State of Illinois
Department of Healthcare and Family Services

Office of Inspector General

Annual Report Fiscal Year 2022

JB Pritzker, Governor
Brian J. Dunn, *Inspector General*

To Governor Pritzker, Senators, Representatives, and the Residents of Illinois:

Enclosed for your review is the annual report for Fiscal Year 2022 for the Office of Inspector General for the Illinois Department of Healthcare and Family Services (OIG).

Fiscal Year 2022, my first full year as Inspector General, was defined by organizational transformation and investment. OIG continued to find more effective ways to work during the ongoing Public Health Emergency (PHE) and to increase the impact of that work. We accomplished this through system development, policy improvement, and staff training, as illustrated through these examples:

- Throughout FY2022, various units of OIG worked with the Department of Innovation and Technology and the Medicaid Managed Care Organization (MCO) Special Investigations Units (SIUs) on the development of a new reporting database that will allow OIG to track the work of the SIUs from start to finish. With this MCO fraud reporting portal, OIG will be able to identify overlapping investigations, intervene in potential criminal matters, and track all investigation outcomes.

- This past year, OIG improved how we process all complaints and referrals. We created a new centralized Complaint Intake Unit that researches all complaints and presents them with recommendations to an interdisciplinary committee. This new approach delineated by clear policies and procedures allows for timely and efficient determinations on all complaints received, eliminating a history of complaint backlogs.

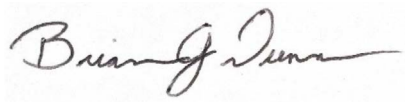
- One final example of transformation and investment stems from our ongoing expansion of the Bureau of Investigations' focus on solely recipient fraud investigations to include investigations of Medicaid providers. This significant change has required investment in trainings on the Medicaid system, waiver programs, and additional investigative techniques. OIG has used its monthly in-house training sessions and newly obtained membership in the Association of Inspectors General to further staffs' professional development.

Of course, while investing time and resources into structural, procedural, and technological improvements, the OIG must also remain focused on the daily responsibilities of ensuring program integrity and oversight. This year's report demonstrates that OIG's various bureaus have remained steadfast in that mission.

Despite the PHE's ongoing impact to the flow of the Audit Section's work, OIG's auditors completed or oversaw the completion of over 2000 audits, resulting in the identification of almost $6 million in overpayments to providers. OIG collected $13.7 million from providers in FY2022 related to overpayments identified by the Audit Section in this and prior years. Related to investigations, the Bureau of Internal Affairs completed over 100 misconduct investigations and over 500 background check investigations, ensuring integrity among HFS's employees and contractors. The Bureau of Investigations completed 988 recipient and provider fraud investigations this past year. OIG's Office of Counsel to the Inspector General (OCIG) pursues accountability for sustained findings in some of those audits and investigations by filing administrative actions. In FY2022, OCIG filed 127 recoupment, termination, and application denial actions.

As OIG moves into the next fiscal year, it will continue both to invest in the future of strong oversight for Illinois Medicaid and to tend to the immediate demands of holding providers and recipients accountable for abuse of the system.

Respectfully,



Brian J. Dunn
Inspector General

Table of Contents

Selected Acronyms and Abbreviations

Bureau of Fraud Science & Technology	BFST
Bureau of Internal Affairs	BIA
Bureau of Investigations	BOI
Bureau of Medicaid Integrity	BMI
Centers for Medicare and Medicaid Services	CMS
corporate integrity agreement	CIA
Division of Child Support Services	DCSS
Dynamic Network Analysis	DNA
Fraud, Waste, and Abuse	FWA
fee-for-service	FFS
Freedom of Information Act	FOIA
Healthcare Fraud Prevention Partnership	HFPP
Illinois Department on Aging	IDOA
Illinois Department of Financial and Professional Regulation	IDFPR
Illinois Department of Healthcare and Family Services	HFS
Illinois Department of Human Services	DHS
Illinois State Police	ISP
long-term care	LTC
Long-Term Care Asset Discovery Investigations	LTC-ADI
Managed Care Organization	MCO
Medicaid Fraud Control Unit	MFCU
Medical Quality Review Committee	MQRC
National Association for Medicaid Program Integrity	NAMPI
National Health Care Anti-Fraud Association	NHCAA
New Provider Verification	NPV
Office of Counsel to the Inspector General	OCIG
Office of Inspector General	OIG
Payment Error Rate Measurement	PERM
Provider Analysis Unit	PAU
Public Health Emergency	PHE
Recipient Analysis Unit	RAU
Recovery Audit Contractor	RAC
Supplemental Nutrition Assistance Program	SNAP
Temporary Assistance for Needy Families Program	TANF
Unified Program Integrity Contractor	UPIC
U.S. Department of Health and Human Services	HHS

ANNUAL REPORT FY2022

OVERVIEW OF HFS OIG

OIG Mission and Authority

Mission

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

Authority

Pursuant to OIG's enabling statute, 305 ILCS 5/12-13.1 et seq., OIG has the following jurisdiction and powers.

Jurisdiction

Oversight of the Illinois Department of Healthcare and Family Services (HFS) programs, including the Illinois Medical Assistance Plan (Medicaid); the Illinois Department of Aging's programs; and any programs of the Illinois Department of Human Services (DHS), as established by agreement.

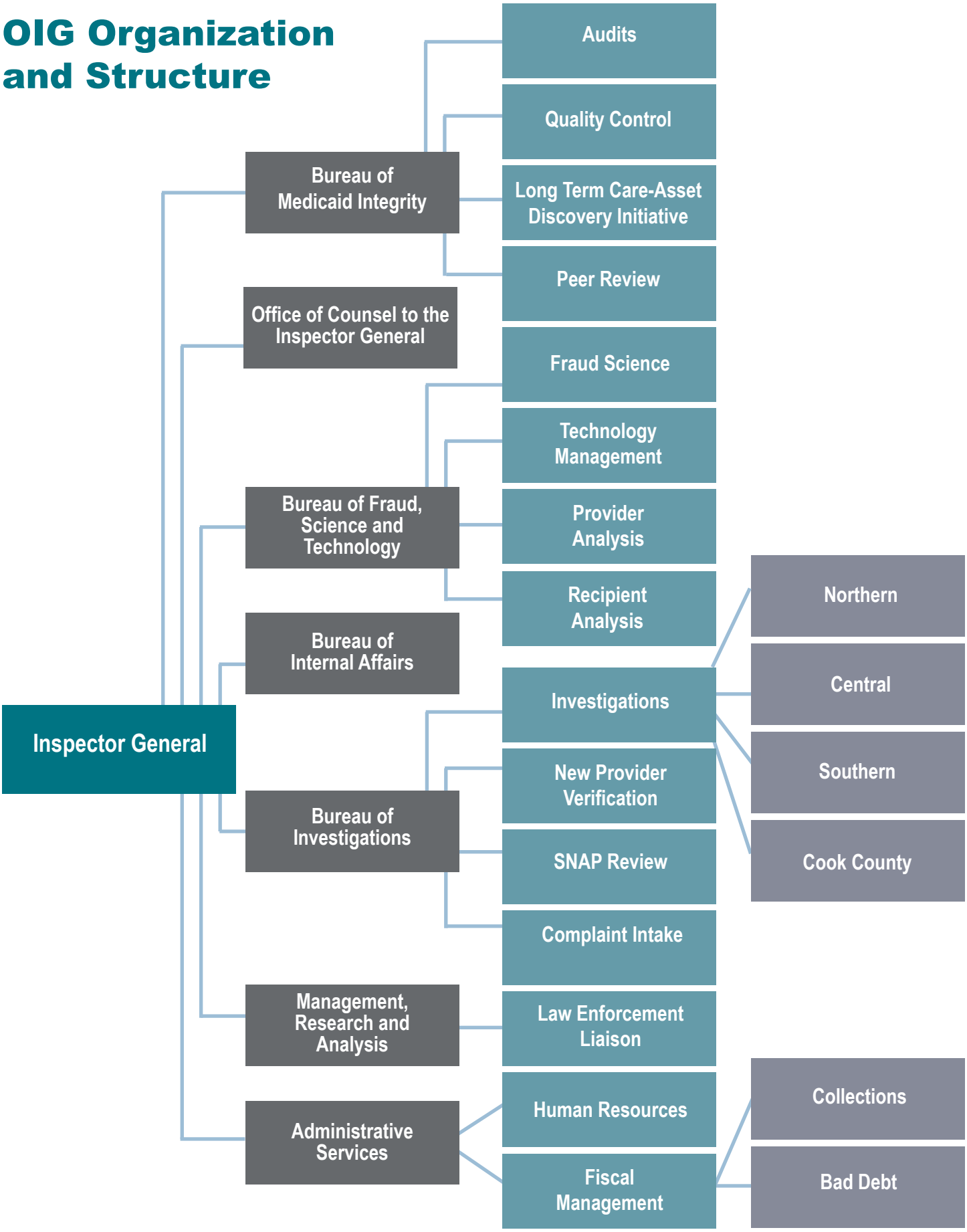
Powers

1. Investigation of misconduct by employees, vendors, contractors, and medical providers
2. Prepayment and post-payment audits of Medicaid providers
3. Monitoring of quality assurance programs
4. Measuring quality control
5. Investigation of fraud or intentional program violations
6. Initiating actions against contractors, vendors, or medical providers for program violations; sanctions by other entities; monetary recoveries or violations of contracts

Additional authority

7. Access to information necessary to perform duties of the office
8. Data sharing with state and federal authorities
9. Denial and suspension of payment
10. Denial, suspension, or termination of provider enrollment in Medicaid
11. Serving as Illinois Medicaid's primary liaison with law enforcement
12. Subpoena power

OIG Organization and Structure



OIG Leadership Team

Brian Dunn – *Inspector General*

Brian joined OIG in April 2021 after having served for six years as the First Deputy Inspector General and General Counsel for the City of Chicago Office of Inspector General. Prior to that, Brian was General Counsel for the Illinois Department of Human Services (DHS) and the Illinois Department of Commerce and Economic Opportunity, and an Associate General Counsel for the Office of the Governor of Illinois. Before joining public service, Brian worked as a litigation associate for Mayer Brown LLP and clerked for the Honorable James Moran in the U.S. District Court for the Northern District of Illinois.

Stephanie Snow – *Chief of Staff*

Stephanie joined OIG in November 2022 as the Office's first Chief of Staff. Stephanie was most recently the Chief Assistant Inspector General for the City of Chicago's Office of Inspector General. After graduating from The John Marshall Law School, Stephanie served as a law clerk and staff attorney for several federal courts, including the U.S. District Court for the Eastern District of Wisconsin, the U.S. District Court for the Northern District of Illinois, and the U.S. Court of Appeals for the Eighth Circuit. Stephanie joined the City of Chicago OIG in 2020 as an Assistant Inspector General and was later promoted to Chief AIG, where she counseled OIG staff on all aspects of their work, including investigations, program audits, reviews, and inquiries.

Anthony Florio – *Deputy Inspector General of Investigations*

Tony joined OIG in March 2022 after having worked in the City of Chicago's Office of Inspector General Investigations Section for seventeen years. Over that time, Tony worked his way from an Investigator I to a Chief Investigator, leading a team in complex investigations involving comprehensive data analysis, surveillance, extensive interviewing, and high-profile criminal allegations.

Nathan Kipp – *Chief Legal Counsel*

Nathan joined OIG in February 2022 after having served nearly half of a decade in offices of inspectors general for City of Chicago sister agencies: first, as an Assistant Inspector General for the Chicago Board of Education, and then as both the Deputy Inspector General and Interim Inspector General for the Chicago Park District. A seasoned litigator, Nathan previously practiced law as a member of the global litigation groups within Mayer Brown LLP and Winston & Strawn LLP, where he handled complex and class-action lawsuits. Before entering private practice, he served as a Staff Attorney for the U.S. Court of Appeals for the Seventh Circuit before transitioning to the role of a judicial clerk for the Honorable Michael S. Kanne.

Lisa Castillo – *Bureau Chief of Medicaid Integrity*

Lisa began working with the State of Illinois in 2012, when she joined HFS as an Administrative Law Judge presiding over actions filed by OIG. Prior to becoming Bureau Chief, she worked for the Office of Counsel to the Inspector General (OCIG), litigating cases involving recoupment of overpayments identified by in-house and contractor audits, as well as termination actions against Medicaid-enrolled providers. While in OCIG, Lisa specialized in Recovery Audit Contractor (RAC) audits, litigating cases involving hospital utilization review and medical coding. As part of her RAC specialization, Lisa obtained credentialing from the American Association of Professional Coders in 2019 as a certified medical coder. Lisa's extensive public legal service background also includes practice in criminal law, as she served as an Assistant State's Attorney for Cook County for eight years.

Phronsie Spaulding – *Assistant Bureau Chief of Medicaid Integrity*

Phronsie joined HFS' Division of Program Integrity (which became the Office of Inspector General in 1994) in September 1988 as a Social Service Career Trainee. This position was responsible for the federally mandated review of claims paid through the Medicaid Management Information System. Phronsie promoted into several positions within OIG and currently oversees the operations of federally mandated audits and eligibility reviews, recipient verification of services, and Long-Term Care - Asset Discovery Investigations.

Cindy Daugherty – *Healthcare Standards Administrator*

Cindy joined OIG in February 2016 as the Provider and Recipient Analysis Unit Manager. Cindy has over thirty years of nursing and managerial experience from a variety of healthcare settings, including hospital medical and surgical units, emergency departments, a long-term care psychiatric facility, and outpatient surgical clinics. Cindy previously worked in the HFS provider billing unit within the Bureau of Professional and Ancillary Services. Cindy became a Certified Professional Coder in 2018. In April 2022, she assumed the role of Healthcare Standard Administrator supervising the OIG Peer Review Unit.

Clovia Malatare – *Manager of the Bureau of Medicaid Integrity Audit Section*

Clovia joined the OIG's Bureau of Medical Quality Assurance (which later became the Bureau of Medicaid Integrity) in June 1996 as a Public Service Administrative Intern. Over time, she worked her way from Administrative Assistant to Executive I. In September 2019, she became the audit manager for the Bureau of Medicaid Integrity. Prior to joining OIG, Clovia worked for the Illinois Department of Employment Security from May 1991 to October 1993. Clovia was an educator for a private college until her return to state service in 1996.

Brian Bond – *Bureau Chief of Investigations*

Brian has been with OIG since September 2012. He assumed his current role as Bureau Chief in October 2022 after acting into the position since March 2021, while continuing to serve as the Supervisor of the Southern Unit for Investigations. Brian has been with HFS since October 1998, serving in various capacities including the Department's State Purchasing Officer. Brian also served in several leadership positions within the Department's Finance division.

Joshua Hughes – *Bureau Chief of Internal Affairs*

Joshua joined OIG in November 2018 after serving for five years as an Investigator with the Illinois Office of Executive Inspector General for the Agencies of the Illinois Governor. Prior to working for the State of Illinois, Joshua spent a decade within the federal government as a contractual investigator and in operations at the National Security Agency. Joshua is also a veteran of the U.S. Navy.

Eddie Escamilla – *Assistant Bureau Chief of Internal Affairs*

Eddie joined OIG in June 2020. Prior to the OIG, Eddie spent twelve years working at the Illinois OEIG as a Supervising Investigator and Grant Review Initiative Team Leader. Eddie also spent a decade in law enforcement as a Police Officer, Field Training Officer, Detective, and Lead Hostage Negotiator for the Metro Nashville Police Department and Chicago Police Department. In addition to OIG duties, Eddie is a member of the HFS Diversity, Equity and Inclusion Taskforce and the HFS Strategic Planning Taskforce. Eddie graduated from Western Illinois University.

Wei-Shin Wang – *Bureau Chief of Fraud Science and Technology*

Wei-Shin has worked for HFS for thirty years. Prior to starting at OIG in 2007, he served as a Project Director and developed a statewide Medicaid initiative tracking mental health fee-for-service and grant-in-aid providers. From 2007 to 2011, Wei-Shin also served as the Project Manager and Acting Project Director for the Centers for Medicare and Medicaid Services (CMS) Medicaid Transformation Grant. During that time, Wei-Shin successfully led a team to establish the comprehensive, online Dynamic Network Analysis (DNA) system to monitor the services and payments for all Medicaid providers and recipients. CMS's Center for Program Integrity has recognized the use of the DNA system as an industry best practice.

Steve Bandy – *Assistant Bureau Chief of Fraud Science and Technology*

Steve started with HFS in 1987. For the past five years he has served in OIG's Bureau of Fraud Science and Technology as operational and analytical support to the office and HFS at large. Before joining OIG, he served as analytical support for the implementation of Medicaid's provider enrollment system, IMPACT; managed programs focused on provider reimbursement, unpaid bills, and eligibility issues; started a new unit to provide electronic claim transaction support; was a budget support analyst; and analyzed access to care across the state. Steve also provided SQL and NOMAD programming and support for the Enterprise Data Warehouse and the older mainframe, respectively. While serving with U.S. Air Force, Steve graduated from Southern Illinois University with Bachelor of Science in Industrial Technology and completed an Associate Degree in Radio Communications.

Melissa Block – *Manager of Management, Research, and Analysis*

Missy joined OIG in November 2013, continuing her career in state government. Prior to OIG, Missy spent over five years with HFS' Provider Enrollment Services, and two years at the Illinois Department of Financial and Professional Regulation. Missy began her state service as a Graduate Public Service Intern for the University of Illinois at Springfield, working as a Recycling and Energy Educator for the Illinois Department of Commerce and Economic Opportunity from 2000-2004.

Kimberly Herrington – *Human Resources Liaison*

Kimberly joined OIG in September 2019. Previously, she worked at DHS's Bureau of Recruitment and Selection for fourteen years. Prior to that, she worked in DHS's Human Resources since 1997. Kimberly assists and offers advice to all OIG staff related to Human Resources and Labor Relations.

Marsha Eiter – *Fiscal Manager*

Marsha joined OIG in February 2013 as the Assistant Bureau Chief of the Bureau of Fraud Science and Technology. Marsha later transitioned to the Bureau of Medicaid Integrity as Audit Manager and then as Assistant Bureau Chief overseeing the Audit and Peer Review Units. Subsequently, Marsha transferred to her current position as Fiscal Manager. Marsha joined the Illinois Department of Public Aid, later HFS, as a budget analyst in 1988. Marsha left state service in 2007 and worked as an IT consultant with the Illinois Department on Aging and OIG for three years. She then worked for United Healthcare as a Senior SAS Programmer and UNIX administrator for three years until joining OIG.

OIG Bureau Overview

Bureau of Medicaid Integrity

The Bureau of Medicaid Integrity (BMI) is tasked with ensuring program integrity and quality in Illinois's Medicaid Program by detecting fraud, waste, and abuse. BMI's program integrity activities include compliance audits of paid claims, quality-of-care reviews of medical records, and oversight responsibility for audits conducted by federally-mandated, external auditors — the Recovery Audit Contractor (RAC) and the Unified Program Integrity Contractor (UPIC). BMI also verifies with recipients that they received services for which Medicaid was billed and investigates unallowed asset transfers of those applying for long-term-care medical assistance. BMI is composed of the following sections/units:

- Audit
- Peer Review
- Quality Control
- Long Term Care – Asset Discovery Investigations

Bureau of Investigations

The Bureau of Investigations (BOI) provides professional investigative services and support to HFS, DHS, and IDOA to prevent, identify, investigate, and eliminate fraud, waste, and abuse in all programs administered by the Departments. BOI investigates allegations of suspected fraud, waste, and abuse by providers in and recipients of HFS and DHS programs including Medicaid and its waiver programs, SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families), and the Child Care Program. BOI may refer its investigations to law enforcement for criminal prosecution or to OIG attorneys for administrative sanctions against a provider or recipient. BOI works with state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. BOI is composed of the following sections/units:

- Complaint Intake Unit
- Investigations
- New Provider Verification and Monitoring
- SNAP Fraud Unit

Bureau of Internal Affairs

The Bureau of Internal Affairs (BIA) investigates allegations of misconduct by HFS and IDOA employees and contractors, and also engages in proactive efforts to identify fraudulent staff activity and security weaknesses. In addition, BIA is also responsible for monitoring the security of HFS staff and facilities.

