FY2025

State of Illinois
Department of Healthcare & Family Services
Office of Inspector General

ANNUAL REPORT

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

MESSAGE FROM THE INSPECTOR GENERAL

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

I am pleased to present the Fiscal Year 2025 annual report for the Office of Inspector General for the Illinois Department of Healthcare and Family Services (OIG).

At this moment, government oversight, corruption, and fraud in public programs are topics of national conversation. Independent of media and political interest, the work of this office carries on with a focus on achieving the greatest impact on program integrity with our dedicated resources. This annual report highlights our success in that endeavor.

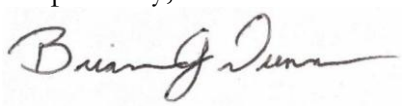
After years of significant organizational change, OIG settled into our work in three key areas – investigations, audits, and legal sanctions. A few noteworthy accomplishments that are featured more fully in the following pages:

- For investigations, OIG made 82 criminal referrals to the Medicaid Fraud Control Unit within the Office of the Illinois Attorney General, most which followed a full investigation by OIG's Bureau of Investigations. In addition, OIG made a number of additional referrals to federal and local law enforcement. This represents a 43% increase over last year and a 382% increase over two years ago.
- For audits, the Recovery Audit Contractor program has led to the identification of almost $77 million in overpayments, pushing audit collections to $26.5 million, over three times as much as last year.
- For legal sanctions, OIG's Office of Counsel to the Inspector General has steadily increased its productivity filing 229 administrative actions against Medicaid providers, a nearly 50% increase over last year and a 194% since FY2021. OIG also imposed 31 payment withholds against providers being investigated for fraud — a 121% increase over last year.

While we deepened our experience in certain areas, we also expanded into new territory, tackling new challenges. For example, OIG's Bureau of Fraud Science and Technology spearheaded an inquiry into managed care capitation payments for deceased recipients. OIG's analytic project, which is ongoing, led to the recovery of over $16 million in FY2025, with tens of millions more expected to be recovered this year. OIG's Long-Term Care Asset Discovery Initiative also began issuing spousal support orders to ensure that individuals with means are contributing their appropriate share to the costs of long-term care when seeking assistance from the Illinois Medicaid Program. This year's report details many more examples of long-standing efforts and new endeavors in program integrity.

While we welcome interest from all corners in government oversight and fraud prevention, we recognize that this attention can wax and wane. Regardless, OIG will remain steadfastly committed to safeguarding public dollars and ensuring that the vital services and benefits provided by Medicaid and other government benefit programs remain available for those Illinoisans in need.

Respectfully,



Brian J. Dunn
Inspector General

IMPORTANT LINKS

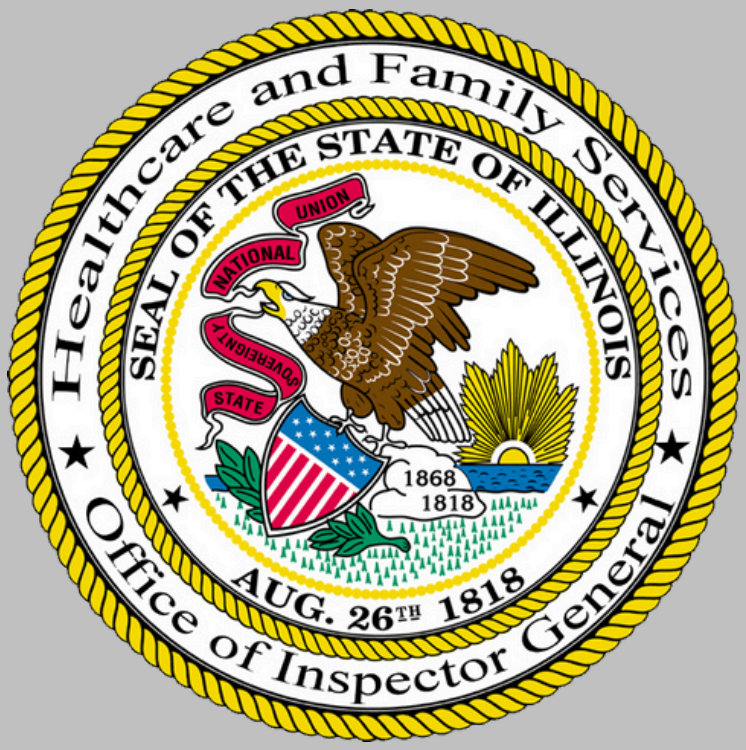
Website – https://hfs.illinois.gov/oig/welcome.html
Complaint Portals – https://hfs.illinois.gov/oig/reportfraud.html
Exclusion List – https://ilhfspartner3.dynamics365portals.us/sanctions/

