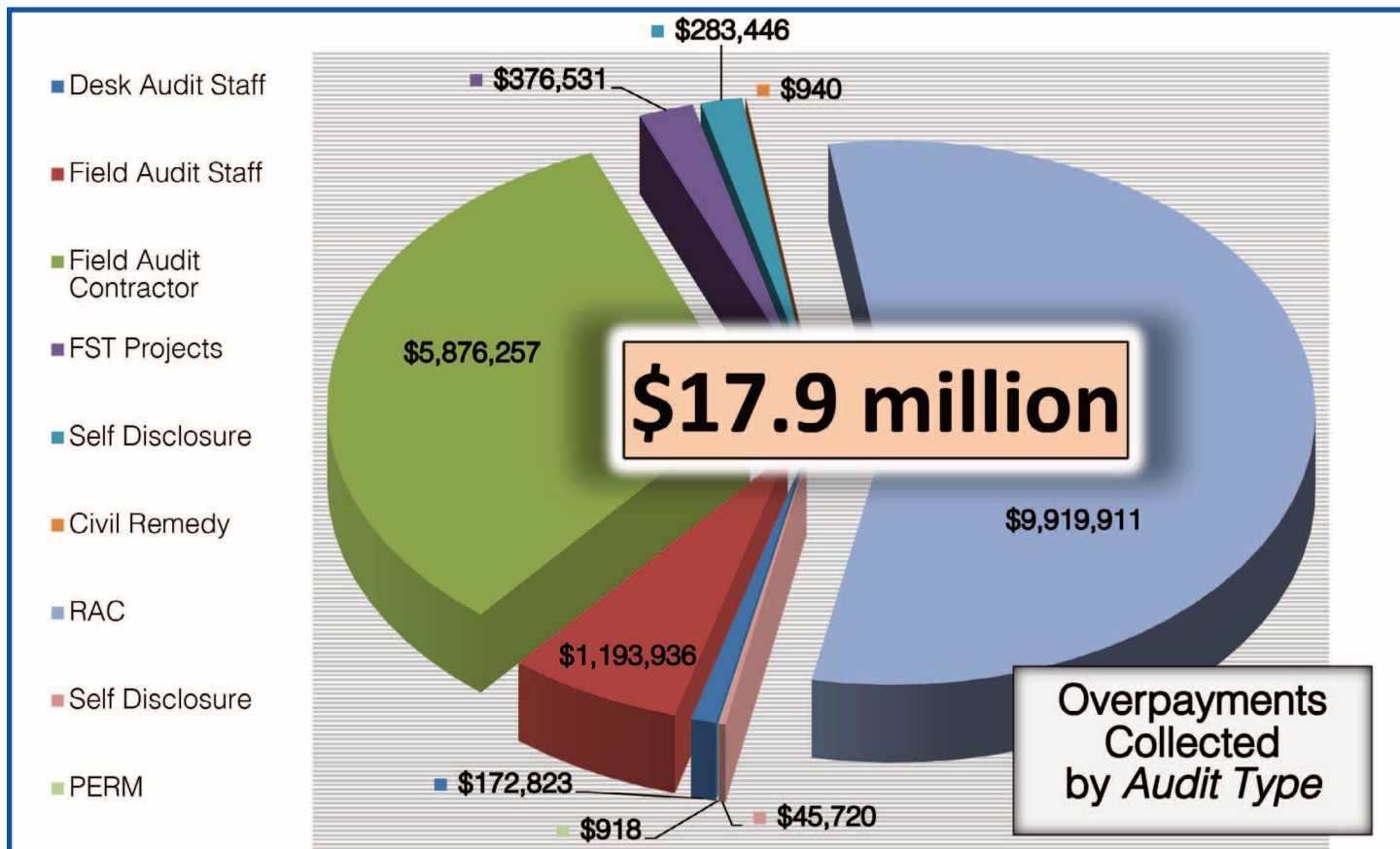


Overpayments Identified by *Provider Type*



These figures include adjustment made to receivables when required.

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Long Term Care – Asset Discovery Investigations

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 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 Unit (LTC-ADI) of this size. This is also the only unit to have a review look-back period of five years on asset reviews.

The unit is responsible for ensuring that LTC residents requesting coverage for LTC services are asset 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-ADI 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 analysts complete reviews of financial records and applicant information up to five years back 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 applicants of their eligibility for the Program.

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

FY20 LTC-ADI Highlights

Applications processed: 2,070 applications

Total savings: \$125,418,153

ROI of \$42.8339 for every \$1 spent

LTC-ADI proactively works on researching new and revised workflow methods to increase efficiency. 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 must spend time obtaining the necessary documentation before the analysts can review the documents.

Senate Bill #2913 was passed in 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. During FY19, the Department implemented a policy known as “Provisional Eligibility” (PE) pursuant to an injunction order in *Koss v. Norwood*. Under PE, the Department must approve pending applications for long-term care benefits when it fails to make a determination on the application within federally mandated timeframes.

Currently, the LTC-ADI unit consists of 24 staff members, including: a manager, clerical staff, analysts, supervisors, and an attorney. The clerical staff assist with research and obtaining documents, such as applications or verifications of assets, from the Integrated Eligibility System (IES). Once all 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 or if any unallowable transfers of resources occurred in the prior 5 years. Often, 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 is 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 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

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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 to minimize delays in processing. The OIG's headcount is very limited and staff turnover is also an issue for the unit. Many alternative workflow processes have been utilized to reduce the backlog and create efficiency.