Bureau of Fraud Science and Technology

The Bureau of Fraud Science and Technology (BFST) is responsible for OIG's introduction, development, and maintenance of new technologies. BFST utilizes these technologies to analyze, detect, and prevent fraud, waste, and abuse by providers and recipients. BFST oversees OIG's Dynamic Network Analysis Predictive Modeling System (DNA), its primary data analytics system, and OIG's Case Administrative System Enquiry (CASE), its case tracking and document-management system. BFST trains OIG staff on these systems and technologies. BFST initiatives center on supporting OIG's mission to ensure program integrity by evaluating and promoting data integrity. BFST is composed of:

- Fraud Science Team (FST)
- Technology Management Unit (TMU)
- Provider and Recipient Analysis Section (PRAS)

Management, Research, and Analysis Section

The Management, Research, and Analysis (MRA) Section conducts and coordinates complex technical processes that impact healthcare oversight. MRA coordinates OIG's various bureaus and units in collective efforts internally, and OIG's various partners and stakeholders, including law enforcement and the MCOs externally. MRA staff is responsible for reporting findings and making recommendations based on the results from research studies and data analysis to prevent and detect healthcare fraud and to increase efficiency within OIG. MRA is also responsible for evaluating program policies and procedures relating to Medicaid oversight and serves as the OIG liaison with HFS staff to facilitate the work of all OIG bureaus. The MRA Manager is the liaison with the MCOs and oversees the Fraud, Waste, and Abuse Executive (FAE).

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides legal advice to the Inspector General and OIG leadership, and advocates on behalf of all of OIG's programmatic units. OCIG acts as in-house legal counsel, providing legal support for OIG's audits, investigations, inspections, and reviews. OCIG also handles all administrative prosecutions of sanctions against Medicaid providers, including terminations, overpayment recoupments, payment suspensions, and enrollment application denials.

Fiscal Management Unit

The Fiscal Management Unit oversees all fiscal matters, including general collections, bad debt, procurement, personnel timekeeping, and budget responsibilities. Fiscal Management staff monitors OIG's annual budget and expenditures, and requests additional funds through the budgeting process as needed for special projects and initiatives.

External Partners

OIG works with a variety of external partners in its effort to prevent and investigate fraud, waste, and abuse in Illinois Medicaid and other federal programs. These partners include other state and federal agencies, external contracted auditors, and public/private associations. Several of OIG's key partnerships are highlighted below.

State

Medicaid Fraud Control Unit (MFCU)

Under federal law, states are required to operate a Medicaid Fraud Control Unit, which is tasked with investigating and prosecuting Medicaid provider fraud and abuse or neglect of residents in healthcare facilities. Illinois' MFCU is operated by the Illinois State Police with support from the Office of the Illinois Attorney General. OIG, as HFS' liaison with law enforcement agencies, is statutorily mandated to report suspected Medicaid fraud to MFCU. OIG works with MFCU on active investigations and prosecutions of Medicaid providers, gathering information and data, identifying subject matter experts on policy and programs, and providing witness testimony in criminal and civil proceedings. OIG and MFCU collaborate through both formal and informal communication to ensure that both administrative and criminal proceedings advance without conflict.

Illinois Department of Financial and Professional Regulation (IDFPR)

Many of the providers enrolled in Medicaid work in professions licensed and regulated by the Illinois Department of Financial and Professional Regulation. To maintain Medicaid enrollment, a provider must hold all required professional licenses in good standing. The suspension or termination of a professional license will result in OIG pursuing a provider's termination from Medicaid. Due to the overlap in OIG's oversight and IDFPR's regulatory jurisdiction, OIG works closely with IDFPR to ensure that the agencies' efforts are coordinated, and that each agency is aware of any actions against common providers. OIG and IDFPR share information through referrals, document requests, data reports, and monthly meetings, to maintain high-quality, professional care in Medicaid.

State Agencies Operating Waiver Programs

DHS and IDOA have been delegated the day-to-day operations for certain waiver programs under Illinois Medicaid. In this role, these agencies often receive information regarding potential fraud, waste, and abuse in their waiver programs. DHS and IDOA also maintain the expertise on their waiver policies, their network of providers, and their client population. OIG works closely with both agencies and their investigative units on allegations that relate to their waiver programs and associated providers

Federal

Centers for Medicare and Medicaid Services (CMS) Center for Program Integrity (CPI)

The mission of the federal Centers for Medicare and Medicaid Services' (CMS) Center for Program Integrity (CPI) is to detect and combat fraud, waste, and abuse in the Medicare and Medicaid programs. Working in tandem with providers, states, and other stakeholders, CPI supports accurate enrollment and billing practices. OIG's work with CPI includes participating in monthly Technical Advisory Group (TAG) calls with other state partners to discuss topics including fraud schemes, provider enrollment, data analytics and managed care. CPI staff also work with OIG and other states' program-integrity units and the Universal Program Integrity Contractor (UPIC) to provide audit and investigation assistance.

U.S. Department of Health and Human Services Office of Inspector General (HHS OIG)

The HHS OIG fights fraud, waste, and abuse in Medicare, Medicaid, and various other HHS programs. As HHS OIG's jurisdiction encompasses Medicaid at a national level, it overlaps with OIG's jurisdiction. If HHS OIG's investigations implicate Illinois Medicaid providers, OIG may provide information or of her support to the investigation. Further, when an HHS OIG investigation results in the federal exclusion of an Illinois Medicaid provider, OIG takes reciprocal action to terminate that provider from Illinois' Medicaid program.

Federal Bureau of Investigation/Drug Enforcement Agency/Department of Justice

OIG supports federal law enforcement agencies including the Federal Bureau of Investigations (FBI), the Drug Enforcement Agency (DEA), and the U.S. Department of Justice (USDOJ) in investigations of Medicaid fraud. OIG serves as the primary liaison between these entities and the Medicaid program to coordinate data collection and relevant policy research.

Contractors

Unified Program Integrity Contractor (UPIC)

The UPIC program is a no-cost resource to states' Medicaid agencies established under the Federal Deficit Reduction Act and authorizes external auditors to monitor and audit potentially fraudulent Medicaid claims as well as identify overpayments made to individuals or entities receiving federal funds. OIG's Bureau of Medicaid Integrity utilizes the UPIC auditor, CoventBridge, to conduct medical reviews, utilization reviews, and reviews of potential fraud. OIG works with UPIC on its audits and acts in response to its findings, including education, recouping overpayments, and suspending or terminating providers.

Recovery Audit Contractor (RAC)

Illinois contracts with Gainwell, Inc. on a contingency-fee basis to conduct audits of state Medicaid claims for enrolled providers of goods and services under the traditional fee-for-service model. RAC audits identify overpayments and underpayments according to the State of Illinois plan. RAC overpayment determinations are referred to OIG Bureau of Collections or OCIG for any appealable issues.

Public/Private Partnerships

National Association for Medicaid Program Integrity (NAMPI)

The National Association for Medicaid Program Integrity (NAMPI) was formed over thirty-five years ago by officials from various states interested in improving information sharing regarding Medicaid program integrity efforts. Today, NAMPI is composed of professionals from a wide variety of disciplines representing Medicaid programs from all 50 states. Through monthly information sharing sessions, regional meetings, various trainings, and annual conferences, OIG gains and shares information on national trends and prevalent fraud schemes and provides staff with meaningful educational and training opportunities.

Healthcare Fraud Prevention Partnership (HFPP)

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing. Partners include the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations. OIG is a participating member that uses HFPP's information sharing sessions, whitepapers, and studies to educate staff and develop potential leads for further inquiry.

National Health Care Anti-Fraud Association (NHCAA)

The National Health Care Anti-Fraud Association's (NHCAA) mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of healthcare fraud and abuse. OIG participates in NHCAA to further develop staff skills and access information on national trends.

Managed Care Organizations (MCOs)

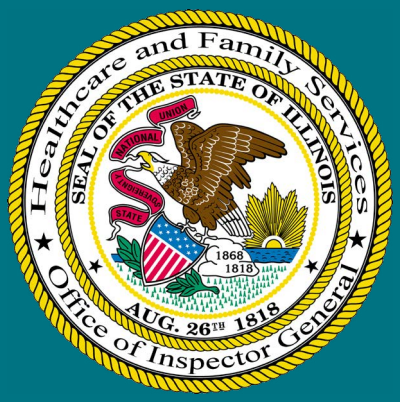
HFS's mission includes improving the health of Medicaid recipients by providing access to, and coordination of, quality healthcare. Pursuant to the Illinois Medicaid reform law and Save Medicaid Access and Resources Together Act, along with the federal Affordable Care Act, Illinois contracts with health-insurance companies to provide healthcare services to Medicaid recipients. Under this managed care model, Medicaid recipients enroll with a Managed Care Organization (MCO). The MCOs must create comprehensive networks of care, including primary and behavioral health care providers, hospitals, and specialists. The MCOs must ensure continuity of care to their Medicaid customers through a Primary Care Provider and offer care coordination to help participants with complex healthcare needs.

In January 2018, Illinois transitioned its managed-care program into a more streamlined, accountable, and integrated program, HealthChoice Illinois (HCI). The goal of HCI is to provide enhanced quality and improved outcomes at a sustainable cost. Currently, there are four MCOs contracted to provide services statewide. Six MCOs that operate in Cook County also contract with plans to implement (1) the YouthCare Program in conjunction with the Illinois Department of Children and Family Services, and (2) the Medicare Medicaid Alignment Initiative (MMAI) program for those recipients eligible for both Medicare and Medicaid benefits. In FY2022, the six companies providing services under one of the three contracts with HFS were Aetna Better Health of Illinois, Blue Cross Community Health Plans, CountyCare Health Plan, Humana, Meridian Health, and Molina Healthcare.

OIG works collaboratively with the MCOs on their program-integrity efforts. The MCOs are statutorily and contractually required to have dedicated fraud, waste, and abuse staff to investigate and prevent fraud in the Medicaid program. OIG monitors the work and outcomes of the MCOs' Special Investigations Units through regular reporting and the review of fraud referrals. OIG meets monthly with the investigative teams to coordinate efforts, identify trends, and discuss findings

Important Links

- Website Office of Inspector General Home | HFS (illinois.gov)
- Complaint Portal Report Fraud | HFS (illinois.gov)
- HFS OIG Medicaid Exclusion List Provider Sanctions Search | HFS (illinois.gov)



ANNUAL REPORT FY2022

ACTIVITIES AND IMPACT IN FISCAL YEAR 2022

Financial Impact

OIG Officewide

Dollars Recovered

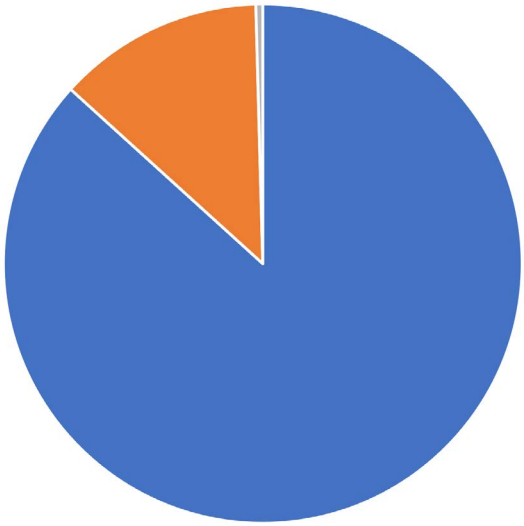
Dollars recovered are overpayments that have been **collected** based on the results of an investigation, audit, inspection, or review. Dollars recovered would first have been calculated as an overpayment identified in Questioned Costs, either from this fiscal year or a prior fiscal year.

Total: $15,845,316

Provider Audits: $13,741,071

Global Settlements: $2,036,080

Restitution: $68,165



Questioned Costs

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.

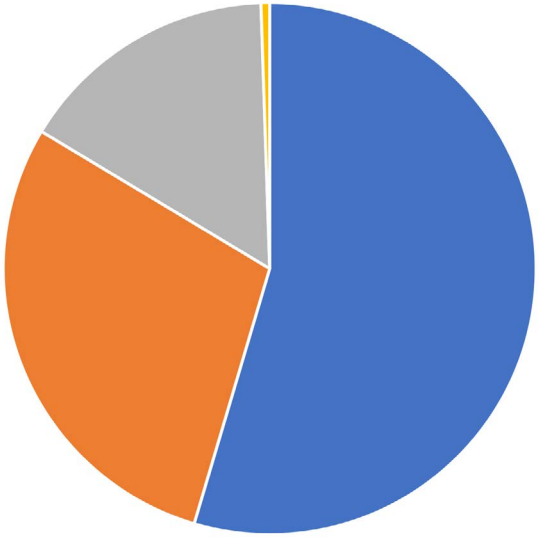
Total: $25,235,035

Provider Audits: $13,807,816

Client Eligibility: $7,347,690

SNAP: $4,011,364

Restitution: $132,709



Funds Put to Better Use

Funds put to better use are those which were **not expended** after identifying that the operational, medical, contract or grant expense was unnecessary. These measures align with those used by the federal Government Accountability Office.

Total: $47,341,451

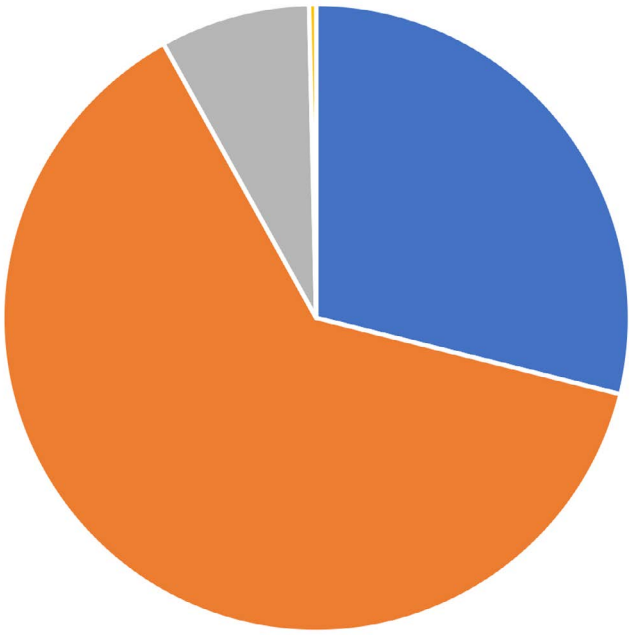
***Recipient Restriction Program:* $29,822,651**

***Provider Sanctions:* $13,687,066**

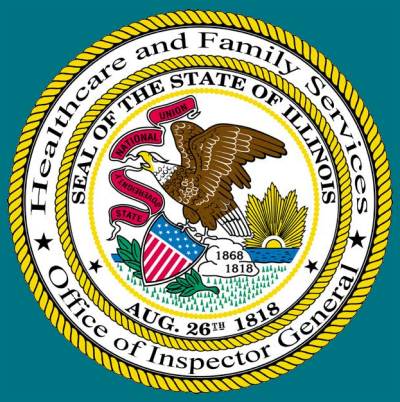
***SNAP:* $3,660,581**

***Client Overpayments:* $171,153**

***LTC-ADI:* 0[1]**



[1] During this fiscal year, HFS continued to suspend the resource test for long-term-care applicants due to PHE. Accordingly, OIG was unable to process any penalties or resource spenddowns. As part of its Long-Term Care Asset Discovery investigations, OIG continued to review applications referred to this office to make preliminary eligibility findings, but no savings could be realized.



ANNUAL REPORT FY2022

BUREAU OF MEDICAID INTEGRITY (BMI)

Audits

The Audit Section under the Bureau of Medicaid Integrity strives to maintain the program integrity of HFS's Medicaid programs through targeted audits for all providers enrolled in the Medical Assistance Program. These audits evaluate provider compliance with state and federal law and Department policy to ensure that improper payments of Medicaid monies are identified and recouped. BMI audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, and durable medical equipment suppliers. A Medicaid provider may also submit to a self-disclosure audit as the result of the provider's own investigations and review of their billing practices.

The Audit Section has oversight responsibility for the RAC and UPIC. The RAC reviews fee-for-service paid claims for compliance with state rules and regulations. The UPIC conducts investigations and audits to reduce fraud, waste, and abuse in the Medicaid programs.

The audits conducted by BMI and by the contracted auditors may result in the recoupment of identified overpayments, entry into a corporate integrity agreement, termination from Medicaid, or referral to MFCU for prosecution.

2022 Highlights

Sampling Protocol: The current audit sampling protocol was reviewed to determine whether the auditing process could be made more efficient without diminishing its integrity. BMI's samples were composed, on average, of 350 claims. BMI continues to work with BFST and their statisticians to decrease the sample size to 130-150 claims for a standard audit sample while maintaining a 95% confidence interval and an error rate of .05%. In addition, BMI is reviewing the process for individual cases to be evaluated for an initial probe audit.

Electronic Health Records (EHR) Review: In 2011, CMS established EHR incentives for Medicare and Medicaid providers (now called the "Medicaid Promoting Interoperability Program") to encourage the adoption, implementation, upgrading, and demonstration of meaningful use of certified electronic health record technology. OIG is tasked with ensuring EHR compliance by auditing providers who took advantage of these incentives to upgrade their electronic systems. Illinois receives a 90% federal match on employee salaries to conduct these EHR compliance audits. For FY2022, OIG completed 1367 EHR audits. This audit program is now complete.

Unified Program Integrity Contractor (UPIC): UPIC, operating under a Joint Operating Agreement, works both with the OIG and CMS to identify overpayments made to providers or entities receiving federal funds under Medicaid and to determine if fraud, waste, or abuse occurred. For FY2022, BMI focused on enhancing the process and relationship between OIG and Midwest UPIC contractor CoventBridge. OIG implemented stronger validation and vetting processes, allowing for the reduction of a case backlog, in addition to referring more leads for UPIC's consideration.

Recovery Audit Contractor (RAC): During FY2022, Gainwell Technologies, Inc., took over ownership of Health Management Services, Inc. , OIG's contracted RAC. The change of ownership brought about internal RAC staffing changes which in turn presented an opportunity for the OIG to reevaluate RAC-OIG communications and procedures. Prioritizing the identification, recovery, and disposition of outstanding RAC audit claims took precedence during the year. In addition, BMI, OCIG, and OIG's Bureau of Collections identified areas of improvement for managing the RAC program. Importantly, BMI was identified as OIG's primary liaison for the RAC. During FY2022, a request for proposal was prepared for the award of a new RAC contract in FY2023.

Provider Self-disclosures: The federal Patient Protection and Affordable Care Act (ACA) requires providers to timely identify and repay Medicaid overpayments. Under the ACA, providers are obligated to report, explain, and repay overpayments within 60 calendar days of identification. OIG monitors a self-disclosure protocol that allows providers to voluntarily refer such overpayments upon detection to avoid penalties and sanctions. Although there was a pause in audits due to the PHE, providers consistently utilized this protocol to report self-identified overpayments. Providers identified and repaid approximately $766,499 to HFS through self-disclosure in FY2022. Some highlights are as follows:

Nursing services by non-qualified staff (#1364191): OIG recouped $27,218 when a provider discovered an employee was working on a suspended nursing license. The provider performed a self-audit and reported this overpayment.

Billed both commercial insurance and Medicaid (#1372057): When a newly acquired private duty nursing company converted its financial statements from cash accounting methodology to an accrual accounting system, it identified duplicate billing and payments from both commercial insurance and Medicaid. OIG recouped $92,797.