TABLE OF CONTENTS

SELECTED ABBREVIATIONS AND ACRONYMS

Bureau of Fraud Science and 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
Dynamic Network Analysis	DNA
Electronic Data Warehouse	EDW
fraud, waste, and abuse	FWA
fee-for-service	FFS
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 Department of Public Health	IDPH
Long-Term Care Asset Discovery Initiative	LTC-ADI
managed care organization	MCO
Medicaid Fraud Control Unit	MFCU
Medical Quality Review Committee	MQRC
New Provider Verification	NPV
Office of the Illinois Attorney General	OAG
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
Unified Program Integrity Contractor	UPIC
U.S. Department of Health and Human Services	HHS

Activities and Impact in FY2025



FY2025 SIGNIFICANT ACTIVITIES

FY2025 FINANCIAL IMPACT

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 overpayments identified in Questions Costs, either from this fiscal year or a prior fiscal year.

Provider Audits:	$26,556,807
Global Settlements:	$5,293,572
Spousal Support:	$2,075,080
Restitution:	$1,670,176
Post-mortem Capitation:	$16,319,426
Total:	**$51,915,061**

Questioned Costs are *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.

Provider Audits:	$82,126,177
Provider Investigations:	$55,782,979
Client Overpayments:	$2,011,014
Spousal Support Orders:	$2,313,660
Restitution:	$252,332
Total:	**$142,486,162**

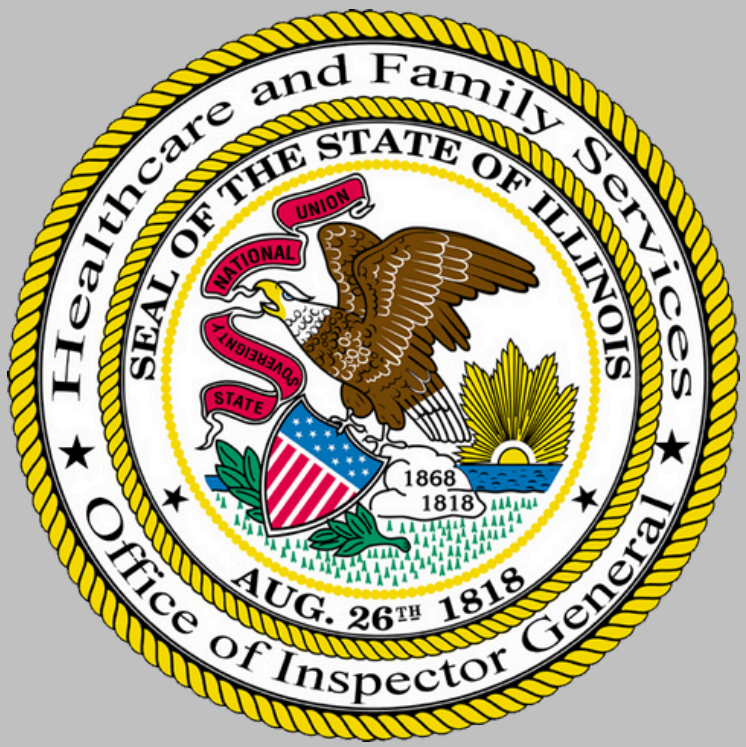
Cost Avoidance represents *funds which were not expended* after identifying that the operational, medical, contract, or grant expense was unnecessary.

LTC-ADI:	$119,451,394
Recipient Restriction Program:	$11,787,265
Provider Sanctions:	$45,216,717
Residency Verifications:	$1,696,276
Total:	**$178,151,653**