In the past, these reviews were always conducted prior to the applicant receiving State assistance. However, due to PE and the COVID-19 public health emergency, post-eligibility reviews have been implemented and all cases are being approved by DHS using no resource test and no penalties issued. After the COVID-19 public health emergency is over, the penalty and spenddown periods can be calculated and corrected.

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

"But what about my inheritance?"

"I didn't report on my application that I had farm ground, because I want my kids to inherit it."

"I shouldn't have to use all my 401k funds to pay for my husband."

FY20 Case Examples of Excess Resources

An application for benefits was received at the OIG, containing minimal information regarding assets. Upon review of the application, the analyst discovered that the applicant retained ownership of over 2,800 shares of Abbott

Laboratory stock with a value of \$226,944. The applicant will have to spend down the excess resources in order to receive Medicaid benefits. In addition, the applicant gifted her children over \$80,000, for which a penalty was issued.

During a review, an analyst discovered that the applicant and his brother operated a farm. The property was set up in a land trust which specifically gave him $\frac{1}{2}$ interest in 5 parcels of farm ground. The applicants share was valued at \$1,286,157. In addition to the property, the applicant also owned livestock and farm machinery with a value of \$129,387. These resources are available to be used for payment of LTC benefits for the applicant, and not Illinois Medicaid.

In this case, an analyst determined that the applicant owned farmland worth \$419,802, which was contiguous to applicant's former home. The analyst determined this farmland and the attached home should be considered as available resources and not be exempted as his homestead. The applicant stated on the application that he resided in his car and it was later uncovered that another relative occupied the home. This case was appealed by the applicant. The appellant provided an appraisal of the property valuing it at \$280,125 and argued that the property should be exempt as the applicant resided in his car on the property prior to his nursing home admission. OIG asserted that the property should not be considered exempt homestead. In the final administrative decision (FAD), the Bureau of Hearings found that applicant did reside in his vehicle, which could not be considered exempt homestead as it was not a dwelling, and therefore found the farmland to be an available resource. The final administrative decision upheld the spenddown for the farmland in the amount of \$280,125.

During a review of assets, an analyst determined the value of the applicant's real estate at \$99,525 based on the most recent tax assessment. The case was appealed, and the appellant argued that this value was too high and submitted an appraisal in support of its position. OIG argued that the appraisal was not relevant as did not appraise the property at issue, but instead was an appraisal of a nearby property. In the FAD, the Bureau of Hearings found that appellant had failed to meet its burden of proof and upheld OIGs findings of total available resources in the amount of \$99,525.

In this case, an analyst reviewed an application with minimal asset information provided. The analyst discovered the

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applicant had created a trust in 2002. After reviewing the language in the trust, it was deemed the applicant had access to the income and principal. The 120 acres of farm ground and homesite were held in the name of the trust and therefore the total amount of assets available to the applicant was \$695,164 to spend towards LTC care.

Upon review of an irrevocable trust, for which the applicant is the beneficiary, the analyst determined the asset was available to the applicant. The trust was created by her deceased husband and per the language of the trust, the income and principal are available to the applicant. The total value for the resources held in the trust was \$129,972 and consisted of two bank accounts and bank stock. These assets are available for the applicant to use for nursing home expenses. The decision was appealed and upheld by the Bureau of Hearings.

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 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 in the total number of months of the penalty. Common statements made by applicants when the analysts determine they have made unallowable transfers:

"I took all my mom's money because I thought she was going to die...she didn't die...but I wasn't expecting to have to pay the nursing home."

"My mom wanted our family to take a vacation."

"That was our family's farm, we are entitled to it."

"Dad used his retirement account to help out our family, that is what he wanted."

FY20 Case Examples of Asset Concealment/Unallowable Transfers

During an investigation, an analyst uncovered the applicant transferred her home, valued at \$694,130, to her daughter prior to admission to the nursing home. The daughter

attempted to use the exemption of the "caregiver child" but was unable to give any verifications that she (the daughter) ever lived in the home. In addition, the applicant also gifted approximately \$70,000 to her daughter. The OIG imposed a penalty of \$764,130.

In this case, an applicant became ill a few years prior to her nursing home admission. During this time of illness, the applicant's children withdrew funds and used her debit card daily. Once all the funds ran out, the applicant was placed in a nursing home. As a result, a penalty of \$203,000 was imposed.

An analyst review of an application revealed an applicant paid taxes for her daughters' out of state home, grandchild's tuition for college, and moved all other funds to the daughter's checking account just before her admission to the nursing home. OIG imposed a penalty of \$253,068, as it was obvious the transfers were done to qualify the applicant for Medicaid benefits.