CPA Audit completions: In prior years BMI contracted with a Certified Public Accountant firm to assist in conducting post payment audits of long-term care facilities. The objective of a CPA audit is to confirm the propriety of Medicaid payments to long-term care facilities and identify problem areas requiring special attention. These audits were routine financial audits establishing non-extrapolated overpayments. During FY2022, the CPA contract ended without BMI actively seeking renewal. BMI worked with the CPA contractor to review remaining audits and refer providers with outstanding balances for administrative recovery actions. During FY2022, BMI completed 11 audits with 9 identified overpayments totaling $2,190,542. In the future, the majority of LTC audits previously completed by CPA contractors will be referred to OIG's RAC with some LTC audits performed by BMI auditors.

Pharmacy: BMI's audits of Medicaid-enrolled pharmacy providers ensure compliance with policies, rules and regulations with a focus on prescriptions and drug inventory. Prescription audits identify billing of unauthorized substitution of drugs or strength, non-covered drugs, unauthorized refills, improper billed quantity, and billing for split dispensing fees. Inventory audits ensure that pharmacies have enough drugs to support billings for Program-covered prescriptions. Additionally, script audits focus on compliance with proper completion and retention of pharmacy records, including purchase invoices, and other financial records. Various pharmacy audits are ongoing.

2022 Statistics

New Audits Initiated: 3,292

Audits Completed: 2,073

Electronic Health Records: **1,367**
RAC: **623**
Self-disclosure: **41**
Transportation: **12**
CPA Long Term Care Audit Review: **11**
UPIC: **6**
Pharmacy: **4**
Global Billing: **3**
In-house Nursing Homes: **2**
Medical Practitioner: **2**
Special Project: **1**
PERM: **1**

Overpayments Identified[2]: $5,968,368

CPA Long-Term Care Audits: **$2,446,912**
RAC: **$2,404,039**
Self-disclosures: **$766,499**
UPIC: **$133,708**
Transportation: **$26,287**
Medical Practitioner: **$10,015**
Special Project: **$5,862**
Global Billing: **$3,324**
In-house Nursing Homes: **$1,056**
PERM: **$346**
Electronic Health Records: **$0**

Payment Agreements Entered: 13

Audits Sent for Legal Action: 7

[2] This represents the overpayment amount that the Audit section identified as a result of its audit. The actual amount established as an account receivable may be different as the result of negotiation, settlement, or an administrative hearing. The amount that OIG collects may be different from both Audit's identified overpayment and the established account receivable if the provider fails to pay its debt.

Peer Review

The Peer Review Unit (PRU) consists of nurses and physicians tasked with conducting utilization and quality-of-care (QOC) reviews of healthcare furnished to Medicaid clients by providers such as physicians, dentists, podiatrists, audiologists, chiropractors, nurse practitioners, and optometrists. QOC concerns include risk of harm (when there is a risk to the patient that outweighs the potential benefit of the service), medically unnecessary care (service provided is not needed and/ or exceeds the patient's needs), and grossly inferior quality of care (when flagrantly poor care is provided to a patient).

PRU cases originate from hotline complaints, referrals from internal units and external agencies such as the IDFPR, the Illinois Department of Public Health, Illinois State Police, or MCOs.

Nurse analysts determine what services are in question by the referral allegation. Data analytics are then used to identify recipients who received those services from the provider under investigation. PRU nurses and HFS physician consultants perform in-depth record reviews to determine if documentation meets acceptable quality guidelines, supports the level of service billed to the Department and was medically necessary. When minor concerns are noted during this review process, the Department sends a letter to the provider indicating areas needing improvement and guidance for the recommended improvement. However, if the identified concerns are more serious, the provider may be required to appear before the Medical Quality Review Committee (MQRC) where physician consultants question the provider to determine if appropriate care was rendered to Medicaid clients.

After an MQRC review, the Committee makes a recommendation to OIG regarding the appropriate action, which include sending a letter to the provider identifying concerns; requiring the provider to implement corrective action within a certain time period; referring the matter internally or externally for further action; recommending administrative action, such as termination, entry of a corporate integrity agreement, suspension, or denial of reinstatement or enrollment; or closing the matter with no further action. OIG considers the Committee's recommendations and notifies the provider of the final decision. MQRC meetings have been on hold during the PHE.

In addition to reviewing complaint referrals, PRU also conducts quality-of-care reviews for any providers that submit a Medicaid enrollment application and were previously terminated, suspended, or withdrew from the Medicaid Program, or had an action/discipline noted on their license.

2022 Highlights

Development of Remote MQRC Process: MQRC meetings have been on hold since the start of the PHE. In FY2022, PRU developed and implemented new procedures allowing it to conduct remote MQRC reviews with the subject providers. The first MQRCs under the new rules are scheduled to commence in FY2023.

Re-review of Physician Who Prescribed Large Quantities of Opioids (#1235060): In 2017, PRU conducted a physician review that revealed the provider's documentation frequently did not support issued opioid prescriptions. Therefore, PRU referred the provider to appear before the MQRC. The committee unanimously recommended sending a Letter of Concern to the provider indicating the

areas needing improvement and included immediate corrective actions to be implemented. They also recommended a re-review in 2-3 years to validate improvement. PRU also notified IDFPR, which placed conditions on the provider's license and fined them $5,000 for the prescription concerns related to PRU's findings. In FY2022, PRU completed the recommended re-review of this provider. OIG's physician consultant held a conference call review and confirmed the provider's documentation had vastly improved and appropriate medical care was rendered to Medicaid recipients. Minor documentation improvements were suggested and the case was closed.

Reinstatement case on a HFS suspended provider (1364386): HFS had previously suspended a physician provider as a result of PRU's findings of grossly inferior quality of care to Medicaid patients. IDFPR also placed the provider's license on probation and extended that probation several times. After the provider failed to abide by consent order rules and to report HFS' Medicaid suspension, IDFPR suspended the doctor's license and fined him $10,000. As the provider had repeatedly sought reinstatement into the Medicaid program, PRU worked to obtain medical records from the provider and arrange for an MQRC. The provider has failed to cooperate with the reinstatement process, so PRU has blocked his reinstatement.

2022 Statistics

Cases Reviewed: 48

Quality-of-Care Reviews: **26**
Enrollment Application Reviews: **6**
Re-instatement Reviews: **10**
Re-enrollment Reviews: **5**
Provider Revalidations: **1**

Case Review Outcomes:

Quality-of-Care Review Outcomes
- Letter of Concern: **1**
- Letter of Education: **2**
- Letter with No Concern: **2**
- No Further Action/No Concerns/Allegation Not Substantiated: **4**
- Closed Based on Inactive Provider Status: **1**
- Closed/No Longer Needed: **16**

Enrollment Application Review Outcomes
- Approved: **5**
- Denied: **1**

Re-instatement/Review Outcomes
- Approved: **9**
- Application Withdrawn: **1**

Re-enrollmentReview Outcomes

Enrolled: **3**
Monitor: **1**
Denied: **1**

Provider Revalidation Outcomes

Approved: **1**

MQRC Conducted: **0**

Quality-Control Review

Quality Control Review (QC)/Central Analysis Section (CAS) oversees the federally mandated Medicaid Eligibility Quality Control (MEQC) program and the Payment Error Rate Measurement (PERM) initiative. The MEQC program focuses on improving the quality and accuracy of Illinois' Medicaid and Children's Health Insurance Program (CHIP) eligibility determinations through annual reviews. The MEQC program is intended to complement the PERM program by ensuring state operations make accurate and timely eligibility determinations so that Medicaid and CHIP services are appropriately provided to eligible individuals. The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The PERM is conducted every three years. QC conducts the eligibility reviews for MEQC and aids the federal auditors for PERM. CAS is responsible for the coordination of the completion of questionnaires, on-site reviews, and systems access and identification of the universe of claims for federally contracted auditors. CAS also acts as the liaison between the Department's staff responsible for the payment of claims and the federal auditors.

In addition, CAS coordinates the development of, and monitors, corrective action plans designed to eliminate or reduce errors utilizing various methods, including training, system programming, and policy changes.

2022 Highlights

Independent Review Project (IRP): As proposed and accepted by CMS in the PERM Review Year (RY) 2019 and MEQC RY2020 Corrective Action Plans, QC began to review randomly sampled cases for compliance with state and federal eligibility rules and procedures outside of PERM and MEQC reviews. Data from the IRP is used to evaluate the effectiveness of implemented corrective actions from all projects and address newly identified eligibility issues in advance of future cycles of the PERM and MEQC reviews. Because MEQC RY2023 reviews began within just a month of the end of the RY2022 PERM cycle, only one month of reviews were conducted for this project to date. IRP reviews will restart at the conclusion of MEQC RY2023 reviews and continue until the next PERM.

Illinois Residency Verification Review: First initiated in FY2021, QC continued to process reviews for Medicaid recipients who potentially no longer reside in Illinois as identified by claims and capitation data. In FY2022, QC reviewed 1406 cases and identified 603 cases in which it was unable to reverify the recipient's Illinois residence, a primary factor in eligibility for medical benefits. The total potential cost avoidance for this project to date, based on four months of capitation payments for each ineligible recipient, is $2,375,759 with $355,929 of this identified in FY2022. While eligibility could not be canceled during the PHE, QC noted all cases for review at the next redetermination.

2022 Statistics

Total Cases Reviewed: 2877

Independent Reviews: **37**

Illinois Residency Reviews: **1406**

- Verified Residency: **803**
- Unable to Verify Residency: **603**
- Cost avoidance based on Verifications: **$355,929**

PERM RY22: **1262**

MEQC RY22: **172**

Long-Term Care – Asset-Discovery Investigations

Long-Term Care – Asset Discovery Investigations (LTC-ADI) conducts reviews of LTC applications triggered by specified criteria related to the transfer and disclosure of assets. Undisclosed assets or those transferred for less than fair market value result in penalty periods where the recipient will be ineligible to receive Medicaid payments. During these penalty periods, the recipient is liable for the LTC expenditures at a private pay rate. LTC-ADI reviews trusts and other legal documents to determine if they meet current policy requirements. By preventing improper conduct related to eligibility, LTC-ADI ensures program funds go to qualified applicants who have no other means to pay for their own care. Adverse determinations may be appealed in an administrative-hearing process. This section manages LTC applicant appeals for asset determinations. Once all appeals are exhausted, the final determination regarding LTC eligibility is implemented by the local DHS Family Community Resource Center.

2022 Highlights

Eligibility Waivers Due to the PHE: During FY2022, the resource test for long term care applicants continued to be suspended due to the PHE. Accordingly, OIG was unable to process any penalties or resource spenddowns. LTC-ADI continued to review applications referred to OIG to make preliminary eligibility findings. OIG intends to use these findings to determine actual eligibility at the end of the PHE when the penalties and spenddowns can be imposed. In FY2022, OIG prepared recommendations on 176 cases to be implemented upon the expiration of the PHE. In these cases, OIG identified $9.2 million in excess resources and $18.3 million in unallowable transfers.

Extensive Training Mandated to LTC-ADI Staff: During FY2022, the LTC-ADI staff researched issues related to commonly held resources and their applicable policies and rules. LTC-ADI created presentations on these topics as training tools and to ensure consistency in the staff's work. LTC-ADI compiled the trainings into a manual for all staff. This tool will now also be used for orientation of all new staff. In addition, LTC-ADI created instructions on how to enter assets into the system to ensure optimum report data and drafted common templates for OIG's case recommendation narratives. These tools will serve the analysts when the PHE ends, and asset discovery referrals increase.

Time Study of Applications Referred to OIG: During FY2022, LTC-ADI tracked cases from the day they were referred to completion of the case. With case tracking, LTC-ADI identified if there were any problems with the workflow for each type of case and calculated metrics for case processing.

Held Cases: The following cases are currently being held:

Revocable trust that upon the spouse's death became irrevocable: Applicant applied for benefits to help cover LTC charges. Upon review of the application the LTC-ADI analyst discovered that there was a revocable trust in the name of the applicant's deceased husband. The OCIG attorney gave input on the trust, and it was found to be a

revocable trust that upon the spouses' death the trust was to become irrevocable. The spouse passed away in 2020 and per the trust language, funds of $639,909 were entitled to the applicant and can be used for the applicant's care.

Farm ground transferred to child retaining a life estate: Applicant has applied for LTC benefits. Upon review, the LTC-ADI analyst identified that three parcels of farm ground and the applicant's prior homestead were transferred to a child retaining a life estate. The transfer deeded all the property within one year of the application for benefits. Under program rules, the penalty will be approximately $1.5 million

505 acres of farm ground transferred to family members: While reviewing the LTC application, the LTC-ADI analyst found six parcels of land measuring 505 acres transferred to family members. In addition to the property, money was also transferred, creating a penalty in the amount of $1,041,022. The analyst also found assets including two rental properties, several vacant lots, and two Harley Davidson motorcycles.

Funds and Property transferred to family: Upon review of the application submitted for LTC services the analyst found that ten certificates of deposit (CDs) totaling $179,165 were liquidated and transferred to family members. In addition to the CDs, two parcels containing 58 acres of farmland with a value of $332,977 were sold and funds were dispersed to family. The family also quit claim deeded the property that was previously the applicant's homestead with an assessed value of $42,285 to the irrevocable trust established by the applicant for the benefit of the family.

Funds transferred to irrevocable trust: The applicant created an irrevocable trust that prohibited distributions to the applicant therefore transfers to the trust were penalized. The applicant gifted $114,394 from his bank account to his family. The applicant also transferred investment accounts, bank accounts and life insurance policies to the irrevocable trust, the total that was transferred was $999,591, creating a total penalty for this applicant of $1,113,986.

Excess Resources: During review of an LTC application, an analyst found that the applicant owned a property that was deemed non-homestead and therefore a non-exempt asset. In addition to the property, he also had funds in bank accounts, three vehicles, an ATV, a boat with a trailer and a Harley-Davidson motorcycle. The total amount of the applicant's penalty is $142,812.

2022 Statistics[4]

Applications Reviewed: 508

Applications Held By LTC-ADI with Recommendations: 176

Value of Unallowable Transfers: **$18,392,286**
Value of Excess Resources: **$9,281,597**
Penalty and Spenddown Recommendation: **72**
Penalty Only: **64**
Spenddown Only: **40**
Insufficient Information from Recipient: **71**

"Healthcare fraud causes billions of dollars in losses, it deprives real patients of the crucial health care services they need, and it can endanger the lives of real patients[.]" – FBI Assistant Director Robert Johnson

[4] Due to the PHE, the number of applications referred to OIG for review has been greatly reduced as eligibility requirements have been suspended. LTC-ADI has continued its review of referred applications and has returned the majority of those cases to the DHS. Findings regarding ineligibility, excess assets, and unallowable transfers have not been acted upon due to PHE, so none of the savings identified have been realized. LTC-ADI held its recommendations on 176 applications with the expectation that, once the PHE ends, the Department will impose the appropriate spenddown or penalty in response to OIG's recommendation.

ANNUAL REPORT FY2022

BUREAU OF INVESTIGATIONS (BOI)

Complaint Intake Unit

BOI's Complaint Intake Unit serves as the central fraud intake unit for OIG. Complaint Intake processes fraud and abuse referrals received from MCOs, local DHS offices, members of the public, and other stakeholders, alleging potential fraud by Medicaid providers and recipients, and related to other benefit programs. Referrals are processed via phone hotline and online intake referral sites, as well as through direct communication with state and federal agencies and law enforcement entities.

Complaint Intake conducts thorough research on fraud and abuse allegations by reviewing internal Medicaid data and by accessing databases from a variety of sources, including, but not limited to, DHS, the Illinois Secretary of State, the Illinois State Police, the Illinois Department of Public Health, the Illinois Department of Employment Security, and HFS's Division of Child Support Services. OIG then determines what further action to take on the allegation, if any.

2022 Highlights

Complaint Intake Unit Development: The Complaint Intake Unit, which was formed at the end of FY2021, established policies and procedures regarding its collection and analysis of information for presentation at OIG's weekly complaint intake meetings. The unit also began a pre-intake committee meeting to achieve greater efficiencies in operation.

Allegations Substantiated: For some complaints involving beneficiary fraud, the Complaint Intake Unit is able to substantiate the allegation through its own investigation and it is unnecessary to route the matter to the Investigations section for further review. In FY2022, Complaint Intake staff substantiated 62 cases through its own research and analysis and was able to refer those cases directly to the DHS Bureau of Collections for further action.

2022 Statistics

Complaints Received: 6021

Complaints Processed: 3299

Client Eligibility Complaints: **2994**
Provider Complaints: **305**

Investigation Referrals: 784

Client Eligibility Referrals: **732**
Provider Referrals: **52**

Recipient Program Overpayments Referred for Collection: $171,153

SNAP: **$152,491**
TANF: **$18,662**

Investigations

BOI's Investigations Section is divided into four units – Southern, Central, Northern, and Cook County. This section conducts investigations into fraud, waste, and abuse in programs administered by HFS and DHS. Historically, BOI focused its investigations on allegations of suspected fraud by recipients of federal benefits. However, during FY2021, the Bureau began a transition to re-focus resources on the investigation of fraud, waste, and abuse by Medicaid providers. In its investigations, BOI may work with the State Police's Medicaid Fraud Control Unit, state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. As the result of BOI's investigation against a provider, OIG may refer the matter for criminal prosecution or seek administrative sanctions through its legal office. BOI also continues to investigate recipients alleged to have engaged in eligibility fraud or abuse of their benefits from Medicaid, SNAP, TANF, or the Child Care Program. These investigations may result in the identification of overpayments, termination of benefits, or prosecution by state and federal agencies. BOI is currently involved in a transition of SNAP fraud investigations to DHS, the agency responsible for administering SNAP, which is expected to be complete in FY2023.

2022 Highlights

Continued Expansion Focusing on Provider Investigations: In FY2021, BOI began the process of expanding its focus to include the investigation of fraud, waste, and abuse allegations against Medicaid providers. In FY2022, BOI continued this expansion by identifying relevant training opportunities for staff, developing new policies and procedures, and establishing working relationships with internal and external stakeholders.

Significant Criminal Investigations

Failure to Report Responsible Relative (Case No. 1317789): OIG determined that a recipient of public assistance failed to report that her husband resided in her home and was receiving income from his employer. This case was referred for prosecution and on November 2, 2022, the recipient pleaded guilty in the Illinois First Judicial Circuit Court in Saline County to one count of theft and was sentenced to 24 months of probation, ordered to pay restitution of $36,103 and received fines of $3,149 including court costs and associated fees.

Failure to Report Self-Employment Income (Case No. 1359892): OIG established that a recipient of public assistance knowingly misrepresented her self-employment status to obtain public assistance benefits in excess of $300. The recipient owned a cleaning service and did not disclose this income as required by law. On November 22, 2022, the recipient pleaded guilty in the Illinois Eighth Judicial Circuit Court in Calhoun County to theft (greater than $500), and was sentenced to 24-months of probation, restitution of $30,049 and a fine of $1,097, plus court costs and fees.

Failure to Report Responsible Relative (Case No. 1354920): OIG concluded that a recipient of public assistance in Monroe County, failed to report that the father of her children was living

in the home and had employment income that was not reported to DHS, which generated an overpayment of $18,257. This case was presented to the Monroe County State's Attorney's Office on September 29, 2021. On May 4, 2023, criminal charges were dropped after the recipient paid back the overpayment.

Failure to Report Responsible Relative (Case No. 1367543): OIG concluded that a recipient of public assistance failed to accurately report her household composition from November 1, 2016 through October 31, 2020. A responsible relative resided in the home and received employment income that was not reported to DHS. This generated an overpayment of $28,807. This case was referred to the Randolph County State's Attorney's Office in May 2022.

Failure to Report Self-Employment Income (Case No. 1368456): OIG concluded that a recipient of public assistance did not report that the father of her children was living in the home and that he received employment income that was not reported to DHS. OIG established an overpayment of $16,536. This case was referred to the Randolph County State's Attorney's Office in May 2022.

Significant Client Eligibility Investigations

Failure to Report Responsible Relative (Case No. 1375990): OIG conducted an eligibility investigation and found that from June 2016 through May 2022, a SNAP recipient failed to report that the father of her children was part of her household and earned wages, even though the father had resided in the home for years. As a result, the recipient received an overpayment of $39,288 in SNAP benefits.