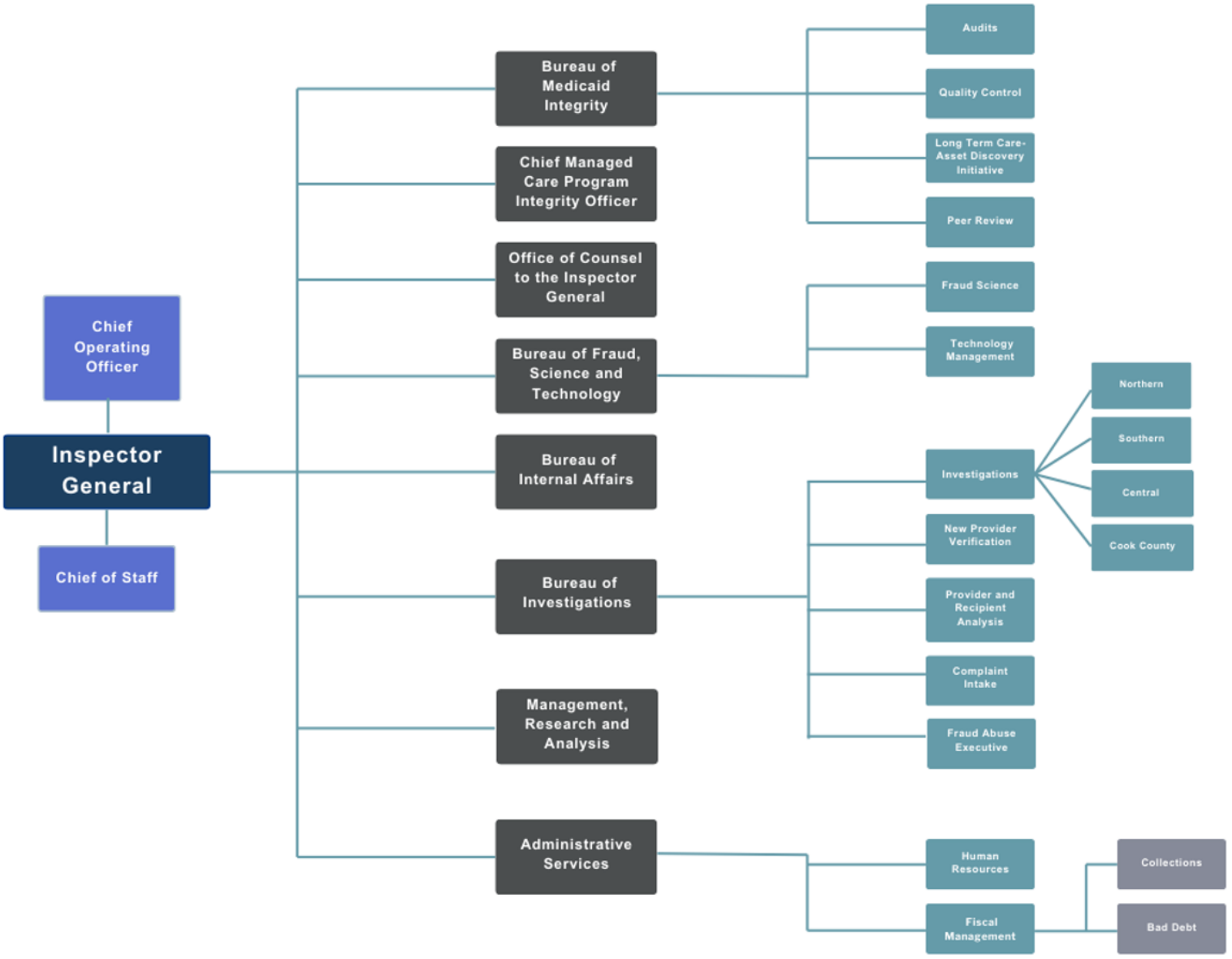
MCO Overpayments and Recoveries are *overpayments that the managed care organizations' special investigation units identified* were paid to network providers as the result of fraud, waste, or abuse. OIG reviews these findings and approves the overpayments for collection, if appropriate. Currently, under their contracts with HFS, the MCOs retain these monetary recoveries.

MCO Overpayments Approved for Recovery:	$28,467,027
MCO Overpayments Recovered:	$4,116,762

About HFS OIG



ORGANIZATION AND STRUCTURE



OIG MISSION AND AUTHORITY

Mission
The mission of the HFS OIG is to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct in the Illinois Medicaid program.

Jurisdiction, Powers, and Authority
Under HFS OIG's enabling statute, 305 ILCS 5/12-13.1 *et seq.*, HFS OIG is charged with oversight of the programs of the Illinois Department of Healthcare and Family Services, including the Illinois Medicaid program; the Illinois Department on Aging's programs; and certain programs of the Illinois Department of Human Services, as established by agreement.