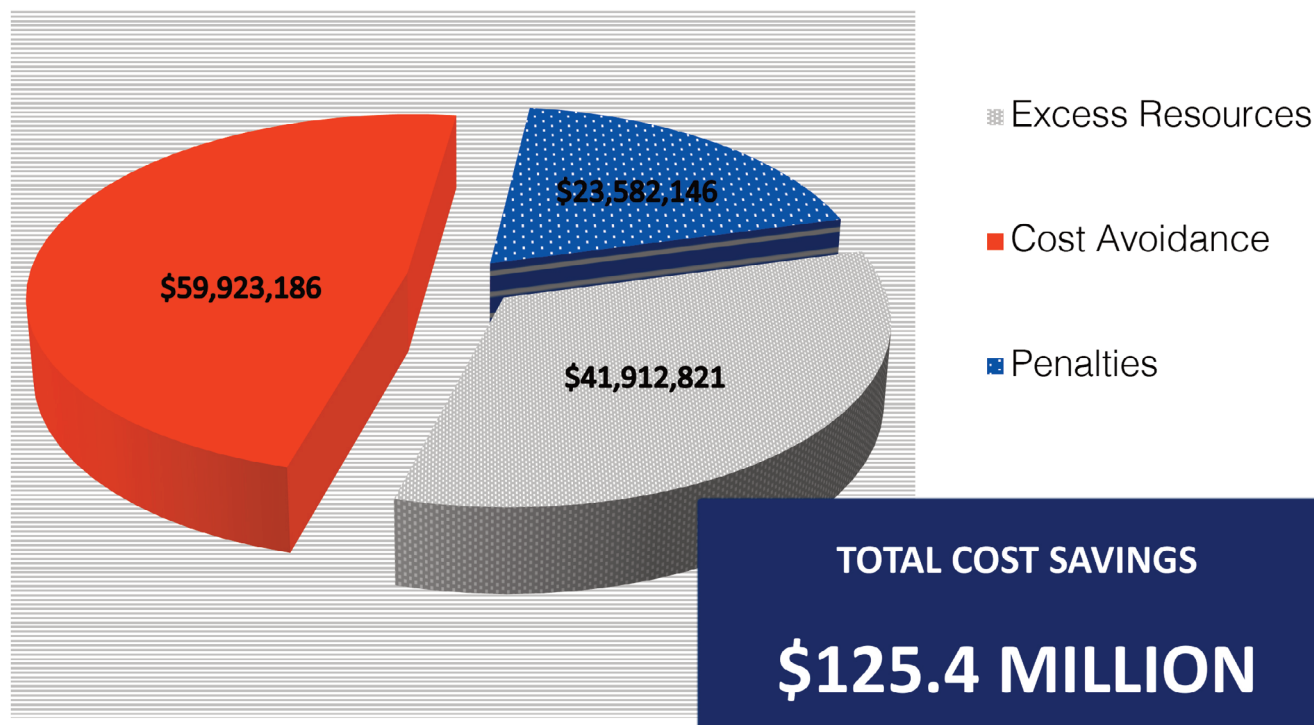
During an investigation, the analyst determined that the applicant and her community spouse created an irrevocable trust prior to his admission to the nursing home. This was done to "protect" their investment account and one savings account. As the resources were moved into an irrevocable trust within the 5-year lookback period, a penalty was imposed in the amount of \$164,000.

An analyst determined that the applicant made transfers consisting of large cash withdrawals and transfers to applicant's son totaling \$313,809 and a penalty of the same amount was imposed. The case was appealed, and the appellant argued that the transfers were not gifts but were made to assist the applicant's son in remediating a mold issue at his home. In the FAD issued by the Bureau of Hearings, it was found that appellant had failed to meet his burden of proof and the penalty of \$313,809 was upheld.

During a review, an analyst discovered that just over a year before admission to the nursing home, the applicant had sold an out of state property (with acreage) for contract for deed. The applicant did not receive any money for the property, valued at \$175,000, nor was the contract actuarially sound. A penalty of \$175,000 was imposed as the property was sold for less than fair market value.

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Long Term Care - Asset Discovery Investigations



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 home health agencies, physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. Peer review cases can originate from hotline/complaints; referral from a Managed Care Organization; referral from the Provider Analysis Unit, Recipient Restriction Unit, Audit Unit or other agencies such as the Illinois Department of Financial Professional Regulation (IDFPR), Illinois State Police-Medicaid Fraud Control Unit (ISP-MFCU), or Illinois Department of Public Health (IDPH).

Peer Review cases can also be re-reviewed by the Peer Review unit for previously identified quality of care concerns which were not serious enough to pursue formal termination. Peer Review will review the provider again to see if the previously noted 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 the Peer Review to conduct a quality of care review. If a potential provider submitted his/her application in IMPACT but had a red flag such as a discipline on his/her license, an enhanced enrollment case will be created and sent to the Peer Review to conduct a quality of care review. The moratorium of allowing new Home Health providers to enroll in Illinois Medicaid was lifted in January of 2019. Therefore, as these high-risk providers submit IMPACT applications, they are submitted to OIG for review. Peer Review will be reviewing the new home health agency applicants that may include an on-site visit and record review and will then recommend enrolling or deny enrollment.

The Peer Review staff reviewer can visit 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 staff

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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 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; 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. Due to the COVID-19 public health emergency, all upcoming MQRC meetings have been placed on hold until further notice.

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).¹² DHS is responsible for the Supplemental Nutritional Assistance Program (SNAP) and AFDC quality control reviews.