Failure to Report Household Composition (Case No. 1376784): OIG conducted an eligibility investigation and found that from January 2015 through May 2022, a SNAP recipient had failed to report that the father of her child was part of her household and earned wages. As a result, the recipient received an overpayment of $34,425 in SNAP benefits. The investigation found that the recipient also received an overpayment of $684 in TANF grant assistance from July through September 2018.

Failure to Report Household Composition (Case No. 1282444): OIG conducted an eligibility investigation and found that from February 2014 through July 2021, a SNAP recipient did not report to DHS that her husband resided in her home and had unreported income. Neither the responsible relative's income nor his presence in the home was reported to DHS. As a result, the recipient received an overpayment of $58,255 in SNAP benefits.

Failure to Report Absent Children (Case No. 1363470): OIG conducted an eligibility investigation and found that from October 2017 through December 2021, a DHS recipient had failed to report that he did not have custody of the two children he claimed on his assistance case. The client was court ordered to only have supervised visits with his children. As a result, the recipient received an overpayment of $20,219 in SNAP benefits.

Disqualification for Failure to Report Household Member, Income as Well As Income From a Parent's Relocation (Case No. 1355933): OIG received a referral from DHS alleging that a recipient failed to report their spouse in the home, spouse's income or income, from the parent's relocation. OIG compiled evidence establishing an overpayment of $25,449 in SNAP benefits for failure to comply with the program rules and regulations. Once the client received the charges, they chose to sign a waiver and agreed to a disqualification of 12 months from the program.

Disqualification for Receiving Duplicate Assistance (Case No. 1181596): OIG processed a DHS referral identifying a client that had received SNAP assistance in both Illinois and Wisconsin during the same time period. There was an overpayment of $7,340. Client declined to sign a waiver and the case was presented to an administrative law judge. Based on the evidence presented, the judge upheld all evidence as credible, resulting in a 10-year disqualification as well as a cost savings of $24,000 to the state.

Disqualification for Failure to Report Household Composition and Income (Case No. 1320537): OIG received a DHS referral alleging a recipient failed to report her husband in the home and his income from an airline company. OIG obtained documentary evidence corroborating the allegations. The recipient completed several applications from June 2012 through April 2018 attesting that her spouse was unemployed. The client's failure to adhere to the program rules resulted in a $52,005 overpayment. Based on the evidence presented at the Administrative Disqualification Hearing, the hearing officer found that the recipient committed an intentional program violation and was disqualified for a period of 12 months.

Disqualification for Trafficking SNAP Benefits (Case No. 1296574): The recipient was charged with improperly using a LINK card at a specified retailer. OIG staff presented evidence to the administrative law judge showing that the recipient had three high dollar transactions at a retailer that, based on store inventory breakdown, could not support the large transaction amounts that totaled $531. This was the third time client had been found in violation of the program rules which therefore resulted in a permanent disqualification. The state's cost savings were $23,040.

Failure to Report Responsible Relative (Case No. 1365520): OIG concluded that a SNAP recipient failed to report that the father of her children resided in her home and received employment income. DHS Bureau of Collections calculated that, as a result, the recipient received $30,256 in SNAP overpayments for the period from August 2018 to January 2022.

Failure to Report Recipient and Children Moved Out of State (Case No. 1336281): OIG concluded that a SNAP recipient failed to report that she and her children resided in the State of Indiana. DHS Bureau of Collections calculated that, as a result, the recipient received $21,064 in SNAP overpayments for the period of June 2018 to January 2022.

Failure to Report Responsible Relative (Case No. 1329100): OIG concluded that a SNAP recipient failed to report that a responsible relative, the father of her children, resided with her and received employment income. DHS Bureau of Collections calculated that, as a result, the

recipient received $22,246 in SNAP overpayments for the period of December 2017 to March 2020 and $15,820 for the period of June 2020 through December 2021.

Failure to Report Responsible Relative (Case No. 1333313): OIG concluded that a SNAP recipient failed to report that a responsible relative, the father of her children, resided with her and received employment income. DHS Bureau of Collections calculated that, as a result, the recipient received $46,469 in SNAP overpayments for the period of May 2017 to April 2022.

Failure to Report Responsible Relative (Case No. 1376838): OIG concluded a SNAP recipient failed to report that a responsible relative resided in the home and received unreported income. DHS Bureau of Collections calculated that, as a result, the recipient received $29,542

Disqualification for Trafficking SNAP Benefits (Case No. 1296574): The recipient was charged with improperly using a LINK card at a specified retailer. OIG staff presented evidence to the administrative law judge showing that the recipient had three high dollar transactions at a retailer that, based on store inventory breakdown, could not support the large transaction amounts that totaled $531. This was the third time client had been found in violation of the program rules which therefore resulted in a permanent disqualification. The state's cost savings were $23,040.

Failure to Report Responsible Relative (Case No. 1362897): OIG concluded that a SNAP recipient failed to report that a responsible relative was residing in the assistance unit with unreported income. DHS Bureau of Collections calculated that, as a result, the recipient received $22,910 in SNAP overpayments for the period of November 2017 to July 2021.

Failure to Report Responsible Relative (Case No. 1360710): OIG concluded that a SNAP recipient failed to report that a responsible relative was residing in the assistance unit with unreported income. DHS Bureau of Collections calculated that, as a result, the recipient received $24,600 in SNAP overpayments for the period of May 2016 to February 2021.

Failure to Report Responsible Relative (Case No. 1340149): OIG concluded that a SNAP recipient failed to report that a responsible relative was residing in the assistance unit with employment income. DHS Bureau of Collections calculated that, as a result, the recipient received $5,642 in SNAP overpayments for the period of November 2017 to October 2018 and $27,152 for the period of December 2018 to August 2021.

Failure to Report Responsible Relative (Case No. 1347847): OIG concluded that a SNAP recipient failed to report that a responsible relative was residing in the assistance unit with employment income. DHS Bureau of Collections calculated that, as a result, the recipient received $49,023 in SNAP overpayments for the period of December 2015 to September 2021.

2022 Statistics

Investigations Opened: 1010

Client-Eligibility Cases: **783**
Provider Cases: **53**
Prosecutions: **171**
Childcare-Program Cases: **3**

Investigations Completed: 1004

- Client-Eligibility Cases: **829**
- Prosecutions: **144**
- Provider Cases: **319**

Outcomes

- Client-Eligibility Cases
  - Founded: **544**
  - Unfounded: **285**
- Provider Cases
  - Closed: **20**
    - Allegation Not Substantiated: **18**
    - Allegation Substantiated: **2**
  - Referred to DHS for Action: **2**
  - Referred to law enforcement: **8**
  - Referred to Aging: **1**
- Prosecutions
  - Referred to Prosecutor: **9**
  - Convictions: **4**
  - Declined Prosecution: **7**
  - Insufficient Evidence to Refer for Prosecution: **124**

Open Investigations: 2,096

Identified Overpayments

- Client-Eligibility Cases: **$7,347,690**
- Established Restitution in Criminal Actions: **$132,709**

New Provider Verification and Monitoring

The New Provider Verification unit (NPV) reviews new applications, application modifications, and revalidations for all high-risk providers — transportation, durable medical equipment (DME), pharmacy with DME, home health — and any other providers of concern for issues such as past convictions or sanctions. NPV gathers and reviews additional information such as, background checks, licenses, insurance, and corporate records. NPV, after working with HFS Provider Enrollment Services and the applicant, makes a recommendation to OIG leadership as to whether to grant or deny the applicant's enrollment.

NPV continues to monitor new providers that are designated as high risk for fraud (based on their provider type) for one year after enrollment. Provider billing activities and claims are analyzed at several different periods during a provider's conditional enrollment, at 180 days and again just prior to their first year of enrollment. As a part of that process, the NPV analyst contacts the provider to offer guidance and answer any questions they may have regarding serving as a Medicaid provider. If no concerns are identified after a year of monitoring, then the provider becomes a fully enrolled Medicaid provider. If problems are identified, the matter is presented to OIG's Provider Review Committee, which may decide to extend the provider's conditional enrollment or to disenroll the provider.

2022 Highlights

New review process for Individual Providers: In FY2022, NPV established a new process with the DHS Division of Rehabilitation Services to quickly and comprehensively review Individual Provider applications for Medicaid enrollment. DRS' Home Services Program has thousands of enrolled providers that require review before providing services. NPV's new processes included development of an agency-to-agency database, real-time communication, established processing times, and a uniform denial process.

NPV investigation blocks terminated, indebted owner: OIG received an application for a developmental training provider. NPV determined that the owner was associated with four prior OIG cases involving a transportation company, a daycare provider, a childcare provider, and client eligibility. OIG had previously terminated the owner as a Medicaid provider in 2012 based on findings she operated a transportation company during the same hours she purportedly ran a daycare. The owner also had unreported self-employment income from the transportation company and received subsidized childcare payments to which she was not entitled. Through all four cases, the owner had an overpayment debt of $81,348. Based on NPV's review, the owner's application was denied. The owner appealed the decision, but OIG's denial was upheld after the owner failed to appear at the appeals hearing.

2022 Statistics

Reviews Conducted: 563

New Applications Reviewed: **320**
Modifications Reviewed: **221**

Revalidation Applications Reviewed: **1**
Re-enrollment/Re-instatements
Reviewed: **21**

Review Outcomes

New Applications
Approved: **224**
Denied: **9**
Withdrawn: **1**
Pending: **86**

Modifications
Approved: **201**
Denied: **0**
Pending: **20**

Revalidations
Approved: **1**
Denied: **0**

Re-enrollment/Re-instatement
Approved: **20**
Denied: **1**

Providers Monitored During FY2022: 141

Monitoring Term Ended: **72**
Enrolled: **37**
Disenrolled: **35**
Monitoring Term Ongoing: **89**

"The daily relevance of health care crimes is clear. When medical professional, administrators, and executives abuse the trust placed in them, taxpayers and patients suffer. Greed-based health care schemes can result in substandard care that is not only wasteful, but at times, life-threatening; and they can drive up the cost of care for us all." – Lisa Miller, Deputy Assistant Attorney General, U.S. Department of Justice

Supplemental Nutrition Assistance Program (SNAP) Fraud Unit

The SNAP Fraud Unit processes complaints against SNAP recipients who have participated in benefit trafficking schemes. The Unit also processes complaints involving recipients who do not follow the reporting guidelines of the program. Recipients are required to report all household members, changes in income, verification of residency, along with several other requirements to determine eligibility. When they fail to do so, the Unit will pursue appropriate disqualification measures. Recipients who intentionally violate SNAP rules and regulations are disqualified from the program for a period of twelve months for the first offense, twenty-four months for the second offense, and permanently for the third offense. Recipients who receive duplicative assistance or engage in trafficking are disqualified for ten years. Cost avoidance on SNAP cases is calculated based on the average amount of food-stamp standards during the overpayment period, multiplied by the length of the disqualification period. Unit staff represent the Department in DHS' Administrative Hearings to suspend subjects' benefits because of their abuse. OIG began transitioning this function to DHS during FY2022.

2022 Statistics

Referrals Received: 877

Case Reviews Completed: 455

Resolved by waiver: 58

Cases Referred to Administrative Hearings: 570

Disqualification Hearings Scheduled: 1,584

Disqualification Hearings Held: 1,297

Administrative Hearing Decisions Rendered: 1,321

In favor of OIG: **1,120**
Not in favor of OIG: **201**

Disqualified Recipients: 1,178

Cases Closed: 1,380

Responses to Law Enforcement Inquiries: 1,018

Identified Overpayment: $4,011,364

Cost Avoidance: $3,660,581

ANNUAL REPORT FY2022

BUREAU OF INTERNAL AFFAIRS (BIA)

BIA Highlights

The Bureau of Internal Affairs (BIA) investigates allegations of misconduct by HFS and IDOA employees, contractors, and vendors. BIA's primary source of misconduct allegations are from external sources; however, BIA also identifies misconduct through proactive monitoring, including employee internet traffic and forensic reviews of state-owned computer equipment. At the conclusion of BIA's investigative activities, it prepares a report with findings for the appropriate Department's division administrators. BIA also holds various security responsibilities for HFS, including monitoring the safety of employees and visitors in Department buildings; conducting background checks on new hires and staff who require access to Secretary of State data and/or federal tax information; granting and revoking facility access for employees and contractors; monitoring and reviewing security camera footage from the facilities; conducting wellness and fit-for-duty checks; and conducting threat assessments for the Department. BIA serves as the Illinois Emergency Management Agency and State Emergency Operations Center liaison, coordinates emergency operation efforts, and communicates all pertinent information throughout HFS.

2022 Highlights

Division of Child Support Services (DCSS) Oversight: In FY2022, BIA established investigatory responsibility of employees who inappropriately accessed DCSS's database of child support cases. DCSS staff are prohibited from accessing child support cases involving themselves, family members, friends, or anyone for whom there is an appearance of a conflict of interest.

Badging and Facility Access: During FY2022, BIA processed and issued new identification cards to 727 HFS employees and contractors for facility access.

Background Checks: During FY2022, BIA completed 552 background checks of HFS employees and applicants.

COVID-19 Planning and Response: Throughout the year, BIA continued to ensure HFS had safe working facilities for staff after months of remote work. BIA worked with IEMA and SEOC to gain personal protective equipment (PPE) and COVID-19 tests for HFS staff, discussed emergency plans, and communicated guidance from daily briefings. BIA worked with Labor Relations and Personnel on how to make HFS facilities as safe as possible.

Medical Training and Emergency Medical Equipment: This past year, BIA worked with HFS' Bureau of Training to establish CPR/AED training for facility staff and contracted security officers. The training ensures each facility has security guards and safety coordinators that are trained and familiar with the AEDs. AEDs can be used to assist anyone who is experiencing sudden cardiac arrest. BIA also worked with HFS' Bureau of Administrative Services to ensure that wall-mounted medical kits contain appropriate and necessary medical supplies.

Significant Investigations

Misuse of Sick Time Leads to Discovery of Lies: In April 2021, BIA received a complaint that an HFS medical assistant consultant misused Authorized Benefit Time (ABT) by using sick time to travel for vacation. When management asked the employee to report back to the office, the employee told management that working in an office setting was not possible due to an immunocompromised child in the home. The employee stated that the child was attending school remotely for the same reasons. BIA conducted several surveillances on the HFS employee and observed the employee driving the purportedly immunocompromised child to attend school in person. BIA also witnessed the employee leave home unmasked to have lunch at a crowded restaurant with a group of people while using ABT sick time to cover time spent beyond the allotted lunch period. BIA also subpoenaed airline records and analyzed the employee's use of benefit time. Though the employee denied traveling and insisted that a child was sick on the date in question, BIA found that the employee had in fact traveled out of state on a flight with the immunocompromised child. BIA interviewed the employee and the employee provided false and misleading statements to investigators. BIA determined that the employee violated numerous HFS policies including, but not limited to, unauthorized use of sick time, inappropriate behavior, falsification of records, and failure to cooperate in an investigation. As a result of the investigation, the HFS employee received a 29-day suspension.

Employee Delivers Food and Riders Instead of Work: In April 2021, BIA received a complaint that an office coordinator was driving for UBER while on compensated state time. BIA obtained Lyft and UBER driving records for the office coordinator and compared them to times when the employee was supposed to be working for HFS. An analysis of records showed that on 46 days the employee was in fact working for UBER or Lyft during the same time as they reported working for HFS. BIA determined that the employee also falsified timesheets and misused ABT sick time while working secondary employment. As a result of the investigation, the employee was terminated.

Facebook Harasser Gets Reprimanded: In January 2022, BIA received a complaint that an administrative assistant with HFS sent a vulgar Facebook Messenger private message to a member of the public that contained what the recipient perceived as a "rape threat." BIA determined that the administrative assistant identified themselves as a state employee on their Facebook page. BIA interviewed the administrative assistant and the employee admitted to sending the Facebook messages as well as other messages that could be perceived as vulgar and/or threatening. BIA determined that the actions of the administrative assistant violated the State of Illinois Code of Conduct. As a result of the investigation, the administrative assistant received a written reprimand.

Chronic Tardiness Nets Five-Day Suspension: In September 2021, BIA received complaints that a staff development specialist got into a verbal altercation with a custodian at an HFS facility and was vaping marijuana during the workday in the office. BIA determined the initial allegations were unsubstantiated. However, during the investigation, BIA found that the employee was late for work forty-four times from June to September 2021 and that the employee purportedly worked

overtime on several days before their shift but did not arrive at the office until after their start time. As a result of the investigation, the staff development specialist was suspended for five days.

ABT Abuse, Computer Misuse, and Failure to Cooperate Results in 15-Day Suspension: In July 2021, BIA received a complaint that a child support specialist was arriving late to work, taking extended breaks and lunches, falsifying timekeeping records, and using their state computer for personal use. BIA found that from June to July 2021, the child support specialist was tardy five times and misreported on timesheets each of those days. BIA reviewed two months of the employee's work emails and found numerous personal email messages. During the investigation, BIA also identified that the employee misused ABT sick time to prepare for a family member's wedding. The child support specialist was interviewed on three occasions and provided several differing explanations for the use of ABT time and state email. BIA determined that the child support specialist violated numerous HFS policies, including but not limited to, failing to follow the affirmative attendance policy, abusing sick time, failing to cooperate in an interview, and misusing the State of Illinois email and computer systems. As a result of the investigation the employee received a 15-day suspension.

Misuse of State Equipment Calls for a 7-Day Suspension: In July 2021, BIA received a complaint that a lead caseworker specialist misused the State telephone system, made personal telephone calls on a recorded line, and used a State of Illinois computer for personal use. BIA reviewed six months of the caseworker's internet history and determined the caseworker used the internet for personal use. BIA analyzed the caseworker's use of the HFS recorded hotline and identified numerous recorded calls not related to state business. During an interview, the employee admitted to using the internet, telephone system, and state email system for personal use. As a result of the investigation the caseworker was suspended for seven days.

Inappropriate KIDS Access Results in Suspensions: During FY2022 BIA self-initiated ten investigations involving Division of Child Support Services staff accessing their own child support case or a family member's child support case. As a result of the investigations, five cases were substantiated, and resulted in the following:

- Office Coordinator: 7-day suspension
- Office Coordinator: 7-day suspension
- Office Specialist: 7-day suspension
- Child Support Specialist I: 7-day suspension
- Executive II: 7-day suspension

2022 Statistics

Total Cases Opened: 666

Misconduct Investigations: **107**
Background Investigations: **558**
Threat Assessments: **1**

Total Cases Completed: 655

Misconduct Investigations: **102**
Background Investigations: **552**
Threat Assessments: **1**

Findings in Misconduct Investigations

Substantiated: **16**
Unsubstantiated: **19**
Administratively Closed: **67**[1]

Findings in Background Investigations

Candidates Not Hired: **10**
Employees Disciplined/Resigned: **0**

Outcomes in Substantiated Investigations

Resignation/Termination: **1**
Suspension: **11**
Written Reprimand: **2**
No discipline: **2**

Average Case Length

Misconduct Investigations: **31 Days**[6]
Background Investigations: **3 Days**
Threat Assessment: **1 Day**

[1] A case is closed administratively when the matter is not within OIG's jurisdiction and is referred to the appropriate agency or department, or, in BIA's assessment, it has been or is being appropriately treated by another entity, the matter was consolidated with another investigation or, in rare circumstances, BIA determined that further action was unwarranted.

ANNUAL REPORT FY2022

BUREAU OF FRAUD SCIENCE AND TECHNOLOGY (BFST)

Fraud Science Team and Technology Management Unit

The Fraud Science Team (FST) and Technology Management Unit (TMU) of BFST develop fraud-detection routines to prevent and detect healthcare fraud, abuse, overpayments, and billing errors, and manage OIG's supporting IT infrastructure. FST oversees the development and maintenance of the Dynamic Network Analysis (DNA) system. DNA routines are analytical computer programs written in Statistical Analysis System (SAS) and Teradata SQL utilizing HFS' Data Warehouse along with other third-party data sources.