HFS OIG is empowered to:

- Investigate misconduct by employees, vendors, contractors, and medical providers.
- Perform prepayment and post-payment audits on Medicaid providers.
- Monitor quality assurance programs.
- Measure quality control of programs.
- Investigate fraud or intentional program violations.
- Initiate actions against contractors, vendors, or medical providers for program violations, issue sanctions against providers, recover assessments against hospitals and long-term care facilities, and for contract violations.

HFS OIG has the authority to:

- Access information necessary to perform its duties.
- Share data with other state and federal agencies.
- Deny and suspend payments to providers and vendors.
- Deny, suspend, or terminate a provider's enrollment in the Illinois Medicaid program.
- Serve as the Illinois Medicaid program's primary liaison with law enforcement.
- Subpoena the attendance and testimony of witnesses and the production of records.

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 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 of the United States District Court for the Northern District of Illinois. Brian is a Certified Inspector General with the Association of Inspectors General.

Matt Langer - Chief of Staff

Matt joined OIG in September 2025. He has a wealth of experience with state government, healthcare, and Illinois managed care companies. Matt spent the past decade with health insurers, Centene and Blue Cross Blue Shield Association, working as a Compliance Manager, Director of Product Performance, and Managing Director. Prior to his work with insurers, he spent six years with the State of Illinois, first working in the Governor's Office on legislative affairs and policy, and then as a Deputy General Counsel and Senior Deputy Counsel for DHS. At DHS, Matt led the Division of Administrative Hearings and Rules and chaired the state's Administrative Hearings Review Committee. He earned a J.D. from New York Law School and an MA in Public Administration from New York University.

Kelly Waldhoff - Chief Operating Officer

Kelly joined OIG in September 2025. She spent the last 19 years working for the U.S. Department of Health & Human Services, Office of Inspector General. Most recently she served as the Director of Organizational Development, where she led national initiatives that improved HHS OIG organizational effectiveness, led strategic planning, modernized policies and procedures, and designed and executed training programs for OIG staff. During her tenure, Kelly also served as the Deputy Regional Inspector General in the Chicago HHS OIG field office where she led national program evaluation compliance reviews in complex regulatory areas including provider enrollment, data quality, and the Medicaid Drug Rebate Program. Kelly earned an MA in Health Administration and Policy from the University of Chicago and a BS from the Kelley School of Business at Indiana University. She also holds a Certification in Healthcare Compliance from the Healthcare Compliance Association.

Anthony Florio - Deputy Inspector General for Investigations

Tony joined OIG in March 2022 as the Deputy Inspector General for Investigations after having worked in the City of Chicago's Office of Inspector General 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 and administrative allegations. Tony is a licensed attorney, and is also a Certified Inspector General and a Certified Inspector General Investigator with the Association of Inspectors General.

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. Nathan is a Certified Inspector General with the Association of Inspectors General.

Isela Arellano - Chief Managed Care Program Integrity Officer

Isela initially joined OIG in February 2018 as Counsel to the Inspector General. Before working for OIG, Isela served as an Administrative Appeals Hearing Officer for the Departments of Healthcare and Family Services and Human Services. Isela has a long history in public interest law, having worked as an associate for a Wisconsin-based firm, championing the legal rights of workers, families, and labor unions prior to her time in public service. A graduate of the University of Wisconsin Law School, Isela is licensed to practice law in Wisconsin and Illinois. She is a Certified Inspector General Auditor with the Association of Inspectors General, and a Certified Coder with the American Association of Professional Coders.

Lisa Castillo - Bureau Chief, Bureau of Medicaid Integrity
Lisa oversees the daily operations of four distinct Medicaid compliance units in OIG consisting of Audits, Peer Review, Quality Control, and Long-Term Care Asset Discovery. Lisa also manages a breadth of complex external Medicaid audits including the UPIC and the RAC. Before becoming Bureau Chief, Lisa served in OIG's Office of Counsel to the Inspector General where she litigated administrative actions for recovery and terminations. Lisa has also served as an HFS Administrative Law Judge and a Cook County Assistant State's Attorney. Lisa earned her JD from the University of Illinois at Chicago and her Bachelor of Science from DePaul University. She obtained credentialing from the American Association of Professional Coders as a Certified Medical Coder and Certified Professional Medical Auditor. Lisa is a Certified Inspector General Auditor with the Association of Inspectors General.