FY20 Peer Review Highlights

Completed Cases:

Full Peer Reviews: 42

Modified Peer Reviews: 0

Reinstatement Reviews: 14

Enhanced Enrollment Reviews: 4

Home Health Reviews: 22

Medical Quality Review Committee Meetings held in FY20: 7

Results from Completed Cases:

Reinstatements approved: 12

Approved enrollments of new provider: 25

Withdrew reinstatement/enrollment request: 3

Letters of concern: 8

Letters of no concern: 3

Terminations: 1

Corporate Integrity Agreements in lieu of termination: 7

Voluntary withdrawals from Illinois Medicaid: 3

Administratively closed cases: 20

Total Cases Open and Assigned: 144

Full Peer Reviews: 48

Modified Peer Review: 1

Reinstatement Reviews: 4

Enhanced Enrollment Review: 0

EQ Health Reviews: 86

Home Health Reviews: 5

Medical Quality Review Committee Meetings scheduled to be held in FY21: 5

Total Cases on Tickler or Needing Assigned: 77

Full Peer Reviews: 76

Modified Peer Reviews: 1

Reinstatement Reviews: 0

Enhanced Enrollment Reviews: 0

Home Health Reviews: 0

¹² The AFDC program changed to the Temporary Assistance to Needy Families (TANF) in 1996.

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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 coordinates efforts between the CMS contractors and staff throughout the Department to identify the universe, finalize the sample, gather case records, review the cases and complete a CAP.¹³

As required by 42 CFR 455.20 and 433.116, the OIG operates the Recipient Verification Procedure (RVP). The OIG sends letters to 1,000 recipients each month to verify whether services billed by providers were received. The universe of paid claims is identified each month and 1,000 claims are randomly selected. Recipients are requested to e-mail or phone the OIG office with their response only if they did not receive the service. The “no” responses are analyzed and considered for further action (provider audit, focused provider review, referral to Medicaid Fraud Unit, etc.).

During FY20, QC performed reviews for MEQC, PERM and RVP which resulted in the following:

- 5,391 letters sent to recipients to verify the receipt of services.¹⁴ Of the letters sent, the OIG received 1,181 responses. Of those, 1135 recipients (21%) stated “yes” they received the services, 38 recipients (less than 1%) stated “no” they did not receive the services and 8 recipients (less than 1%) stated they were “not sure” they received the services. For the remaining 4210 (78%) letters sent, no response was received from the recipients. For the month of September, 1,000 letters on behalf of durable medical equipment (DME) and optical services were sent to recipients to verify if the services were received. This was done in response to the number of “no” responses received from previous letters indicating that these type services were not being received. Results indicated that less .01% of the DME recipients and .03% of the Optic recipients did not receive the services. These results were analyzed and submitted to the OIG’s Provider Analysis Unit for additional scrutiny.
- 978 PERM eligibility reviews for the review year (RY) 2019. These reviews were completed by a federal contractor. QC staff collected the case review documentation and reviewed the findings. The final reports were issued by CMS in November 2019. PERM error rate findings and reports can be found here on the CMS website.¹⁵ The Corrective Action Plan (CAP) was submitted to CMS on February 24, 2020. CMS’ response has been delayed due to the suspension of all MEQC and PERM activities due to the COVID virus.
- 764 MEQC RY20 reviews of Medicaid and CHIP applications, renewals, denials and cancellations (closed cases) were completed during FY20. The errors and discrepancies identified are related primarily to income budgeting, notices (not sent, no reason, inaccurate, etc.) and case documentation. A total of 800 cases were required to be reviewed for federal reporting on or before August 2020. However due to the COVID virus, CMS extended the reporting date to November 1, 2020. In addition, they eliminated the payment review portion of the reviews and lessened the amount of data being required for submittal.

¹³ PERM also includes medical record and data processing reviews which are coordinated by the OIG. The OIG also coordinates and ensures the completion of the Corrective Action Plan (CAP) for these reviews as well.

¹⁴ As of May 2020, the number of letters sent was increased to 1,000 from 500 per month. In addition, the procedure was changed to require recipients to respond to the letter only if they did not receive the service.

¹⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIPCompliance/PERM/PERMErrorRateFindingsandReport.html>

The Office of Counsel to the Inspector General

SECTION



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 and settlements with providers. OCIG renders program guidance to the OIG Bureaus, as well as to the health care industry, concerning healthcare statutes and other OIG enforcement activities.

In FY20, OCIG terminated, denied, suspended or excluded 118 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 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. OCIG attorneys also assist the OIG with contract issues related to the HFS Managed Care Program. Finally, OCIG assists with responses of Freedom of Information Act and subpoena requests.

Like other OIG units, OCIG faced various challenges brought about by the COVID-19 public health emergency. The filing of new administrative cases came to a halt as the office closed and remote working policies were put into place. Efforts to resume hearings involve issues such as service of process, proper notice, scheduling, and whether such hearings can be held remotely. An increase in Provider bankruptcies and economic challenges has also influenced the resolution of cases.

FY20 OCIG Highlights

Hearings Initiated

Denials: 2
HHS Decertification Referrals: 1
Termination Cases: 73
Term/Recoup Cases: 19
Recoupment Cases: 77

Final Actions

Termination Cases: 114¹⁶
Suspended: 1
Voluntary Withdrawals: 0
Recoupment Cases: 201
Barrment: 35

Reinstatement Actions

Denied Applications: 3
Reinstatement Cases: 12
Disenrollment Cases: 22
Payment Withholds Imposed: 11¹⁷

Total Medical Provider Sanction Dollars

Funds Put to Better use: \$2,519,640.40¹⁸

OCIG terminated, denied, suspended or excluded 69 providers, individuals and entities from participation in the Illinois Medical Assistance Program.