2022 Highlights

DNA Framework Updates: In FY2022, DNA remained a critical analytical tool for OIG staff to ensure program integrity and combat Medicaid fraud, waste, and abuse. More than 9,500 jobs were submitted and over 42,000 pages were viewed by OIG staff using the DNA. The complaint intake profile, recipient profile, provider profile, marriage divorce, and recipient claim details reports were the most frequently used analyses. The DNA team enhances the models based on management guidance and user feedback. Additional functionality and module development occur in alignment with BFST priorities. New developments include Early Warning by Recipients, CASE Inquiry integration, Payee Inquiry, Incarceration Report, and Provider Ownership Report. Enhancements include Early Warning by Provider Type expansion, Sanction Inquiry, and DNA user schema management.

Early Warning by Recipients: Early Warning by Recipients is an active model ranking all recipients by multi-dimensional views. The model combines recipient related scores for payments, prescribers, office visits, ER visits, narcotic drugs, and controlled drugs to generate an overall risk score for each recipient. Primary measures used for examining recipient medical behavior include the number of office visits, ER visits, pharmacies, controlled drug prescriptions, narcotic drug prescriptions, and the average daily consumed Morphine Milligram Equivalents (MME). Each measure has a predefined threshold. For example, eight ER visits in one year is considered acceptable. Additionally, different weights are allocated for each measure in the model. Weights are adjusted when necessary. Users can query information for each measurement or comprehensive score to identify potential recipient abuse in the medical program.

CASE Inquiry Addition: The Case Administration and System Enquiry (CASE) is OIG's case management tool, used to store and track provider and recipient audits and investigations. The DNA team created a search function to link information from the CASE system with OIG's analytics tool, DNA. This new module allows users to filter information in the CASE system, including the text fields. Users can also filter by weighted keywords, date ranges, and other fields. A timeline chart displays case progress with referral notes and case notes in chronological order. The module allows searching for all cases associated with individual providers.

Payee Inquiry: The Payee Inquiry module was added to the DNA system to allow users to search payee information from the Enterprise Data Warehouse (EDW). Users can search for payee by the payee ID, name, national provider identifier (NPI), address, zip code, and phone number. For an NPI search, a user can enter a single NPI or multiple NPIs. The search results show basic payee demographic information along with its associated providers. Additionally, the module provides links to run provider inquiries directly from the result.

Incarceration Report: The DNA team continuously develops new modules to help users quickly collect concise and useful information following priorities identified by OIG management. According to state regulations, when an individual receiving medical benefits is incarcerated in an Illinois Department of Corrections (IDOC) facility, the medical benefit is restricted to inpatient hospitalization and related professional medical services rendered in the hospital. The DNA team studied recipient managed care eligibility overlapping with incarceration through the OBRA CI code (incarcerated individual). An incarceration report was developed to reflect recouped and non-recouped capitation payment during incarceration. The incarceration summary report aggregates total claim count, unrecouped unduplicated recipient count, unrecouped capitation payment, recouped unduplicated recipient count, and recouped capitation payment by different MCOs for the date range individuals were incarcerated. The incarceration detail report lists each recipients' managed care exclusion type, OBRA code, and begin and end dates with corresponding capitation payment during incarceration or BMC exclusion at claim level.

Provider Ownership Report: Ownership provides valuable information for audit and investigation of cases such as Long Term Care asset discovery or to identify potential fraud connected to provider networks. The Provider Ownership Report was developed to display business ownership or entity relationships. The report allows users to query by provider ID, IMPACT ID, NPI, owner's name, or owner organization. The report lists provider demographic information, all owner names, legal names, doing business as names, owner type, ownership percentage, TIN/EIN, and all addresses such as correspondence and physical location. The report, for reference purposes, also includes all audited or investigated cases involving the provider.

Miscellaneous Reports and Inquiries Development: Following BFST's guidance and instruction, the DNA team converted a selection of existing canned BI-Query reports into the DNA system. The PA Recipient Search and PA Services Performed are used to determine if a recipient received any personal assistance services and the PAs providing these services. The PA Recipient Search allows users to search by recipient ID, name, or address. Name only searches often generate fuzzy matches. The PA Services Performed allows users to search by recipient ID for a time frame and results include information for all PA providers with related service counts. The Duplicate Claim Check Report was created to verify if duplicate submissions occurred for a sample of claims. Users can query multiple DCNs or specify provider ID, Impact ID, NPI, recipient ID, or procedure codes for a given time frame. The DCN Inquiry allows users to enter multiple DCNs and quickly retrieve service details for check-up and reference.

Early Warning by Provider Type Expansion: The Early Warning by Provider Type module provides an active model ranking providers within provider types from a multi-dimensional view (payment, common client, time dependent billing, procedure codes, and prescriptions). Higher ranks indicate providers are riskier. Continuing last year's expansion, the DNA team applied similar statistical models and tested new routines on additional provider types to include nurse practitioners, registered nurses, and licensed practical nurses. In addition, the results were improved for better action links and charts.

Sanction Enhancement: Accurate sanction information is critical for program integrity efforts and preventing terminated providers from participating in state medical programs. The existing DNA Sanction Query model performs an inquiry on the providers from various federal and state data sources. In FY2022, the DNA team integrated the additional sanction data sources of IMPACT and the CMS Data Exchange (DEX) into the model. IMPACT combines the Medicaid terminations file and Medicare revocation file, which contain all terminations and revocations published by CMS since 2014; DEX contains all terminations reported by IL SMA to CMS. The DEX file is downloaded weekly and processed in line with the sanction data model. In the past, monthly provider sanction updates were prepared for relevant partners via a manual process. The DNA team revised and automated the process to improve efficiency of the time-consuming workflow and improve accuracy for the error-prone manual process.

DNA User Schema Management: The DNA System relies on various schema authorizations for end users to access different data sources for report generation and inquiries. Permission is controlled by the Enterprise Data Warehouse (EDW) during user account creation. Since the schema authorization is managed outside of the DNA System and the external identity system configuration may not sync with permission requirements at the granular level, users often encounter errors for certain types of requests. To address this issue, the EDW schema requirements tool was added to help identify database permission requirements for related modules. The tool collects program information, as well as database permissions required by the programs. DNA system administrators can filter by page name, program name, or schema name to quickly find the required specification.

2022 Statistics

DNA Reports Generated: 9,556

DNA Pageviews: 42,411

Help Desk Inquiries: 1,186

Data Requests Completed: 52

Provider Analysis Unit (PAU)/Recipient Analysis Unit (RAU)

In the Provider Analysis Unit (PAU), nurses with clinical expertise analyze provider claims and records for indications of fraud, waste, or abuse. The nurse analysts conduct in-depth reviews of billing records to determine if claims and services are appropriate. They review billing patterns, research aberrant billing practices, determine business inter-relationships, and investigate suspicious pharmaceutical prescribing patterns. Upon completion, the analysts present their findings to the Provider Review Committee (PRC), which decides whether to continue a criminal and/or administrative investigation for issues such as fraud in billing practices, risk of harm to patients, substandard quality of care, and overprescribing. The committee may decide to issue a letter of concern or education to the provider; refer the provider within OIG to be audited, investigated or peer reviewed; or refer the provider to an external partner such as the UPIC, DEA, IDFPR, or the MFCU.

The Recipient Analysis Unit (RAU) is composed of medical consultants who oversee the Recipient Restriction Program (RRP), which identifies, detects, and prevents abuse of medical and pharmaceutical benefits by recipients enrolled in Medicaid. The program assigns at-risk recipients to one Primary Care Physician, Primary Care Clinic and/or Primary Care Pharmacy, so ensuring the recipient receives coordination of all medical and pharmaceutical benefit services (including referrals to specialists) by that primary care provider. Emergency and inpatient hospital services are not restricted. When recipients utilize various prescribing providers and pharmacies they are at a significant risk for adverse and potentially life-threatening situations. The RRP program, often referred to as a “lock-in” or “restriction program,” is designed to promote optimal recipient safety through care coordination. The primary leads for potential lock-ins are the selection algorithm developed in the DNA system and external complaints received by OIG.

2022 Highlights

Focus on Provider Reviews: With the establishment of the centralized, interdisciplinary Complaint Intake Unit (CIU) in FY2021, all current OIG internal and external referrals are reviewed and processed by the CIU. CIU replaced the former procedure where all internal and external OIG referrals were assigned to PAU to review, triage, and create cases. The former process created a significant backlog, which was exacerbated by staffing changes within the reviewing unit. In FY2022 the focus has been to remove this backlog using the past review process created before the advent of CIU. The current backlog has been substantially reduced, as cases are assigned to their appropriate unit for review and PAU analysts complete their assessments. Going forward, all incoming OIG referrals are reviewed by CIU, reducing the potential of a future backlog.

Ambulance Provider with Multiple Billing Concerns (Case No. 1364897): An MCO referred an ambulance provider billing for transportation services without corresponding medical claims for the dates of service billed. PAU identified the following billing issues: potential transport of a deceased recipient; potential upcoding Basic Life Support codes and services to Advanced

Life Support Services for transportation for outpatient services; possible billing for services not rendered; no corresponding services; non-covered services; billing wrong dates of service; and billing services using vehicles with invalid license plates, or vehicles not enrolled in IMPACT and approved for Medicaid billing. PRC recommended a BMI field audit, referral to HHS-OIG for Medicare exposure, audit by the MCOs, and allowance to recoup the identified overpayment.

Provider Prescribing Concerns (Case No. 1327036): A PAU analyst flagged this provider for prescribing opioids, benzodiazepines, and muscle relaxers concurrently (referred to as a "Triple-Threat" due to its risk of respiratory depression, overdose, and possible death). This referral resulted in two PAU reviews in 2019 and 2022. The initial 2019 review identified excessive quantities of opioids along with the "Triple-Threat" combinations prescribed by this provider with three instances of adverse recipient responses. These findings resulted in a referral to the Drug Enforcement Administration (DEA) and a scheduled re-review. The re-review was conducted in 2022 from which PAU discovered the "Triple-Threat" prescribing pattern had continued. The provider was referred for an OIG Peer Review and to IDFPR.

Provider Prescribing Concerns (Case No. 1329006): As the result of a RAU referral, a PAU analyst found a provider concurrently prescribed opioids, benzodiazepines, and muscle relaxers ("Triple-Threat") where the primary diagnosis did not support their medical necessity nor the frequency of billed office visits. The provider had previously entered into a three-year OIG Corporate Integrity Agreement requiring yearly reviews of medical services, prescribing patterns, and chart documentation with a resulting IDFPR reprimand. The prescriber was referred for a Peer Review by a nursing and medical consultant to assess for documentation of billed services and justification of prescribing patterns.

Provider Prescribing Concerns (Case No. 1381354): A contracted HFS medical consultant referred a provider for concurrent prescribing of opioids, benzodiazepines, and muscle relaxers ("Triple-Threat") with limited office visits and quality of care concerns. The provider was sent a Letter of Education, and five reviewed patients under the prescriber were referred to the Recipient Analysis Unit (RAU) for possible placement in the Recipient Restriction Program.

2022 Statistics

PAU

Cases Opened: 42

From MCO Referrals: **29**
All Other Referrals: **13**

Analyses Conducted: 98

Cases presented to Provider Review: **52**
Cases presented to Complaint Intake: **7**
Cases with no further action taken: **37**
Open for follow up: **2**

Analyses Outcomes: 98

- Referred to MFCU: **3**
- Referred to Peer Review: **8**
- Education to Provider: **6**
- Referred to OIG Audit: **9**
- Referred to OIG Investigations: **3**
- Referred for External Audit: **5**
  - MCO Audit/Action: **2**
  - UPIC: **2**
  - HHS-OIG: **1**
- Referred for OCIG Action: **3**
- Periodic Follow-up: **3**
- Pending Action: **4**
- No Further Action: **54**

RAU

Cases Reviewed: 1,601

- New Case: **1,531**
- Re-evaluation after 12 months: **50**
- Re-evaluation after 24 months: **20**

Case Review Outcomes

- Recommendations for Restrictions: **259**
  - Fee For Service Customer: **6**
    - Restricted: **4**
    - Deceased: **1**
    - No Restriction: **1**
  - MCO Customer: **253**
- Cases Closed: **1997**
  - Restriction Released: **3**
  - Eligibility Cancelled: **1**
  - Deceased: **13**
  - HMO Dual: **5**
  - HMO No Restriction: **1213**
  - MCO Restricted: **713**
  - No Restriction: **49**

Total FFS Restrictions and MCO Restriction Recommendations at End of SFY2022: 238

- FFS: **1**
- MCO: **237**

Cost Avoidance: $29,822,651

- MCO Members: **$29,790,244**
- Fee for Service: **$32,407**

ANNUAL REPORT FY2022

MANAGEMENT, RESEARCH, AND ANALYSIS SECTION (MRA)

MRA Highlights

The Management, Research, and Analysis (MRA) Section serves as the liaison between OIG and external partners. Specifically, the Fraud Abuse Executive (FAE) coordinates communication between OIG and law enforcement and works with the MCOs on data requests for criminal and civil investigations. The MRA Manager facilitates and oversees communication regarding MCO audits, investigations, and other concerns related to fraud, waste, and abuse coming from the MCO Special Investigations Units, which are tasked with combating fraud, waste, and abuse in the Medicaid Managed Care plans.

The FAE coordinates the law enforcement data request program and assists with the review and approval of global settlement agreements generated by the National Association of Attorneys General, HHS OIG, and the U.S. Department of Justice (USDOJ). OIG supports federal law enforcement and oversight counterparts including HHS-OIG, CMS, FBI, USDOJ, U.S. Attorney's Offices, and the National Association of Medicaid Fraud Control Units (NAMFCU).

The FAE monitors law enforcement cases involving the Illinois Medicaid program and identifies key departmental staff members to provide expert-witness testimony at criminal and civil proceedings. Upon completion of the criminal or civil case, FAE assists with internal administrative actions as necessary. Administrative actions can include audits, administrative investigations, or administrative sanctions, such as payment suspensions, overpayment recoupments, and termination from the Medicaid program. In addition to working with law enforcement counterparts, the FAE is responsible for referring cases from OIG to other state and federal agencies. Referrals can be made to IDFPR, the Illinois Department of Public Health, DHS, CMS, HHS-OIG, and the DEA. These referrals can result from Audit, PRU, or PAU cases, in which provider education, licensing concerns, or billing concerns have been identified.

2022 Highlights

Office-Wide Training: MRA facilitates training sessions for OIG staff to improve their knowledge bases and skill sets. In FY2022, OIG's participation in national learning sessions continued to be expanded in collaboration between state sister agencies and national anti-fraud counterparts, like the National Health Care Anti-Fraud Association (NHCAA) and the Healthcare Fraud Prevention Partnership (HFPP).

Beginning in FY2022, OIG started a quarterly office-wide learning series for all staff on a variety of topics. Through the learning series, MRA lead a presentation on managed care in Illinois. The presentation provided essential background information on the transition of Illinois Medicaid from FFS to Managed Care, what it means for Medicaid members and how that transition impacts OIG work product. MRA also presented several in-house trainings on essential software and databases to ensure staff are all trained with baseline skills.

Infonet: MRA led an update of the OIG infonet site. Training resources and news articles are uploaded to the site, creating a library of resources for all staff.

2022 Statistics

Referrals to External Partners: 30

MFCU: **12**

Accepted: **9**

Not Accepted: **3**

Other State and Federal Government: **18**

Responses to Data Requests: 56

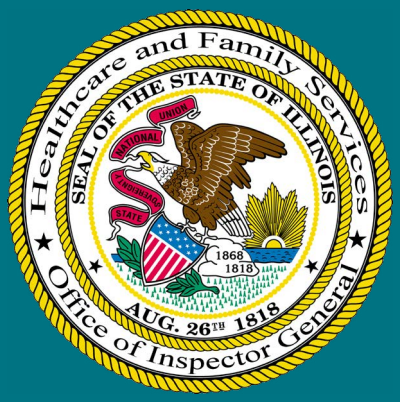
Law-Enforcement Data Requests: **47**

MCO data requests: **9**

Global Settlements: 8

Provider Referred to OCIG for Termination from Medicaid: 34

Office-Wide Trainings: 61



ANNUAL REPORT FY2022

OFFICE OF COUNSEL TO THE INSPECTOR GENERAL (OCIG)

OIG attorneys in the Office of Counsel to the Inspector General (OCIG) represent HFS in administrative hearings to file and advance cases involving Medicaid fraud, waste, and abuse. OCIG further supports OIG operations, including researching termination or exclusion matters, analyzing extrapolation issues, reviewing contracts, assisting with rule and statute implementations and amendments that impact OIG and HFS, and offering compliance advice and representation on HFS programs and operations. OCIG further provides support to each of the OIG bureaus, external contractors, several standing OIG committees, and the following OIG units and programs: the Long-Term Care-Asset-Discovery Unit, the Peer Review Unit, OIG's Medicaid Recovery Audit Contractor, the Medical Quality Review Committee, the New Provider Verification Unit, the Fraud Abuse Executive, and the Fiscal Management Unit. OCIG also handles all of OIG's responses to Freedom of Information Act (FOIA) requests, subpoenas, and represents OIG and, in some instances, HFS, in internal and external litigation matters.

2022 Highlights

OCIG attorneys address sophisticated and cutting-edge legal issues daily. Of the multiple areas that present unique and challenging issues, OCIG's work with HFS's Medicaid Recovery Audit Contractor (RAC) and the OIG's Long-Term Care – Asset-Discovery (LTC-ADI) Unit stand apart, even during more conventional times. However, and as with many facets of the Medicaid program, the declaration of the Covid-19 Public Health Emergency (PHE) in March 2020 lent both areas an added layer of complexity that will continue well after the PHE is lifted. Nevertheless, and as detailed below, OCIG attorneys overcame the myriad challenges relating to the restrictions that have resulted from the PHE.

OCIG's Continued and Growing RAC Initiative: The RAC program promotes the integrity of the Medicaid program and is a part of a significant initiative undertaken by CMS to reduce waste and recoup improper underpayments and overpayments. In 2011, CMS promulgated regulations expanding the RAC program to Medicaid and provided guidance to the states on establishing this program. Under these regulations, states are required to enter into contracts with one or more Medicaid RACs to review claims to identify, among other things, overpayments and recoup those for the states.

The RAC program requires states to develop their own individual programs. OIG has the statutory authority to oversee the Medicaid RAC program in Illinois, subject to oversight by CMS's obligation to prevent, identify, and recover improper payments to individuals, contractors, and organizations. To that end, OCIG attorneys and staff work hand-in-hand with Gainwell Technologies, which OIG has contracted to undertake all RAC audits for the Illinois Medical Assistance Program.

Throughout FY2022, administrative hearings on RAC matters were paused due to COVID precautions. OCIG took this opportunity to work with HMS to undertake an intensive review of outstanding RAC audit overpayments. The majority of those overpayments stem from (1)

hospital utilization reviews, which include post-payment reviews to determine whether services furnished, or proposed by a vendor to be furnished, on an inpatient basis could be effectively furnished more economically on an outpatient basis or in an inpatient healthcare facility of a different type, consistent with the provision of appropriate medical care; or (2) the diagnostic and procedural information supplied by the hospital is legitimate as determined through Diagnostic Related Group (DRG) validation.