Brian Bond - Chief, Bureau 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, 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 as the Department's State Purchasing Officer and in several leadership positions within the Department's Finance division. Brian is a Certified Inspector General Investigator with the Association of Inspectors General.

Wei-Shin Wang - Bureau Chief, Bureau of Fraud Science and Technology
Wei-Shin has worked in state government 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 FFS 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 Medicaid Transformation Grant. During that time, Wei-Shin successfully led a team to establish the comprehensive, online Dynamic Network Analysis system to monitor the services and payments for the state's Medicaid providers and recipients.

Steve Bandy - Assistant Bureau Chief, Bureau 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. 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 the 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 - Section Manager, 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 graduated from Illinois College with a Bachelor of Arts in Economics/Business Administration and Fine Art and 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. Missy is a Certified Inspector General Inspector/Evaluator with the Association of Inspectors General.

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 information technology consultant with the Illinois Department on Aging and OIG for three years. She worked for United Healthcare as a Senior SAS Programmer and UNIX administrator for three years before joining OIG.

Kimberly Herrington - Human Resources/Labor Relations Liaison
Kimberly joined OIG in September 2019, having previously 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 OIG staff related to human resources and labor relations.

OIG'S EXTERNAL PARTNERS

State

Medicaid Fraud Control Unit (MFCU) - Under federal law, states are required to operate a MFCU, which is tasked with investigating and prosecuting Medicaid provider fraud and abuse or neglect of residents in healthcare facilities. Illinois's MFCU is operated by the Office of the Illinois Attorney General. HFS OIG is statutorily mandated to report suspected Medicaid provider fraud to MFCU. HFS OIG and MFCU collaborate 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. HFS OIG and MFCU work together through both formal and informal communication to ensure that both administrative and criminal proceedings advance without conflict.

Illinois Department of Financial and Professional Responsibility (IDFPR) – Many providers enrolled in the Medicaid program work in professions licensed and regulated by IDFPR. To maintain Medicaid enrollment, providers must hold all required professional licenses in good standing. The suspension or termination of a professional license will result in HFS OIG pursuing a provider's termination from Medicaid. Due to the overlap in HFS OIG's oversight and IDFPR's regulatory jurisdiction, these entities work closely to ensure that their efforts are coordinated, and that each agency is aware of actions against common providers. HFS OIG and IDFPR share information through referrals, document requests, data sharing, and monthly meetings.

Illinois Department of Human Services (DHS) and Illinois Department on Aging (IDoA) – DHS and IDoA have been delegated the day-to-day operations for certain Illinois Medicaid waiver programs. Under this delegation, these agencies often receive information regarding potential fraud, waste, and abuse in their waiver programs. DHS and IDoA also maintain expertise on their waiver policies, their network of providers, and their client population. HFS OIG works closely with these 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 CMS CPI is to detect and combat fraud, waste, and abuse in the Medicare and Medicaid programs. Working alongside providers, states, and other stakeholders, CPI supports accurate enrollment and billing practices. HFS OIG's work with CPI includes participating in monthly Technical Advisory Group calls with other states to discuss topics including fraud schemes, provider enrollment, data analytics, and managed care. CPI staff also work with HFS OIG, other states' program integrity units, and UPIC to provide audit and investigation assistance.

Department of Health and Human Services Office of Inspector General (HHS OIG) – The HHS OIG fights fraud, waste, and abuse in Medicare, Medicaid, and other HHS programs. Because HHS OIG has jurisdiction over the federal Medicare program, it overlaps with HFS OIG's jurisdiction over the Illinois Medicaid program. If an HHS OIG investigation implicates Illinois Medicaid providers, HFS OIG may provide information or otherwise support the investigation. Additionally, when an HHS OIG investigation results in the federal exclusion of an Illinois Medicaid provider, HFS OIG takes reciprocal action to terminate that provider from the Illinois Medicaid program.

Department of Justice/Federal Bureau of Investigation/Drug Enforcement Administration – HFS OIG supports federal law enforcement agencies such as the Federal Bureau of Investigation (FBI), the Drug Enforcement Administration (DEA), and the U.S. Department of Justice in their Medicaid fraud investigations. HFS OIG serves as the primary liaison between these entities and the Illinois Medicaid program to coordinate data collection and policy research.

Contractors

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 FFS model. RAC audits identify overpayments and underpayments according to the State of Illinois plan. RAC overpayment determinations are referred to HFS OIG's collections unit or to OCIG for appealable issues.