OCIG also completed 49 PA termination and/or recoupment cases with the Bureau of Administrative Hearings.

OCIG investigated, processed and won 201 recoupment cases.

In addition, in FY20, the Department of Human Services Division of Rehabilitation Services (DHSDRS) negotiated a Collective Bargaining Agreement for their Individual Provider (IP) Background Screening. This agreement has essentially changed how pending and future personal assistant (PA) termination cases are viewed and processed at OCIG. The need or desire for Medicaid recipients to consent and receive home care from individual providers with a criminal history will result in fewer cases being filed, with only a limited number of grounds or crimes being used to terminate or deny enrollment.

¹⁶ This number includes federal exclusion cases.

¹⁷ This number represents new payment withholds imposed during FY20 under all provisions under the jurisdiction of the OIG, including noncompliance with Department requests.

¹⁸ Includes cost savings of \$1,050,575.87 and \$1,469,064.53 in rejected billings.

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FY20 OCIG Highlight Cases – Settlements and Recoupments

Hospital Provider Settles for over \$10K in In-Patient Billing Scheme.

A settlement agreement was executed by and between the Department of Healthcare and Family Services, Office of the Inspector General and an Illinois hospital for \$10,660 in lieu of an administrative recoupment action seeking to recover \$14,826. The settlement encompasses a Recovery Audit Contractor (RAC) audit of two individual claims of service for inpatient stays in June 2015 and January 2017. RAC determined that, based upon a utilization review, these claims did not meet the state's objective standard of InterQual Criteria nor did it rise to the level of an inpatient stay based upon a clinical physician review. It was determined that these services could be effectively furnished more economically on an outpatient basis or inpatient health care facility of a different kind.

Over \$6K Recovered from Ambulance Provider Due to Fraudulent Billing Findings

The Department recovered the total extrapolated overpayment amount of \$6,392 from a Cook County non-emergency transportation services provider. The discrepancies were based upon 8 instances of overpayment due to missing attendant's name, one instance of overpayment due to the medical necessity for the administration of oxygen having not been documented and 4 instances of overpayment due to improper procedure code. The Department recovered the foregoing overpayment in one lump sum payment.

Hospital In-Patient Billing Findings Results in Over \$4,800K Settlement

A settlement agreement was executed by and between the Department of Healthcare and Family Services, Office of the Inspector General and a hospital provider for \$4,877 in lieu of an administrative recoupment action seeking to recover \$6,968. The settlement encompasses a Recovery Audit Contractor (RAC) audit of three individual claims of service for inpatient stays in March 2014, April 2014, and April 2018. RAC determined that, based upon a utilization review, these claims did not meet the state's objective standard of InterQual Criteria nor did it rise to the level of an inpatient stay based upon a clinical physician review. It was determined that these services could be effectively furnished more

economically on an outpatient basis or inpatient health care facility of a different kind.

Hospice Provider Repays over \$85K to Settle Fraudulent Billing Findings

The Department recovered the overpayment amount of \$85,308 from a Medicaid provider of hospice services. The discrepancies in this matter were based upon a review of 7 recipients' medical charts in which 2 of the recipient charts allegedly revealed that they may not have supported the eligibility requirement for hospice care payments. The requirement is that of having a terminal condition with a life expectancy of six months or less, if the illness were to run its normal course. The reviewer of the charts also determined that it was necessary for the charts to reveal a certain quantum of decline in the condition of the recipients. The repayment of the amount of \$85,308 is to be made in one lump sum.

Hospital to Repay Over \$41K to Settle Inpatient Billing Findings

A settlement agreement was executed by and between the Department of Healthcare and Family Services, Office of Inspector General and an Illinois hospital for \$41,738 in lieu of an administrative recoupment action seeking to recover \$59,626. The settlement encompasses Recovery Audit Contractor (RAC) audit findings for eight individual inpatient service claims billed by and paid to the hospital. The claims were determined in a complex RAC review to be noncompliant with the Department's utilization review criteria.

HFS Recovers over \$5,400K from Transportation Provider

A Summary of Audit Findings determined a transportation provider had overpayments of \$5,479 from the Department from January 1, 2012 through December 31, 2012. The audit findings consisted mainly of overpayment due to billing for transportation during an inpatient stay. The provider made payment in full prior to the issuance of the Department's Notice of Intent to Recover.

Provider Ordered to Pay Over \$54K Due to Fraudulent Billing Findings

A final administrative decision was issued by the HFS Director which adopted an administrative law judge's recommended decision for the Department to recover the overpayment amount of \$54,931. The Department's auditors reviewed the

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recipients' room and board accounts. The auditors determined that there were discrepancies based upon the credit balances of the recipients, unapplied income and billing by the facilities for more days than certain recipients were housed in the facilities. The Department is a payer of last resort. If the recipients have income from other sources that exceed a certain predetermined amount, then any income received above that amount is an overpayment and the Department is entitled to recoup that amount. The Department also recouped money listed as credit balances on the recipient ledgers.