In FY2022 OCIG recovered $102,367 in improper Medicaid payments identified by HMS through administrative recovery actions and settlement. As to the administrative recovery actions, OCIG prevailed in five separate actions initiated by hospital providers' appeals of HMS' determinations that payment for inpatient medical services had been improper. In each matter, HMS determined that, based upon a utilization review, the claims neither met the state's objective standard of InterQual criteria,[2] nor rose to the level of an inpatient stay based upon a clinical physician review. HMS and OCIG determined that, in each case, the inpatient services could have been effectively furnished more economically on an outpatient basis or inpatient healthcare facility of a different kind. Through these successful actions, OCIG secured the recovery of $78,641 of Medicaid funds:

In re St. Elizabeth Hospital,
HFS Docket No. 19 RAC 097 ($4,935)

In re Gateway Regional Medical Center,
HFS Docket No. 21 RAC 003 ($59,756)

In re Richland Community Hospital,
HFS Docket No. 21 RAC 015 ($3,458)

In re Palos Community Hospital,
HFS Docket No. 21 RAC 017 ($5,381)

In re Good Samaritan Hospital,
HFS Docket No. 22 RAC 002 ($5,110)

Hospital providers also voluntarily provided payment when confronted with the results of audits based on utilization or DRG reviews. In three matters, providers remitted a total of $10,492 in overpayments where the inpatient services could have been effectively furnished more economically on an outpatient basis or inpatient healthcare facility of a different type:

In re Passavant Area Children's Hospital,
OIG Case No. 1224358 ($2,997)

In re Decatur Memorial Hospital,
HFS Docket No. 19 RAC 026 ($4,291)

[2] InterQual criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The first-level screening is done by the utilization review nurse. If the criteria are met, the services are approved. If the criteria are not met, the case is referred to a medical director for further examination into whether the services were clinically appropriate.

In re Good Samaritan Hospital,
HFS Docket No. 19 RAC 114 ($3,204)

And in a fourth matter, the provider remitted payment of $4,882 where a DRG review reflect-ed that the claim's documentation and supporting medical records did not validate underly-ing diagnostic information: ***In re Presence Covenant Center,*** **OIG Case No. 1328159**. Finally, in HFS Docket No. 19 RAC 045, OCIG successfully negotiated a $8,350 settlement with a hospital provider that, HMS determined, had received $9,823 in improper payments for medical services. The settlement encompassed a RAC audit of two individual claims of service for inpatient care, respectively totaling $1,811 and $8,012. HMS determined that, based upon the inpatient diagnosis-related group, as defined in the DRG group, these claims had an invalid secondary diagnosis code assignment. The difference between the improper diagnosis code assignment and the correct diagnosis code assignments resulted in an overpayment of $9,823, of which OCIG negotiated the settlement of $8,350.

Eligibility Reviews for Long-Term Care Facilities Throughout the COVID-19 Public Health Emergency: After the declaration of the PHE in 2020, HFS suspended its use of the resource test in making eligibility determinations for applicants seeking Medicaid coverage for long-term care services. The resource test examines an applicant's financial eligibility for Medicaid-covered long-term care services after reviewing that applicant's resources, including, but not limited to, real property, financial accounts and investment portfolios, and life-insurance policies. That examination of an applicant's resources may result in the imposition of resource spenddowns and penalty periods. Under a resource spenddown, an applicant is required to liquidate the resources owned that are in excess of the Medicaid eligibility cap; that is, the applicant must "spend down" all resources owned in excess of the cap before the applicant may be eligible for Medicaid-covered long-term care services. A penalty period is the period of time that must pass before an applicant will be ineligible for long-term care services, based on the total value of all unallowable transfers of resources that the applicant made during the sixty months leading up to his or her application. Both spenddowns and the imposition of penalty periods are scheduled to resume in FY2023.

OCIG attorneys work closely with LTC-ADI to employ the resource tests and assess long-term care applicants' eligibility for Medicaid coverage. On behalf of LTC-ADI, OCIG issues recommendations to DHS — which renders all final Medicaid eligibility determinations for long-term care applicants — as to whether any spenddowns or penalty periods should be imposed. DHS then weighs that recommendation when adopting the appropriate course of action regarding an individual's application for Medicaid coverage.

Applicants have the right to appeal the imposition of spenddowns or penalty periods to the DHS administrative tribunal. OCIG attorneys are responsible for defending the decision to impose any spenddowns or penalty periods. Since the resource test was suspended during the PHE, few Medicaid recipients filed appeals. Nevertheless, in FY2022, OCIG prevailed in several decisions that applicants had appealed to circuit courts, and which

the circuit courts had remanded to the DHS administrative tribunal for reconsideration:

***In re Donald Wilson*, OIG Case No. 1280108.** The DHS administrative tribunal accepted OIG's recommendation to impose a penalty on an applicant's transfers that were made for less than fair market value. Upon review of the application, OIG determined the applicant had transferred real property via an unallowable contract for deed containing a balloon payment. OIG recommended the imposition of a penalty in the amount of $24,189 which represented the unpaid balance on the unallowable transfer. In so deciding, the administrative tribunal rejected the recipient's argument that the property should not have been subject to penalty because it was non-marital property and that the transfer was not made to qualify. Specifically, the tribunal found that the property was, in fact, subject to the transfer rules because it was owned by the applicant's spouse, despite being purchased before the marriage. The tribunal also concluded that the recipient had failed to rebut the presumption that the transfer was made to qualify, noting that the transfer had been made in August 2016, which was in close proximity to the applicant's original nursing home admission of May 2016, and two months before his permanent admission in October 2016.

***In re Joanne Thompson*, OIG Case No. 1314936.** The DHS administrative tribunal dismissed the applicant's appeal on the basis that any challenge was, at the time, not ripe. After review of the application and original appeal, OIG determined that the applicant's spouse had excess income that had been received during the pendency of the appeal, and which needed to be included as part of the earlier-imposed resource spenddown. The spouse had purchased two short term annuities, resulting in an income stream of $32,151 per month, in addition to his pension and Social Security income, which totaled $11,352 per month. The excess income totaled $850,060. The applicant argued that the spenddown could not be calculated after the original application date, and that the excess income should not be considered in the decision. In the final administrative decision, the DHS administrative tribunal concluded that, due to the PHE, the department was unable to take any negative action against an applicant. In this case, that meant that the spenddown was not imposed, and the appeal was dismissed as not yet ripe for adjudication.

***In re Mary Squire*, OIG Case No. 1272926.** The DHS administrative tribunal accepted, in part, the OIG's recommendation to impose a spenddown. After reviewing the application, OIG determined that the applicant had excess resources in the backdated months and was therefore ineligible for coverage. The determination of excess resources was originally upheld by the administrative tribunal, but the circuit court determined that the tribunal failed to include resources that were not owned by the applicant. On remand, the applicant argued that the remaining resources should not be counted because they were inaccessible due to the financial exploitation of the applicant. In the final administrative decision, the administrative tribunal concluded that, despite the financial exploitation, the applicant nevertheless remained the lawful owner of her bank account and stock shares. With respect to the circuit court remand, the two accounts identified in the court's order were not owned by applicant, and thus

should not be included in the resource spenddown. The final administrative decision upheld a resource spenddown of $22,815.

Administrative Actions Concluded in FY2022

OCIG represented OIG in 100 actions that were bought to full resolution in FY2022, resulting in the termination of providers' Medicaid enrollments; barrment of providers' owners from further program participation; financial recoveries stemming from standard audits; summary exclusion from the program; and denials of enrollment applications. Attorneys also negotiated a Corporate Integrity Agreement (CIA) in one matter and settlement agreements in fifteen other matters. Those matters are summarized below.

Termination Actions

HFS regulations empower OIG to terminate the enrollment of Medicaid providers, exclude providers from the Medicaid program, and, in certain instances, bar those providers' owners from further participation in the program. See Ill. Admin. Code tit. 89, §§ 140.18(b) & 104.208. For FY2022, the providers for whom the OIG successfully sought termination or barrment fell into six categories:

1. Terminations of personal assistants;
2. Terminations of medical professionals who had had their professional licenses to practice in the State of Illinois suspended, revoked, or otherwise terminated;
3. Terminations of providers who have a criminal record that includes disqualifying criminal convictions;
4. Terminations of providers who have failed to resolve substantial debts owed to HFS;
5. Terminations of providers who have failed to comply with the Medicaid regulations of other states; and
6. Summary terminations of providers who have breached CIAs and settlement agreements, as well as summary exclusions of providers whom the HHS have excluded from the Medicare program or any other state healthcare program.

The individual administrative actions taken in each of these categories are detailed below.

Personal Assistant Terminations (18 Matters)

The Medicaid program covers personal-assistance services that are offered through the Home Services Program of DHS and the Illinois Department of Aging. Personal assistants serve Medicaid recipients over the age of 60, or individuals with disabilities under age 60 who require help with daily living activities in their homes; many of these recipients are at risk of moving into nursing homes or other healthcare facilities. Because personal assistants serve a vulnerable population, OIG is particularly vigilant when identifying and investigating potential instances of personal assistants' misconduct. The following matters are those in which OCIG

successfully sought the termination of personal assistants who have violated HFS regulations.

***In re Chappell Brown*, HFS Docket No. 19 MVH 5025.** OCIG successfully sought the termination of Chappell Brown, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $2,573 for home-based services that he had claimed to have provided to a program recipient when the recipient was, in fact, in a healthcare facility, and not at home. Brown also (1) had been convicted in state court of unlawful possession of a concealed firearm; and (2) lied on his Medicaid enrollment form that he had never been convicted of a crime — each of which constituted additional grounds for the termination of his enrollment as a provider in the program. After Brown had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Maggie Davenport*, HFS Docket No. 20 MVH 031.** OCIG successfully sought the termination of Maggie Davenport, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $10,946 for home-based services that she claimed to have provided to a program recipient when the recipient was, in fact, in a healthcare facility, and not at home. After Davenport had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re [Redacted]*, HFS Docket No. 20 MVH 032.** OCIG successfully sought the termination of [Redacted], a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $26,221 for home-based services that he had provided to a program recipient to whom she was married, which violates program rules. After [Redacted] had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Jessica Wiseman*, HFS Docket No. 20 MVH 037.** OCIG successfully sought the termination of Jessica Wiseman, a Medicaid-enrolled personal assistant, who had impermissibly billed the Medicaid program $1,895 for home-based services that she claimed to have provided to a program recipient

when the recipient was, in fact, in a healthcare facility, and not at home. After Wiseman had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re [Redacted]*, HFS Docket No. 20 MVH 038.** OCIG successfully sought the termination of [Redacted], a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $84,037 for homebased services that he had provided to a program recipient to whom he was married, which violates program rules. After [Redacted] had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Vernita Ward*, HFS Docket No. 20 MVH 040.** OCIG successfully sought the termination of Vernita Ward, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $15,630 for home-based services to a program recipient that he did not perform because he was, in fact, working elsewhere on the dates and at the times that he claimed to have provided the services. After Ward had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default- and recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re [Redacted]*, HFS Docket No. 21 MVH 009.** OCIG successfully sought the termination of [Redacted], a Medicaid-enrolled personal assistant, who impermissibly billed the Medicaid program $42,984 for homebased services that he had provided to a program recipient to whom he was married, which violates program rules. After [Redacted] had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Deandre Norfleet*, HFS Docket No. 21 MVH 031.** OCIG successfully sought the termination of Deandre Norfleet, a Medicaid-enrolled personal

assistant, who had improperly billed the Medicaid program $7,965 for home-based services that he had claimed to have provided to a program recipient on dates when he was, in fact, detained in the Cook County Jail. After Norfleet had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Ulyrica Thorpe*, HFS Docket No. 21 MVH 062.** OCIG successfully sought the termination of Ulyrica Thorpe, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $20,191 for home-based services to a program recipient that she did not perform because she was, in fact, working elsewhere on the dates and at the times that she claimed to have provided the services. After Thorpe had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Raphael Gunn*, HFS Docket No. 21 MVH 064.** OCIG successfully sought the termination of Raphael Gunn, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $13,819 for home-based services to a program recipient that he did not perform because he was, in fact, working elsewhere on the dates and at the times that he claimed to have provided the services. In addition, the Illinois Department on Aging determined that Gunn had physically and emotionally abused his customer in May 2019, as documented in an investigation conducted by that Department's Adult Protective Services Program. After Gunn had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re [Redacted]*, HFS Docket No. 21 MVH 065.** OCIG successfully sought the termination of [Redacted], a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $13,384 for homebased services that he had provided to a program recipient to whom he was married, which violates program rules. After [Redacted] had failed to request a hearing in writing, failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the

administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Joseph Applegate*, HFS Docket No. 21 MVH 067.** OCIG successfully sought the termination of Joseph Applegate, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $10,592 for home-based services to a program recipient that he did not perform because he was, in fact, working elsewhere on the dates and at the times that he claimed to have provided the services. After Applegate had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Mario Lopez*, HFS Docket No. 21 MVH 068.** OCIG successfully sought the termination of Mario Lopez, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $6,976 for home-based services that he claimed to have provided to a program recipient when the recipient was, in fact, in a healthcare facility, and not at home. After Lopez had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Katina Robertson*, HFS Docket No. 21 MVH 069.** OCIG successfully sought the termination of Katina Robertson, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $6,396 for home-based services to a program recipient that she did not perform because she was, in fact, working elsewhere on the dates and at the times that she claimed to have provided the services. After Robertson had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Ruth Drowns*, HFS Docket No. 21 MVH 070.** OCIG successfully sought the termination of Ruth Drowns, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $1,094 for home-based services that she claimed to have provided to a program recipient when the recipient was, in

fact, in a healthcare facility, and not at home. After Drowns had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Paris Foster*, HFS Docket No. 21 MVH 072.** OCIG successfully sought the termination of Paris Foster, a Medicaid-enrolled personal assistant, who had improperly billed the Medicaid program $12,485 for home-based services that Foster had claimed to have provided to a program recipient during hours when Foster was incarcerated. After Foster had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Gina Parkinson a/k/a Gina Capeheart*, HFS Docket No. 21 MVH 073.** OCIG successfully sought the termination of Gina Parkinson, a/k/a Gina Capeheart, a Medicaid-enrolled personal assistant, who improperly billed the Medicaid program $1,499 for home-based services that she claimed to have provided to a program recipient when the recipient was, in fact, in a healthcare facility, and not at home. After Parkinson had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

Terminations Resulting from Professional Sanctions (12 Matters)

The Illinois Department of Financial and Professional Regulation (IDFPR) is the State of Illinois agency that regulates the medical profession by, among other things, ensuring that competent professionals are licensed to provide services to the public. In its role, IDFPR has the authority to revoke, suspend, or otherwise terminate medical professionals' licenses to practice in the State of Illinois when those professionals engage in improper conduct or otherwise fall below the minimum threshold for acceptable performance. If IDFPR sanctions the professional licenses of Medicaid providers, OIG may take action to terminate those providers' enrollments. See Ill. Admin. Code tit. 89, § 140.16(a)(2). In the following matters, OCIG successfully sought the terminations of medical professionals whose licensure had been revoked by IDFPR.

***In re Neil Nelson, MD*, HFS Docket No. 17 MVH 115.** OCIG successfully sought the termination of Dr. Neil Nelson's enrollment as a Medicaid provider after IDFPR had placed his medical license on permanent inactive status because he was suffering from a physical disability, and he was unable to practice medicine. After Nelson had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Robin Crocker-Wilson*, DO, HFS Docket No. 19 MVH 092.** OCIG successfully sought the termination of Dr. Robin Crocker-Wilson's enrollment as a Medicaid provider after IDFPR had suspended her optometry license based on failure to appear at a hearing or file an answer to an IDFPR complaint alleging that she was convicted of driving under the influence of alcohol. OCIG proceeded to file a Notice seeking to terminate her from the Medicaid program. After Dr. Crocker-Wilson had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Nicole Wantoch, RPN*, HFS Docket No. 20 MVH 007.** OCIG successfully sought the termination of Nicole Wantoch's enrollment as a Medicaid provider after IDFPR had suspended her nursing license due to her violation of the terms and conditions of her probation by testing positive for alcohol. After Wantoch had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Stephen Houde, MD*, HFS Docket No. 20 MVH 089.** OCIG successfully sought the termination of Dr. Stephen Houde's enrollment as a Medicaid provider after IDFPR had suspended his medical license due to substance abuse. After Dr. Houde had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Franklin Nwoke, MD,* HFS Docket No. 21 MVH 016.** OCIG successfully sought the termination of Dr. Franklin Nwoke's enrollment as a Medicaid provider after the State of Maryland had suspended his medical license due to

unprofessional conduct in the practice of medicine. After Dr. Nwoke had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Chester Stone, MD*, HFS Docket No. 21 MVH 018.** OCIG successfully sought the termination of Dr. Chester Stone's enrollment as a Medicaid provider after he had surrendered his Missouri medical license. After Dr. Stone had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Thomas Klein, MD*, HFS Docket No. 21 MVH 035.** OCIG successfully sought the termination of Dr. Thomas Klein's enrollment as a Medicaid provider after IDFPR had suspended his medical license for engaging in sexually inappropriate conduct with a patient, which constituted an immediate danger to the public. After Dr. Klein had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Eliza Diaconescu, MD*, HFS Docket No. 21 MVH 038.** OCIG successfully sought the termination of Dr. Eliza Diaconescu's enrollment as a Medicaid provider after IDFPR had suspended her medical license for violating her terms of probation with IDFPR by failing to (1) submit quarterly reports; and (2) ensure that her practice monitor submitted quarterly reports. After Dr. Diaconescu had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Yevgeny Tsyrulnikov, MD*, HFS Docket No. 21 MVH 039.** OCIG successfully sought the termination of Dr. Yevgeny Tsyrulnikov's enrollment as a Medicaid provider after IDFPR had suspended his medical license after he had pleaded guilty to healthcare fraud. After Dr. Tsyrulnikov had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The

administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Phillip Greene, MD*, HFS Docket No. 21 MVH 051.** OCIG successfully sought the termination of Dr. Phillip Green's enrollment as a Medicaid provider after IDFPR had suspended his medical license for violating his terms of probation with IDFPR after he was indicted for healthcare fraud. After Dr. Greene had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Robert Frankle, MD*, HFS Docket No. 21 MVH 057.** OCIG successfully sought the termination of Dr. Robert Frankle's enrollment as a Medicaid provider after IDFPR had suspended his medical license for his failure to pay state income taxes. After Dr. Frankle had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Francis Kayira, MD*, HFS Docket No. 21 MVH 058.** OCIG successfully sought the termination of Dr. Francis Kayira's enrollment as a Medicaid provider after IDFPR had placed his medical license on Permanent Inactive Status due to his failure to comply with the terms and conditions of his probation by failing to timely pass required medical examinations. After Dr. Kayira had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

Terminations Based on Criminal Convictions (7 Matters)

HFS regulations allow for the termination of enrolled Medicaid providers who "engaged in practices prohibited by applicable federal or State law or regulation." See Ill. Admin. Code tit. 89, § 140.16(a)(10). In addition, Medicaid providers can be terminated from the program if they have been convicted in state or federal court of the following disqualifying offenses:

- Murder
- Class X felonies under the Illinois Criminal Code of 1961
- Sexual misconduct that may subject Medicaid recipients to an undue risk of harm

- Criminal offenses that may subject Medicaid recipients to an undue risk of harm
- Crimes of fraud or dishonesty
- Crimes involving controlled substances
- Misdemeanors relating to fraud, theft, embezzlement, or breaches of fiduciary responsibilities
- Other financial misconduct related to a healthcare program

See Ill. Admin. Code tit. 89, § 140.16(a)(12). In the following matters, OCIG successfully sought the terminations of providers who, because of criminal convictions, are prohibited from participating in the Medicaid program.

***In re Erica Miller,* HFS Docket No. 19 MVH 127.** OCIG successfully sought the termination of Erica Miller, a Medicaid-enrolled personal assistant, after she was convicted in federal court of healthcare fraud. After Miller had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Michael Smith*, HFS Docket No.19 MVH 5012.** OCIG successfully sought the termination of Michael Smith, a Medicaid-enrolled personal assistant, after he (1) was convicted in state court on multiple counts of aggravated unlawful possession of a concealed firearm; and (2) lied on his Medicaid enrollment form that he had never been convicted of a crime — each of which constituted additional grounds for the termination of his enrollment as a provider in the program. After Smith had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Kirk Hopkins, MD,* HFS Docket No. 21 MVH 006.** OCIG successfully sought the termination of Dr. Kirk Hopkins' enrollment as a Medicaid provider after he was convicted in federal court of healthcare fraud. After Dr. Hopkins had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Yun Sup Kim, DDS*, HFS Docket No. 21 MVH 007.** OCIG successfully sought the termination of Dr. Yun Sup Kim's enrollment as a Medicaid provider after Dr. Kim was convicted in federal court of healthcare fraud. After Dr. Kim had failed to

request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate Dr. Kim from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Latonia Dixon*, HFS Docket No. 21 MVH 049.**
***In re Catch a Ride Transportation, Inc.*, HFS Docket No. 21 MVH 052.** In two separate administrative actions, OCIG successfully sought the termination of Latonia Dixon, a Medicaid-enrolled personal assistant, and her company, Catch a Ride Transportation, a medical-transportation provider separately enrolled in the program. Each administrative action was based on Dixon's conviction in Illinois state court for defrauding the Medicaid program by billing the program for personal-assistance services that she had not provided. Both Dixon and Catch a Ride failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing. OCIG accordingly asked the administrative law judge to issue a default-and-recommended decision to terminate the enrollments of both Dixon and her company as Medicaid providers. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Luis Carlin*, HFS Docket No. 21 MVH 053.** OCIG successfully sought the termination of Luis Carlin, a Medicaid-enrolled personal assistant, after he was convicted in state court of aggravated criminal sexual abuse of a minor who was under the age of 13. After Carlin had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

Terminations for Failures to Repay Debts to HFS (11 Matters)

Medicaid-enrolled providers' delinquent debts to HFS are cause for the providers' termination from the program. See Ill. Admin. Code tit. 89, § 140.16(a)(9). OCIG successfully took administrative action in the following matters to terminate the enrollment of providers who had failed to repay to HFS moneys owed.

***In re KPT Transportation, Inc.*, HFS Docket No. 20 MVH 045.** After an OIG audit identified discrepancies in the billings of medical-transportation provider KPT Transportation, the company agreed to repay to HFS $11,880 in Medicaid overpayments. KPT Transportation, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate KPT Transportation's enrollment as a Medicaid provider and to bar its owners, Patricia Pate and Maxine

Kidd, from further participation in the program. After KPT Transportation and its owners had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar its owners from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Barry's Drugs*, HFS Docket No. 20 MVH 048.** After an administrative law judge determined that pharmacy provider Barry's Cut Rate Stores, Inc., d/b/a Barry's Drugs, had claimed to provide medication to Medicaid recipients who were, in fact, deceased at the time, the company was ordered to repay $2,154 in Medicaid funds. Barry's Cut Rate Stores, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate Barry's Cut Rate Stores' enrollment as a Medicaid provider and to bar its owners, Barry Golin, Howard Golin, and Jerrold Cichansky, from further participation in the program. After the company and its owners had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar its owners from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Vision Four, Inc.*, HFS Docket No. 20 MVH 043.** Based on the findings of an OIG audit, an administrative law judge concluded that medical-transportation provider Vision Four, Inc. had submitted improper claims for payment that included (1) sixty-one instances of the submission of duplicate claims; (2) three hundred twenty-nine instances of the use of loaded mileage when submitting claims;[3] and (3) twenty-eight instances of billing for the purported provision of transportation services to Medicaid recipients at times when the recipients were, in fact, in healthcare facilities. Those billing improprieties resulted in Vision Four receiving an overpayment of $2,837 in Medicaid funds, which the administrative law judge ordered the company to repay. Vision Four, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate Vision Four's enrollment as a Medicaid provider and to bar its owners — Jamie Barnett, Asherah Barnett, Mack McGhee, and Gerald Williams — from further participation in the program. After the company and its owners had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid

[3] Billing with **loaded mileage** occurs when a medical-transportation provider transports more than one Medicaid recipient simultaneously in an effort to inflate the miles actually driven. The provider bills for mileage associated with each recipient separately, and in addition to one another, when the billed mileage should reflect only the mileage for the one trip. For instance, loaded mileage for one ten-mile joint trip for recipients A and B will not reflect the ten miles actually driven, but instead will reflect the sum of ten miles for recipient A and ten miles for recipient B, for a total of twenty miles.

program and to bar its owners from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Dedicated Transit Inc.*, HFS Docket No. 20 MVH 056.** After an OIG audit identified several discrepancies in the billings of medical-transportation provider Dedicated Transit, Inc., the company agreed to repay HFS $119 in Medicaid overpayments, plus interest owed. Dedicated Transit, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate Dedicated Transit's enrollment as a Medicaid provider and to bar its owner, Kareem Bello, from further participation in the program. After Dedicated Transit and Bello had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar Bello from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In Alef Cab Company*, HFS Docket No. 21 MVH 028.** After Alef Cab Company failed to produce records in response to an OIG audit, an administrative law judge ordered the company to repay to HFS $690,505 in identified Medicaid overpayments. Alef Cab, however, subsequently failed to repay that amount. In response, OCIG successfully sought the termination of Alef Cab's enrollment as a Medicaid provider and the barrment of its several owners — Alexander Kuzmenko, John Reiger, Dmitriy Chernyavskiy, Smitry Kuzmenko, Alex Kabakov — from further participation in the program. After the company and its owners had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar its owners from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re James Middleton*, HFS Docket No. 21 MVH 037.** After an administrative hearing was held regarding Medicaid overpayments identified by an OIG desk audit, an administrative law judge ordered James Middleton to repay $263. Middleton, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate Middleton's enrollment as a Medicaid provider. After Middleton had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Om Red Ganesh, Jatin Patel, and Raju Patel*, HFS Docket No. 21 MVH 041 / *In re JDiscount Pharmacy, Jatin Patel, and Raju Patel*, HFS Docket No. 21 MVH 044.** Two separate administrative actions concluded that, due to billing discrepancies, pharmacy providers Om Red Ganesh and JDiscount Pharmacy received a combined $14,987 in Medicaid overpayments, which an administrative law judge ordered the companies to repay. The companies, however, subsequently failed to repay the identified amount. In response, OCIG successfully sought the termination of Om Red Ganesh's and JDiscount Pharmacy's enrollment as Medicaid providers, as well as the barrment of the companies' owners, Jatin and Raju Patel, from further participation in the program. After the companies and their owners had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar its owners from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Platinum Care, Inc., Jim H. Isdell, and Kristin P. Isdell*, HFS Docket No. 21 MVH 045.** After an administrative hearing was held regarding billing discrepancies that were identified during an OIG audit, medical-transportation provider Platinum Care, Inc., was ordered to repay HFS $69,087 in identified Medicaid overpayments. Platinum Care, however, subsequently failed to repay that amount. In response, OCIG successfully sought the termination of Platinum Care's enrollment as a Medicaid provider and the barrment of its owners, Jim and Kristin Isdell. After Platinum Care and its owners had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar its owners from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Clarence D. Oliver*, HFS Docket No. 21 MVH 047.** After an administrative hearing was held regarding billing discrepancies that were identified during an OIG audit, medical-transportation provider Clarence Oliver was ordered to repay HFS $1,837 in identified Medicaid overpayments. Oliver, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate Oliver's enrollment as a Medicaid provider. After Oliver had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate him from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Vital Products, Ltd., and David A. Umbaugh*, HFS Docket No. 21 MVH 054.** After an administrative hearing was held regarding billing discrepancies that were identified during an OIG audit, medical transportation provider Vital Products, Ltd., was ordered to repay HFS $401 in identified Medicaid overpayments. Vital Products, however, subsequently failed to repay that amount. In response, OCIG successfully sought to terminate Vital Products' enrollment as a Medicaid provider and the barrment of its owner, David A. Umbaugh. After Vital Products and Umbaugh had failed to request a termination hearing in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate the company from the Medicaid program and to bar Umbaugh from further program participation. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

Terminations for Failures to Comply with Other States' Medicaid Regulations (2 Matters)

Federal law mandates that HFS must terminate the enrollment of Medicaid providers when those providers fail to comply with other states' Medicaid programs or federal healthcare programs. See 42 U.S.C. § 1396a(a)(39); 42 C.F.R § 455.416(c). Because the providers in the following matters had violated the regulations of other states' Medicaid programs, OCIG successfully sought the termination of their enrollments.

***In re Accura Medical Laboratory, Inc. and Matthew Stover,* HFS Docket No. 21 MVH 033.** The State of Kansas terminated Accura Medical Laboratory, Inc., from its Medicaid program after concluding that the provider, among other things: (1) was not in compliance with applicable state laws, administrative regulations, or program issuances concerning medical providers; (2) was not in compliance with the terms of its provider agreement; and (3) had its license, registration, or certification suspended. In addition, the State of Missouri terminated Accura Medical from its Medicaid program for program violations, in that the provider had sanctions or any other adverse action invoked by another state Medicaid program. In response, OCIG successfully sought the termination of Accura Medical's enrollment as a Medicaid provider and barrment of its owner, Matthew Stover, from further participation in the Medicaid program. After Accura Medical and Stover had failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OCIG asked the administrative law judge to issue a default-andrecommended decision to terminate Accura Medical and to bar the owner. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Christina Weber*, HFS Docket No. 21 MVH 043.** The State of Indiana terminated Dr. Christina Weber from its Medicaid program because the provider was not in compliance with applicable dental licensure standards. In response, OCIG sought the immediate termination of Dr. Weber's enrollment as a Medicaid provider. After Dr. Weber had failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to terminate her from the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

Corporate Integrity Agreements In lieu of Termination and Summary Termination or Exclusion Actions

Generally, providers are afforded the right to an administrative hearing when termination or exclusion actions are brought against them. There are, however, limited circumstances in which providers can be terminated from the program without first availing themselves of a hearing. One such circumstance is when a provider breaches the terms of a Corporate Integrity Agreement.

Corporate Integrity Agreements are agreements into which providers enter in lieu of termination where grounds for termination exist. The terms of a CIA generally require the provider to repay any identified overpayments of Medicaid funds received, undertake corrective actions to address any improprieties that OIG identifies, and provide OIG with regular reports detailing the results of those corrective actions. Once executed, OIG monitors the provider's compliance with the terms of the agreement. In the event that the provider fails to comply with a CIA, the agreement includes provisions that allow for the provider's immediate termination without the matter being first heard by an administrative tribunal.

In FY2022, OIG entered into six new CIAs to add to the 19 agreements that were already being monitored at the beginning of the year, bringing the total number of CIAs being monitored in FY2022 to 25. Of those 25, 14 CIAs were closed without action taken against the vendor, while 10 agreements continued to be monitored at the close of the year. The OIG also terminated the enrollment of one provider for breaching the terms of a CIA:

***In re Innovative Transportation Enterprise, Inc.*, OIG Case No. 1357733.** OCIG summarily terminated medical-transportation provider Innovative Transportation Enterprise's enrollment as a Medicaid provider and barred the company's owner, Jean Baptiste Twizerumukiza, from participating further in the Medicaid program. OCIG acted against Innovative Transportation Enterprise after the company had violated the terms of a CIA, into which the company had entered with HFS, and by which the company agreed to remedy multiple violations of HFS rules and regulations. Under that agreement, Innovative Transportation Enterprise was mandated to submit annual reports reflecting several compliance obligations. Innovative Transportation Enterprise's first annual report, however, was deficient

as submitted, in that it reflected that, despite having entered into the Agreement, the Company had continued to engage in numerous violations that each warranted termination and barrment.

OIG also immediately excludes from the Medicaid program any provider whom HHS has excluded from the Medicare program or any other state healthcare program. See 42 U.S.C. § 1396a(a)(39). In FY2022, OIG effected summary exclusions of this type in the following twenty-one matters:

In re Jessica Garcia,
OIG Case No. 1231097

In re Kameron Thomas,
OIG Case No. 1242716

In re Jami Mahyew,
OIG Case No. 1306831

In re Marybeth Kobos,
OIG Case No. 1294746

In re DeMario Mitchell,
OIG Case No. 1318518

In re Iesha Lomax,
OIG Case No. 1322691

In re Tapas Dasgupta,
OIG Case No. 1327704

In re Valerie Fain,
OIG Case No. 1350862

In re Lori Wade,
OIG Case No. 1351918

In re Lathon Sundree,
OIG Case No. 1363304

In re Jacquelynn Hubbard,
OIG Case No. 1363304

In re Joseph Mayotte,
OIG Case No. 1369115

In re Dana Tatham,
OIG Case No. 1369128

In re Camilla Gallardo,
OIG Case No. 1376740

In re Shauntea Brown,
OIG Case No. 1376742

In re Shannon Brown,
OIG Case No. 1380983

In re Jill Kane,
OIG Case No. 1380985

In re Marcus Newble,
OIG Case No. 1381057

In re Audra Smith,
OIG Case No. 1384624

In re Keilani Taylor,
OIG Case No. 1384625

In re Robert Wilson,
OIG Case No. 1384626

Denials of Applications for Enrollment (5 Matters)

Providers must apply to become enrolled in the Medicaid program. When applications are denied, applicants have the right to appeal the denials to the HFS administrative tribunal. See Ill. Admin. Code tit. 89, § 104.204. In such instances, OCIG represents the HFS in the appeal hearing. In FY2022, OCIG successfully defended HFS' decision to deny applications in five matters, as detailed below.

***In re Christian Foltys, DDS*, HFS Docket No. 18 MVH 047.** OCIG successfully defended OIG's denial of Dr. Christian Foltys's application to enroll as a provider in the Medicaid program based on his refusal to cooperate with the application process, which required him to schedule a meeting with the OIG's Medical Quality Review Committee. After Dr. Foltys had failed to request a hearing to challenge the denial of his application in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to deny his application to participate in the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Paul Dupont, MD*, HFS Docket No. 19 MVH 018.** OCIG successfully defended OIG's denial of Dr. Paul Dupont's application to enroll as a provider in the Medicaid program based on his refusal to respond to repeated requests for information required as part of the application process. After Dr. Dupont had failed to request a hearing to challenge the denial of his application in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to deny his application to participate in the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Karl Nibbelink, MD*, HFS Docket No. 21 MVH 025.** OCIG successfully defended OIG's denial of Dr. Karl Nibbelink's application to enroll as a provider in the Medicaid program based on his refusal to respond to repeated requests for information required as part of the application process. After Dr. Nibbelink had failed to request a hearing to challenge the denial of his application in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to deny his application to participate in the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Jonathan Renkas, MD*, HFS Docket No. 21 MVH 026.** OCIG successfully defended OIG's denial of Dr. Jonathan Renkas' application to enroll as a provider in the Medicaid program based on his refusal to respond to repeated requests for information required as part of the application process. After Dr. Renkas had failed to request a hearing to challenge the denial of his application in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to deny his application to participate in the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Home Assist Personal Care Co.*, HFS Docket No. 21 MVH 042..** OCIG successfully defended OIG's denial of the application of Home Assist Personal Care Co. to enroll as a provider in the Medicaid program. The company's application was denied on a finding that the company and its owner, Kesu Brown, posed a risk of fraud, waste, and abuse to the Medicaid program. That finding, in turn, was based on a previous OIG investigation that concluded Brown had made numerous false statements in connection with the operation of an enrolled medical transportation company and home daycare business to receive improper Medicaid payments. After Home Assist Personal Care Co. had failed to request a hearing to challenge the denial of its application in writing, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision to deny its application to participate in the Medicaid program. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

Withholdings of Medicaid payments (6 Matters)

In certain circumstances, OIG may direct HFS to withhold all Medicaid payments to be paid to a provider for services rendered, even though OCIG has not yet taken administrative action to terminate the provider or recoup overpayments of program funds:

- When a provider, or certain individuals associated with an institutional provider, has been indicted or charged with a criminal offense that is based on alleged fraud or willful misrepresentation related to (1) the Medicaid program; (2) a federal or another state's medical assistance or healthcare program, or (3) the provision of healthcare services. See 305 Ill. Comp. Stat. 5/12-4.25(F-5).
- When OIG receives from a state or federal law enforcement agency, from a federal oversight agency, or from the results of a preliminary OIG audit, credible evidence that a provider, or certain individuals associated with an institutional provider, has engaged in fraud or willful misrepresentation related to the Medicaid program. See 305 Ill. Comp. Stat. 5/12-4.25(K); Ill. Admin. Code tit. 89, § 140.44(a).
- When, upon the initiation of an OIG audit, an OIG quality-of-care review, or an investigation in which there is credible allegations of fraud on the part of the provider, or certain individuals associated with an institutional provider.[4] See 305 Ill. Comp. Stat. 5/12-4.25(K-5); Ill. Admin. Code tit. 89, § 140.45(a)(1)-(a)(3).
- When a provider, or certain individuals associated with an institutional provider, demonstrates a clear failure to cooperate with HFS. See 305 Ill. Comp. Stat. 5/12-4.25(K-5); Ill. Admin. Code tit. 89, § 140.45(a)(4).

[4] Credible allegations of fraud are defined "to include an allegation from any source, including, but not limited to, fraud hotline complaints, claims data mining, patterns identified through provider audits, civil actions filed under the Illinois False Claims Act, and law enforcement investigations." See 305 Ill. Comp. Stat. 5/12-4.25(K-5). An allegation is considered to be credible when it has indicia of reliability. See id.

OCIG reviews allegations and evidence to recommend to OIG whether the imposition of a payment withhold is appropriate and works hand-in-hand with OIG's Fraud Abuse Executive to coordinate the imposition of any withhold with state and federal law-enforcement agencies, outside oversight agencies, and MCOs.

In FY2022, OIG imposed six payment withholds.[5]

Financial recovery actions (12 Matters)

In addition to undertaking termination administrative actions, HFS regulations allow OIG to recover any overpayments of Medicaid funds identified by an OIG audit. See Ill. Admin. Code tit. 89, §§ 104.206(a) & 140.15(a). As detailed below, in FY2022 OCIG attorneys successfully argued that HFS should be allowed to recover a total of $869,489 in Medicaid overpayments made to providers.

***In re Jaswinder Chhibber, M.D.*, HFS Docket No. 14 MVH 012.** OCIG successfully argued that HFS should be allowed to recover $80,305 in Medicaid overpayments made to Dr. Jaswinder Chhibber, based on OIG audit findings that identified over 1,200 instances of (1) missing records; (2) using improper procedure codes when billing; (3) billing for services not covered by Medicaid; and (4) billing for services that were, in fact, rendered by another provider. After Dr. Chhibber had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $80,305. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Pride Transportation, Inc.*, HFS Docket No. 15 MVH 054.** OCIG successfully persuaded an administrative law judge to (1) terminate medical-transportation provider Pride Transportation, Inc.'s enrollment as a Medicaid provider; (2) bar the company's owners, Crystal Duprey and Lillie Hall, from further participation in the Medicaid program; and (3) allow HFS to recover $282,222 in overpayments. OCIG's administrative action was based on the Pride Transportation's refusal to produce patient medical supply records to the OIG for audit, as well as the company's failures to obtain (1) prior approvals for transportation services provided; and (2) required licenses, registrations, and certifications. After Pride Transportation had failed to request a hearing in writing, failed to appear at the hearing, and otherwise failed to proceed at the scheduled hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision terminating the company, barring its owners, and allowing the recovery of $282,222. The HFS Director subsequently adopted the administrative law judge's recommendation.

[5] Credible Because confidential investigations and audits continue after the imposition of payment withholds, the matters in which payment withholds were imposed, and the legal basis for those payment withholds, will not be reflected in this report.