Hospital Repays HFS over \$17K due to Findings from a Utilization Review

The audit conducted by the Illinois Medicaid Recovery Audit Contractor (RAC) identified overpayments on individual claims of service for an Illinois hospital with the aggregate value of \$17,492. There were four (4) claims identified as discrepant as those claims did not meet the Department's utilization review criteria for inpatient services. The claims encompassed inpatient dates of service of October 21, 2020 to October 22, 2015 with an overpayment of \$4,231; May 13, 2016 to May 16, 2016 with an overpayment of \$4,026; June 16, 2017 to June 17, 2017 with an overpayment amount of \$4,056; and May 13, 2018 to May 15, 2018 with an overpayment of \$5,177. The Hospital made payment in full prior to the issuance of the Department's Notice of intent to Recover.

HFS Recovers over \$88K from a Transportation Provider Due to False Billing

The Department recovered the overpayment amount of \$88,399. This audit exclusively involved the recovery of overpayments based upon 120 instances of missing trip tickets. Department employed its extrapolation statistical analysis and calculated a total recoupment amount of \$88,399.

\$500K Settlement recovered from LTC facilities

The Department recovered the overpayment amount of \$500,000 as part of a global settlement between the Department and the former owner of various LTC facilities. The Department's auditors reviewed the recipients' room and board accounts for the various facilities. The auditors determined that there were discrepancies based upon the credit balances of the recipients, unapplied income and billing by the facilities for more days than certain recipients were

housed in the facilities. The Department is a payer of last resort. If the recipients have income from other sources that exceed a certain predetermined amount, then any income received above that amount is an overpayment and the Department is entitled to recoup that amount. The Department also recouped money listed as credit balances on the recipient ledgers. The credit balances were differentiated by current recipient credit balances, discharged recipient credit balances, expired recipient credit balances, prior period credit balances for discharged recipients and prior period credit balances for expired recipient.

Over \$95K Ordered Recouped from Transportation Provider due to Fraudulent Billing Findings.

A Final Administrative Decision was issued by the HFS Director which adopted an Administrative Law Judge's Recommended Decision to recoup monies from transportation provider Quick Enterprises of Illinois d/b/a Quick Vanns. HFS-OIG filed a Notice seeking to recoup a total of \$95,327 from the provider following desk audits for the audit periods of May 1, 2009 through December 31, 2011, and January 1, 2012 through December 31, 2013 showing overpayments for duplicate billing, improper billing of loaded mileage, and transportation during an inpatient stay. A principal of the corporate entity initially requested a hearing in writing but later withdrew her request on the record. The ALJ issued a Recommended Decision recommending approval of the relief requested in HFS-OIG's Notice and the Recommended Decision was later affirmed by the HFS Director.

FY20 OCIG Highlight Cases – Terminations, Exclusions, Denials

Transportation Provider Terminated and Ordered to pay over \$1.2 Million for Fraudulent Billing Findings.

A final administrative decision was issued by the HFS Director which adopted an administrative law judge's recommended decision for the Department to recover the extrapolated overpayment amount of \$1,209,660, as well as termination of Jovon McDonald's eligibility to participate in the Medical Assistance Program. The Department's auditors reviewed the records of the transportation provider and found 2008 instances of discrepancies totaling the non-extrapolated amount of \$17,421, based upon missing

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records. The Department's auditors also found 844 instances of discrepancies totaling the non-extrapolated amount of \$7,483 of overpayment, based upon billing for transportation services during the time the patient was already in a facility.

Over \$308K Recovered and Provider Terminated from the Medicaid Program

The Department recovered the total extrapolated overpayment amount of \$308,107 from a Cook County non-emergency transportation service entity, Pickup and Go Transportation. The provider was also terminated from the Medical Assistance Program. The discrepancies were based upon 1,400 instances wherein the provider failed to document vehicle license plate numbers, provide proof of vehicle ownership and vehicle insurance, as well as registration cards. Additionally, the provider failed to document medical necessity and the names of drivers and attendants on its trip tickets. Also, the submitted vehicle registration and insurance documentation failed to match the vehicle license plate numbers. Additionally, the driver safety training certificates were expired. The provider also failed to maintain dispatch logs.

Nurse Terminated Due to IDFPR Licensure Sanction

A Final Administrative Decision was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Steven Matthew Dzyban, APN. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the Provider based on the Illinois Department of Financial and Professional Regulation's suspension of the provider's advanced practice nurse and registered professional nurse licenses because the provider failed to report discipline in Tennessee. HFS-OIG proceeded to file an immediate suspension and a termination action. After the provider failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, HFS-OIG requested the administrative law judge to issue a default and recommended decision to terminate the provider from the Illinois Medical Assistance Program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation and terminated the provider.

Physician Terminated Due to Inappropriate Conduct with a Patient

A Final Administrative Decision was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Maher Dalati, MD. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the Provider based on the Illinois Department of Financial and Professional Regulation's suspension of the provider's medical license because the provider engaged in sexually inappropriate conduct with a seven (7) year old pediatric patient. HFS-OIG proceeded to file an immediate suspension and a termination action. After the provider failed to appeal or attend the scheduled administrative hearing, the ALJ granted HFS-OIG's motion for default. The recommended decision was later affirmed by the HFS Director.

Physician Terminated Due to Inappropriate Conduct with a Patient

A Final Administrative Decision was issued by the HFS Director which adopted and upheld an administrative law judge's recommended decision to terminate Shaun A. Kink, MD. HFS-OIG immediately suspended the Provider and filed a Notice seeking to terminate the provider based on the Illinois Department of Financial and Professional Regulation's suspension of the provider's medical license because the provider engaged in sexually inappropriate conduct with a patient. HFS-OIG proceeded to file an immediate suspension and a termination action. After the provider failed to appeal or attend the scheduled administrative hearing, the ALJ granted HFS-OIG's motion for default, and the recommended decision was later affirmed by the HFS Director.