***In re Alphonso Richardson, d/b/a Richardson Medicar Service*, HFS Docket Nos. 20 MVH 019 & 20 MVH 020.** OCIG successfully argued that HFS should be allowed to recover $2,439 in Medicaid overpayments made to medical-transportation provider Alphonso Richardson, d/b/a Richardson Medicar Service, based on OIG audit findings that identified the overpayments. After Richardson had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $2,439. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Specialty Services & Linda and Joseph E. Roudez, III*, HFS Docket No. 20 MVH 029.** OCIG successfully argued that HFS should be allowed to recover $2,372 in Medicaid overpayments made to medical-transportation provider Specialty Services and Linda and Joseph E. Roudez, III, based on OIG audit findings that identified the overpayments. After Specialty Services had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $2,372. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re TDN Transportation*, HFS Docket Nos. 20 MVH 052 & 20 MVH 061.** In two separate administrative actions, OCIG successfully argued that HFS should be allowed to recover a total of $2,077 in Medicaid overpayments made to medical-transportation provider TDN Transportation. The first action (HFS Docket No. 20 MVH 052) was premised on the findings of an OIG desk audit, which identified twenty-four instances in which TDN Transportation had billed for the purported provision of transportation services to Medicaid recipients at times when the recipients were, in fact, in healthcare facilities. As a result, TDN Transportation received overpayments totaling $298. In the second action (HFS Docket No. 20 MVH 061), OCIG presented the findings of an OIG audit that identified 236 instances of (1) additional billing for the purported provision of transportation services to Medicaid recipients during hours when the recipients were, in fact, in healthcare facilities; and (2) billing using loaded mileage, which violates program rules. These instances of improper billing, OCIG asserted, led to TDN Transportation receiving $1,788 in overpayments. In both cases, TDN Transportation failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing. In response, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $2,077. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re J and L Transportation*, HFS Docket No. 20 MVH 063.** OCIG successfully argued that HFS should be allowed to recover $1,396 in Medicaid overpayments made to medical-transportation provider J and L Transportation, based on OIG audit findings that identified 279 instances of (1) duplicate billing; (2) billing for the purported provision of transportation services to Medicaid recipients at times when the recipients were, in fact, in healthcare facilities; and (3) billing using loaded mileage, which violates program rules. After J and L had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $1,396. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Meadowood Nursing Home*, HFS Docket No. 21 MVH 008.** OCIG successfully argued that HFS should be allowed to recover $2,780 in Medicaid overpayments made to long-term care provider Meadowood Nursing Home, based on OIG audit findings that identified discrepancies with the facility's room-and-board records, billing practices, and otherwise deficient record keeping. After Meadowood had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $2,780. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Elfman Pharmacy*, HFS Docket No. 21 MVH 013.** OCIG successfully argued that HFS should be allowed to recover $480,859 in Medicaid overpayments made to pharmacy provider Elfman Pharmacy, based on OIG audit findings that identified ninety-seven instances of missing records, including refill logs. After Elfman Pharmacy had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision recommending the full recovery of $480,859.31. The administrative law judge did so, and the HFS Director adopted the administrative law judge's recommendation.

***In re Carl Vancol, M.D.*, HFS Docket No. 21 MVH 040.** OCIG successfully argued that HFS should be allowed to recover $144 in Medicaid overpayments made to Dr. Carl Vancol, based on OIG audit findings that identified claims that had been submitted for services supposedly performed after a Medicaid recipient's death. Despite an administrative order stating that Dr. Vancol was obligated to repay the $144.66 he failed to do so, leading OCIG to seek the termination of his enrollment as a Medicaid provider. Subsequently an administrative law judge issued a recommended decision agreeing terminating Dr. Vancol from the Medicaid program, which the HFS Director affirmed. Shortly thereafter, Dr. Vancol

immediately repaid the amount owed in full, and OCIG agreed to withdraw the final administrative decision terminating his enrollment.

***In re Avmed Surgical Supply, Inc.*, HFS Docket No. 21 MVH 061.** OCIG successfully persuaded an administrative law judge to (1) terminate Avmed Surgical Supply, Inc.'s enrollment as a Medicaid provider; (2) bar from further participation in the Medicaid program the company's several owners, Shaheen Nadeem, Nadeem Naeem, Banjamin Averick, and Nathan Averick; and (3) allow HFS to recover $14,893 in overpayments. OCIG's administrative action was based on Avmed Surgical Supply's refusal to produce patient medical supply records to the OIG for audit, which subsequently identified the overpayment amount. After Avmed Surgical Supply had failed to request a hearing to challenge the audit findings, failed to appear at the scheduled hearing, and otherwise failed to proceed at the hearing, OCIG asked the administrative law judge to issue a default-and-recommended decision terminating the company, barring its owners, and allowing the recovery of $14,893. The HFS Director subsequently adopted the administrative law judge's recommendation.

Settlement agreements (14 Matters)

As part of OIG's ongoing effort to ensure that HFS resources are preserved where appropriate, and to best conserve the Department's time and money, OCIG is empowered to negotiate settlement agreements to bring matters to a quick resolution and obtain Medicaid funds on an expedited basis. In FY2022, OCIG attorneys successfully negotiated a total $790,622 in settlements to obtain inappropriately disbursed Medicaid funds while preserving valuable State resources and funds. Those settlements are detailed below:

Settlement of $20,000 from Psychiatric Provider, HFS Docket No. 11 MVH 211. An OIG audit identified an overpayment of Medicaid funds to a psychiatric provider in the amount of $283,833, based on the provider's inability to produce records that supported billing claims for group services over the span of two years. To not prolong the matter, which at the time had been pending for over eleven years. the provider agreed to (1) repay $20,000; and (2) waive any claim for payment for any services rendered during the pendency of the litigation.

Settlement of $750,000 from Psychiatric Provider, HFS Docket No. 12 MVH 002. An OIG audit identified an overpayment of Medicaid funds to a psychiatric provider in the amount of over $1.2 million, based on findings that the provider had improperly billed for group psychiatric services that he had not personally provided. OCIG obtained a favorable recommended decision, which allowed HFS to recover the full amount. So as to not prolong the matter, which at the time had been pending for nearly ten years, the provider agreed to repay $250,000 immediately and an additional $500,000 under an installment agreement.

Settlement of $1,450 from Transportation Provider, HFS Docket Nos. 12 MVH 266, 12 MVH 267, 12 MVH 268 & 17 MVH 2088. This consolidated case comprised of four (4) separate matters, in which OIG audits identified an overpayment of Medicaid funds to a medical-transportation provider in the total amount of $9,076, stemming from thousands of instances of (1) billing for the purported provision of transportation services to Medicaid recipients when the recipients were, in fact, in healthcare facilities; (2) billing using loaded mileage, which violates program rules. OIG audits also established that HFS had collected a surplus of $7,501 in two other cases. This amount was offset against the established overpayment amount, leaving $1,574 owed. To settle the matter, the provider agreed to pay $1,450 before the conclusion of the hearing.

Settlement of $4,480 from Transportation Provider, HFS Docket No. 16 MVH 2035. An OIG audit identified an overpayment of Medicaid funds to a medical-transportation provider in the amount of $4,266, stemming from hundreds of instances of (1) billing for the purported provision of transportation services to Medicaid recipients when the recipients were, in fact, in healthcare facilities; (2) billing using loaded mileage, which violates program rules; and (3) duplicate billing. OCIG filed an administrative notice of recoupment of the funds. Before any hearing commenced, the provider agreed to pay $4,480 to settlement matter, which represented the original amount plus $213 in applied interest.

Settlement of $2,691 from Transportation Provider, HFS Docket No. 16 MVH 2037. After an administrative law judge determined that HFS should be allowed to recover $2,691 in Medicaid overpayments made to a medical-transportation provider, the provider entered into a settlement agreement to repay $1,300. When the provider failed to pay that amount, however, OCIG initiated an administrative action to terminate the provider's enrollment as a Medicaid provider and to bar its owner from further program participation. The provider subsequently paid the original overpayment amount of $2,691.21 in exchange for OCIG withdrawing the administrative action.

Settlement of $10,000 from Hospice Provider, HFS Docket No. 19 MVH 078. An OIG audit identified an overpayment of Medicaid funds to a hospice provider, based on the determination that (1) a recipient had exceeded the life expectancy as estimated by the provider; and (2) the provider's medical director had erred when assessing the impact of the recipient's illness and co-morbidities when determining the recipient's life expectancy. After OCIG filed an administrative notice to recover the funds, the provider agreed to settle the matter for $10,000.

Settlement of $2,000 from Transportation Provider, OIG Case Nos. 1283918, 1183932, 1151160, 1151837 & 1151509. This consolidated case comprised of five (5) separate matters, in which an OIG audit identified an overpayment of Medicaid funds to a medical-transportation provider in the amount of $13,004,

originating from thousands of instances of (1) billing for the purported provision of transportation services to Medicaid recipients when the recipients were, in fact, in healthcare facilities; (2) billing using loaded mileage, which violates program rules; and (3) duplicate billing. To settle the matter, the provider agreed to pay $2,000 before OCIG filed an administrative notice to recover the funds.

2022 Statistics

Total Administrative Actions Initiated: 127

- Terminations: **79**
  - Actions Seeking Owner Barrment: **13**
- Recovery of Overpayments: **44**
  - OIG Audit Recoupments: **16**
  - RAC Audit Recoupments: **28**
- Denials of Applications for Enrollment: **4**

Final Actions: 118

- Termination Decisions: **51**
  - Owner Barrments: **14**
- Application Denials: **5**
- Recovery of Overpayment: **22**
  - OIG Audit Recoupment: **12**
  - RAC Audit Recoupment: **10**
- Upholding Denial of LTC-ADI Coverage: **3**
- Summary Exclusions from Medicaid: **21**
- Settlements: **16**

Payment Withholds: 6

Corporate Integrity Agreements

- Ongoing at start of FY2022: **19**
- Entered during FY2022: **6**
- Total Monitored: **25**
- Ended: **15**
- Ongoing at end of FY2022: **10**

ANNUAL REPORT FY2022

FISCAL MANAGEMENT UNIT

Fiscal Management Highlights

The Fiscal Management Unit is made up of Budget, General Collections, Bad Debt Recovery and Procurement. The Fiscal Management Unit maintains and updates OIG's Operations Budget and handles OIG's procurements and intergovernmental-agency agreements. It processes and tracks overpayments established as a result of OIG audits of Medicaid providers, provider settlements, global settlements, and court-ordered restitutions. The Fiscal Management Unit establishes accounts receivable for all finalized overpayments and monitors these accounts until the debts are collected. If a debt is determined to be uncollectible, the uncollected debt case is forwarded to Bad Debt Recovery, which works with the Office of the Illinois Attorney General and the HFS Director's Office to enact and manage the State's process for writing off an uncollectible debt.

2022 Highlights

Budget: OIG's FY2022 Operations budget was $6.9 million. General Revenue Fund expenditures constituted approximately 3% of this amount, while Part F – Public Aid Recoveries Trust Fund expenditures totaled 97%. OIG's Operations budget was allocated as follows:

60%	Health Management Services (HMS), which serves as the OIG's Recovery Audit Contractor vendor, and reflects contingency payments on overpayments that OIG collects.
28%	Other professional contracts, such as OIG's contract with Northern Illinois University for data analytics, court-reporting and audio-transcription services, fingerprinting and background check services, public-records access and search services, various personal-services contracts.
8%	Twenty-eight medical and one statistical consultants.
3%	Other professional expenses, such as contractual reimbursement for nurse and attorney licenses; subscriptions to program-integrity associations; petty cash; copy and photo services; medical, healthcare-coding, and employee book purchases; and reimbursement to employees for conference fees.
1%	Employee and consultant travel.
>1%	Equipment for specialized services that are not part of the HFS Administrative Services or the Department of Innovation & Technology (DoIT) budget.

Collections: The OIG Collections unit handles cases that have resulted in either a final audit determination, a final administrative determination, a provider-settlement agreement, a global settlement agreement or a client-restitution agreement. Once an overpayment is finalized, Collections staff will establish an account receivable for the amount owed to HFS. When a

provider fails to make a payment, the Collections staff will send the provider an initial payment-reminder letter. If the provider does not comply with the initial reminder letter, the collections staff send the provider a fifteen-day demand letter. If the provider does not comply with the fifteen-day demand letter, the accounts are sent to Bad Debt Recovery and to OIG legal staff for termination and barrment of the provider from the Medicaid program. The debt will then be processed by the Fiscal Management Unit's Bad Debt Recovery staff. In FY2022, Collections processed and maintained approximately 1067 accounts receivables. In FY2022, OIG collections by Audit Type and Provider Type were as follows:

Audit Type

RAC Audits – **55%**

Field Audits – **36%**

Self-Disclosure Audits – **6%**

Desk Audits – **1%**

Other Audits – Civil Remedy and PERM - **1%**

Provider Type

Long Term Care Audits – **44%**

Hospital Audits – **44%**

Physician Audits – **5%**

Pharmacy Audits – **6%**

Other Practitioners – **< 1%**

Transportation Audits – **< 1%**

Demand Letters: In FY2022, the Fiscal Management Unit sent out fifteen-day demand letters in 73 non-RAC-related audits. Forty-nine percent of the letters were sent to transportation providers. In response to these letters, the Fiscal Management Unit collected $585,578. Providers owing collectively over $13.6 million in debt were sent to OCIG for program termination and barrment proceedings due to nonpayment.

Bad Debt: When the Fiscal Management Unit has exhausted all attempts at collection and a debt is still outstanding, OIG seeks to have the debt deemed uncollectible. Staff in Fiscal's Bad Debt Recovery Unit determine whether the case will go to an outside collection agency, to the HFS Director's office for write-off, or to the Attorney General's Office for write-off. This determination depends on various factors, including whether the providers or owners have assets and income to cover the debt owed to the Department. Recently finalized bad debt cases include:

Transportation Overpayment of $890,775 (Case #1145474): OIG conducted an audit of transportation provider, Regency Transportation, and identified an overpayment of $890,775. The total overpayment findings were based upon an audit scenario of Non-Corresponding Medical services. This audit was an extrapolated field audit that identified transportation services that were provided to Medicaid Recipients where there was no corresponding office or hospital visit billed to the Department. The owner of the company dissolved the corporation in 2018. The owner failed to appear for the appeal hearing and a motion for default was filed in November 2018. The ALJ submitted a recommended final administrative decision in favor of the Department for the full amount of $890,775. At the time of the final administrative decision, the provider was terminated from participation within the Medicaid program. The provider has not complied with the final administrative decision and has not made payments to the Department for the debt owed. This case was submitted to the Office of the Illinois

Attorney General for write-off in May 2021. The AG's Office approved the write-off for the full amount of $890,775 on February 10, 2022.

Transportation Overpayment of $690,505 (Case #1049518): OIG conducted an audit of transportation provider, Alef Cab Company, and identified an original overpayment of $3,807,054. The total overpayment findings were comprised of two different types of transportation audits:

1. $2,433,254 based on an extrapolated field audit reviewing transportation billings and tickets.;
2. $1,373,799 based on the identification of duplicate transportation services that were billed to the Department.

A re-audit was completed based upon the provider submitting additional documentation to the OIG audit staff for audit review. The re-audit reduced the original audit findings by $1,260,722 for a reaudit total overpayment identified of $2,546,331. The provider appealed the audit findings, and an appeal hearing was scheduled for October 2010. These hearings continued into 2011 with a motion from the owner's attorneys to bar the statistical expert's testimony on this case. In 2012, additional documentation was provided on the audit and another re-audit was done which brought the audit findings down to $1,006,855. Based upon an administrative hearing, an administrative law judge isued a decision in favor of the Department in the amount of $690,505 and termination and barrment of the owners from participation in the Medicaid program. The provider has failed to make any payments on the debt. After attempts at collection, this case was referred to the AG's Office in May 2021. The AG's Office approved the write-off in the amount of $690,505 on February 10, 2022.

Transportation Overpayment of $458,903 (Case #s 1159424, 1151058, 1151383, 1150711 and 1183731): OIG conducted an audit of transportation provider R&L Transportation LLC and identified an original overpayment of $458,903. The total overpayment findings were comprised of four different transportation audits:

1. $445,573 based on an extrapolated field audit
2. $1,340 based on the identification of transportation services billed during an inpatient stay
3. $10,647 based on the identification of transportation services billed for loaded mileage
4. $1,340 based on the identification of transportation services billed for duplicate billings

R&L Transportation LLC did not respond to any of the audit findings and did not cooperate with OIG audit staff. After numerous attempts by the auditors to work with the provider on these findings, the cases were referred to OCIG. An OCIG attorney represented OIG at a hearing to establish the overpayment and a final administrative decision was awarded for $458,903. The provider was also terminated from the Medicaid program. The provider and the company's owners did not cooperate with collection attempts. This case was sent to the AG's Office in February 2021 for write-off. On February 25, 2022, the AG's Office approved a write-off for the total amount of $458,903.

Procurement: The Fiscal Management Unit processed thirty-seven contracts, two amendments, and two intergovernmental agency agreements during FY2022. These included contracts for OIG's medical and statistical consultants; court-reporting and audio-transcription services; and background check and record-search services. The Fiscal Management Unit also helps to oversee OIG's fourteen existing intergovernmental agreements with federal, state, and municipal partners.

2022 Statistics

Procurement

Contracts: **43**
Value of Contracts: **$2,357,367**
Interagency Agreements: **14**
Value of Interagency Agreements: **$700,000**

Collections

Account Receivables: **2,035**
New Account Receivables: **1,516**
Outstanding Account Receivables: **402**
Collection in Full Account Receivables: **17**
Value of New Account Receivables Established: **$13,807,815**
Collected Account Receivables: **$13,736,538**
Open Account Receivables: **$62,055,211**

Bad Debt

Bad Debt Cases Established: **12**
Value of Established Bad Debt Cases: **$524,404**
Cases Sent to Collection Agency: **10**
Value of Cases Sent to Collection Agency: **$329,472**
Total Bad Debt Cases Written Off: **54**
Value of Bad Debt Cases Written Off: **$3,382,586**

"Health care fraud has a human face too. Individual victims of health care fraud are sadly easy to find. These are people who are exploited and subjected to unnecessary or unsafe medical procedures. Or whose medical records are compromised or whose legitimate insurance information is used to submit falsified claims."
–National Health Care Anti-Fraud Association

ANNUAL REPORT FY2022

MANAGED CARE ORGANIZATIONS (MCOs)

MCO Program Integrity Results

Illinois' Medicaid managed care program, HealthChoice Illinois, had six contracted Managed Care Organizations (MCOs) at the end of FY2022. These were Aetna, Blue Cross, Meridian, Molina, CountyCare, and Humana (Medicare-Medicaid Alignment Initiative Plan only). These organizations are statutorily and contractually obligated to operate program-integrity units to identify fraud, waste, and abuse and they report the results of their activities to OIG on a quarterly basis. OIG reviews the MCOs' referrals of potential fraud to determine whether further activity is warranted and provides the authority for MCOs to move forward with overpayment recoveries from Medicaid providers. The results of the MCO's activities in FY2022 are as follows.

2022 Statistics

MCO Audits and Investigations: 837

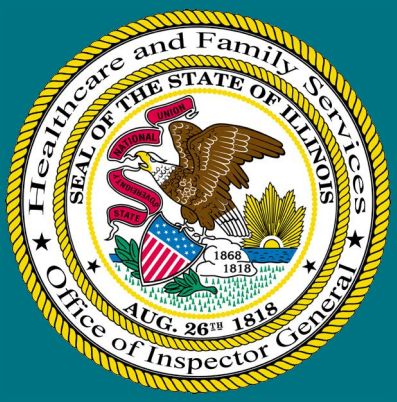
MCO Program Integrity Actions: 276

MCO Member Lock-Ins: 3,218

MCO Identified Overpayments: $7,287,694

MCO Collected Overpayments: $4,656,065

MCO Fraud Referrals to OIG: 172



OFFICE OF INSPECTOR GENERAL

Illinois Department of Healthcare and Family Services

Annual Report FY2022

2200 Churchill Road, A-1
Springfield, Illinois 62702

401 South Clinton Street
Chicago, Illinois 60607

https://www.illinois.gov/hfs/oig
217-524-6119

Medicaid Fraud Hotline
1-844-ILFRAUD (453-7283)

Twitter: @HFSOIG

LinkedIn: www.linkedin.com/company/hfsoig/

Instagram: @HFSOIG

Printed by the Authority of the State of Illinois
11/23 . web . IOCI24-0139