Provider Terminated and HFS Recovers over \$91K for Fraudulent Billing

The Department recovered the total overpayment amount which was attributable to I Think I Can Learning Center and D&G Health Center of \$91,973. The providers, I Think I Can Learning Center and D&G Health Center were terminated from the Medical Assistance Program and Lisa Grybinas was barred from further participation in the Medical Assistance Program.

I think I Can Learning Center and D&G Health Center provided adult individual, family and group psychiatry services and pharmacologic management for child

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patients. The auditors determined that there were 3,300 instances wherein the provider billed for non-covered services. These included claims for social worker visits and for individual and group counseling and psychotherapy that had been rendered by non-psychiatrists. Several violations were also noted: (a) the provider scheduled more than one visit for the same day but billed the Department for multiple days, (b) none of the progress notes showed appointment times or indicated the length of time spent with the patient and (c) daily attendance logs for group counseling were destroyed after receipt of payment from the Department.

Additional discrepancies included 160 instances of overpayment due to billing for missing records, 2,305 instances of overpayment due to missing records of specific services and 2 instances of billing for improper procedure codes.

Personal Assistant Terminated Due to Criminal History and Billing Medicaid While Incarcerated

A Final Administrative Decision was issued by the HFS Director which adopted an administrative law judge's recommended decision to terminate Provider Assistant ("PA") Nathaniel Boyce. HFS-OIG filed a Notice seeking to terminate the PA based on his prior criminal convictions and for billing the State of Illinois for services while he was incarcerated by submitting false time sheets with the fraudulent intent of receiving payment for services not provided. After the PA failed to appeal or attend the scheduled administrative hearing, the ALJ granted HFS-OIG's motion for default. The recommended decision was later affirmed by the HFS Director.

Personal Assistant Terminated for Making a False Statement and for Prior Criminal History

A Final Administrative Decision was issued by the HFS Director which adopted an administrative law judge's recommended decision to terminate PA Alexia Robinson. HFS-OIG filed a Notice seeking to terminate the PA based on her prior criminal conviction and her making a materially false statement on her IMPACT Individual Provider Enrollment Form by indicating that she never had a criminal conviction when she had at least one. The PA appeared for her scheduled administrative hearing; however, she withdrew her request for a hearing on the record. The ALJ granted HFS-OIG's motion for a FAD and the recommended decision was later affirmed by the HFS Director.

FY20 Highlight Cases – Long Term Care Asset Review

The Illinois Department of Human Services Bureau of Hearings (DHS-BAH) upheld the OIG's decision to impose a penalty period. After review of the application, OIG determined the applicant had executed a quit claim deed during the review period to transfer her homestead property to her deceased spouse's children. Additionally, the applicant transferred \$20,000 to her niece during the review period. The appellant did not argue the penalty for the funds transferred to applicant's niece but did assert that the transfer of the homestead should be deemed allowable. Appellant argued that applicant and her deceased spouse had a verbal agreement that she could live in the home until her death at which time it would be transferred to his children. However, the appellant was unable to produce any documentation to support this argument. In the FAD, DHS-BAH found that appellant had failed to meet its burden to show that the transfer of the homestead property was allowable and upheld the penalty period of \$102,108.

DHS-BAH upheld the OIG's decision to impose a resource spenddown. After review of the application, HFS-OIG determined the applicant had available resources of \$104,427. At issue in the appeal was the value of applicant's real estate which OIG valued at \$99,525 based on the most recent tax assessment. The appellant argued that this value was too high and submitted an appraisal in support of its position. OIG argued that the appraisal was not relevant as it did not appraise the property at issue, but instead appraised a nearby property. In the FAD, BAH found that appellant had failed to meet its burden of proof to show that HFS-OIG's valuation was erroneous and upheld total available resources in the amount of \$104,427.

DHS-BAH upheld the OIG's decision to impose a penalty period for unallowable transfers made by the applicant's community spouse. After review of the application, HFS-OIG determined the applicant had transferred her interest in real property and an investment account to her community spouse. The community spouse then transferred those resources to a revocable trust. The trust provided that upon his death, the resources would be distributed to his children. Applicant's community spouse died during HFS-OIG's review. Accordingly, OIG determined a penalty was appropriate as applicant's community spouse, pursuant to the terms of his trust, acted to transfer resources available to the applicant held in a revocable living trust to his children upon his death. The appellant argued that transfers to the community spouse

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were allowable and that a penalty could not be imposed based solely on the death of the community spouse. In the FAD, BAH found that the community spouses' actions to establish a revocable trust which was available to the applicant during his life, but unavailable upon his death was a transfer of resources. Further, as applicant did not receive any form of compensation for the transfer, it found the transfer was made for less than fair market value and the penalty was warranted. The FAD upheld a penalty of \$199,084.

DHS-BAH upheld the OIG's decision to impose a penalty period for an applicant who made transfers for less than fair market value. After review of the application, HFS-OIG determined the applicant had made both transfers to family members and cash withdrawals for which fair market value

was not received. The appellant argued that the transfers made to the applicant's family members were reimbursement for items purchased by those individuals for the applicant or for care and services provided to the applicant. Additionally, the appellant argued that the cash withdrawals were made by applicant's spouse who no longer had the mental capacity to say how the funds were used. The appellant provided no evidence in support of its position on either argument. In the final administrative decision, BAH found the appellant had failed to meet its burden to rebut the presumption that the transfer was made for less than fair market value as no evidence was presented to substantiate the appellant's arguments. Accordingly, the penalty was upheld in the amount of \$97,345.



Acronyms

AABD	Aid to Aged Blind or Disabled	FCRC	Family Community Resource Centers
ACA	Affordable Care Act	FFP	Federal Financial Participation
AFDC	Aid to Families with Dependent Children	FOIA	Freedom of Information Act
AG	Illinois Attorney General	FQHC	Federal Qualified Health Center
AIU	Adoption, implementation, or upgrade	FST	Fraud Science Team
BAH	Bureau of Administrative Hearings	FTI	Federal Tax Information
BFST	Bureau of Fraud Science and Technology	FY	Fiscal Year
BIA	Bureau of Internal Affairs	FFY	Federal Fiscal Year
BMC	Bureau of Managed Care	FWA	Fraud Waste and Abuse
BMI	Bureau of Medicaid Integrity	EHR	Electronic Health Records
BOC	Bureau of Collections	ERP	Enterprise Resource Planning
BOI	Bureau of Investigation	HFPP	Healthcare Fraud Prevention Partnership
CAF	Credible Allegation of Fraud	HFS	Healthcare and Family Services
CAP	Corrective Action Plan	HHA	Home Health Agencies
CAS-QC	Central Analysis Systems- Quality Control	HHS	Department of Health and Human Services
CFR	Code of Federal Regulations	HITECH	Health Information Technology for Economic and Clinical Health
CHA	Chicago Housing Authority	HSP	Home Services Program
CHIP	Children's Health Insurance Program	IGA	Interagency Agreement
CMS (1)	Central Management Services	ICF-MI	Intermediate Care Facility- Mentally Impaired?
CMS (2)	Centers for Medicare and Medicaid Services	ICF-MR	Intermediate Care Facility- Mentally Retarded
CPA	Certified Public Accountant	IDFPR	Illinois Department of Financial and Professional Regulation
CPI	Center for Public Integrity	IDPH	Illinois Department of Public Health
CPIP	Certified Program Integrity Professionals	IEMA	Illinois Emergency Management Agency
DHS-BAH	Department of Human Services – Bureau of Hearings	IES	Integrated Eligibility System
DHS-BOC	Department of Human Services – Bureau of Collections	ILCS	Illinois Compiled Statutes
DHS-DRS	Department of Human Services- Division of Rehabilitation Services	IOC	Illinois Office of the Comptroller
DHS-FCRC	Department of Human Services – Family Community Resources Centers	ISP	Illinois State Police
DME	Durable Medical Equipment	LTC	Long Term Care
DME-POS	Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies	LTC-ADI	Long Term Care- Asset Discovery Investigations
DOJ	United States Department of Justice	MAC	Medical Assistant Consultant
DPA	Department of Public Aid	MAGI	Manually Adjusted Gross Income
EH	Eligible Hospital	MCO	Managed Care Organization
EP	Eligible Professional	MEQC	Medicaid Eligibility Quality Control
ERP	Enterprise Resource Planning	MFCU	Medicaid Fraud Control Unit
FAD	Final Administrative Decision	MME	Average Daily Morphine Milligram Equivalent dose
FAE	Fraud Abuse Executive	MMIS	Medicaid Management Information Systems
FBI	Federal Bureau of Investigation	MRA	Management, Research, and Analysis

Acronyms

MU	Meaningful Use
NAC-MII	National Advocacy Centers - Medicaid Integrity Institute
NHCAA	National Health Care Anti-Fraud Association
NAMFCU	National Association of Medicaid Fraud Control Units
NAMPI	National Association for Medicaid Program Integrity
NEMT	Non-Emergency Medical Transportation
NHCAA	National Healthcare Anti-Fraud Association
NPV	New Provider Verification
OCIG	Office of Counsel to the Inspector General
OIG	Office of Inspector General
PA	Personal Assistant
PAU	Provider Analysis Unit
PCS	Personal Care Services
PERM	Payment Error Rate Measurement
PES	Provider Enrollment Services
PI	Program Integrity
PMP	Prescription Monitoring Program
PE	Provisional Eligibility
PPE	Personal Protective Equipment
PSA	Public Service Administrator
RAC	Recovery Audit Contractor
RAU	Recipient Analysis Unit
ROI	Return On Investment
RR	Responsible Relative
RRP	Recipient Restriction Program
RVP	Recipient Verification Procedure
SAP	Systems, Applications, and Products
SEOC	State Emergency Operations Center
SIU	Special Investigative Unit
SMART	Save Medicaid Access & Resources Together (Act)
SNAP	Supplemental Nutritional Assistance Program
SURS	Surveillance Utilization Review Subsystem
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



OIG Statutory Mandate

The OIG is authorized by 305 ILCS 5/12-13.1. By an Executive Order, the Inspector General Reports to the Governor through the Office of the Executive Inspector General. 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 recipients
- 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 (HCI) 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 2020 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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