Unified Program Integrity Contractor (UPIC) – UPIC is a no-cost resource to state Medicaid agencies established under the Federal Deficit Reduction Act. It authorizes external auditors to monitor and audit potentially fraudulent Medicaid claims as well as identify overpayments made to individuals or entities receiving federal funds. HFS OIG utilizes the UPIC auditor CoventBridge to conduct medical reviews, utilization reviews, and fraud inquiries. HFS OIG works with UPIC on its audits and acts in response to its findings, including issuing letters of education, recouping overpayments, and suspending or terminating providers.

Public-Private Partnerships

Healthcare Fraud Prevention Partnership (HFPP) – The 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 antifraud associations. HFS 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 Association for Medicaid Program Integrity (NAMPI) – NAMPI was formed over 35 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, trainings, and annual conferences, HFS OIG exchanges information on national trends and prevalent fraud schemes and provides staff with meaningful educational and training opportunities.

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

STAFFING AND PROFESSIONAL DEVELOPMENT

HFS OIG continues to undertake initiatives to foster the continuous growth and professional development of our staff.

HIRING AND STAFFING

Hiring and Staffing: In FY2025, HFS OIG welcomed 16 new hires and promoted 2 employees within the office. By the end of the fiscal year, HFS OIG's workforce totaled 145 staff members. This growth highlights our ongoing commitment to attracting top talent and strengthening our team's capacity to support program integrity efforts across the Illinois Medicaid program.

PROFESSIONAL DEVELOPMENT

Through targeted professional development, certification, and training initiatives, HFS OIG is committed to equipping its staff with the knowledge, skills, and tools necessary to excel in their roles and advance the agency's anti-fraud and program integrity mission. Notable professional development achievements in FY2025 include:

Certifications and Credentials: Many HFS OIG staff are members of the Association of Inspectors General (AIG), a national organization of state, local, and federal inspectors general and their employees. AIG offers training seminars and certification institutes for members. HFS OIG staff attained the following designations in FY2025:

- 8 Certified Inspector General Investigators
- 5 Certified Inspector General Auditors
- 2 Certified Inspector General Counsel

Through FY2025, 34 current HFS OIG staff in total have attained AIG certifications.

HFS OIG staff are encouraged to actively engage in cross-agency collaboration and participate in professional organizations to expand expertise, strengthen leadership skills, and mentor others in advancing program integrity. Investing in our staff enhances skill sets and directly assists with OIG related work product. In FY2025:

- The Chief of Staff and Complaint Intake Unit's Manager were accepted in the AIG Mentorship Pilot Program (to facilitate knowledge sharing and promote career development).
- A Bureau of Investigations (BOI) Supervisor was selected by Illinois Central Management Services (CMS) to participate in the 2025 cohort for the Governor's Office Academy of Leadership (G.O.A.L.), a prestigious program that advances public service leadership in IL.
- OIG was invited by HFPP to explore Partner Champion opportunities. During the initial design phase of an HFPP study, Partner Champion states collaborate with HFPP to provide input on data analysis, fraud scheme specifics, and Medicaid-related issues. OIG collaboration was highlighted in the HFPP article "Taking Advantage of HFPP Resources."

Teaching and Presentations: OIG's participation in national learning sessions continued in collaboration with state and national antifraud counterparts, such as NHCAA, IAMHP, NAMPI, HFPP, and the Medicaid Integrity Institute (MII). In FY2025, HFS OIG continued to focus on professional development opportunities by sending staff to a variety of in-person conferences, virtual events and training boot camps including:

- MII: Program Integrity in Medicaid Managed Care
- NAMPI Annual Conference, panel discussion "P.A.R.I.S.: Say Bonjour to Cost Savings!"
- DePaul Law JHLI Health Care Compliance Conference, presentation and panel discussion "Office of the Inspector General Fiscal Year Review"
- AIG Illinois Chapter Fall webinar, presentation and panel discussion "A Note from the Auditors: Front-Line Perspectives on IG Performance Auditing and Evaluations"
- NHCAA Annual Training Conference
- AIG Annual Training Conference
- AAPC Healthcon
- NHCAA Bootcamp
- OIG and RAC (HMS) hosted a virtual webinar for Illinois hospitals and the Illinois Hospital Association (IHA)

Internal Trainings: During this fiscal year, 192 educational training sessions were shared, up from 72 in FY2024, an increase of over 166%. This strategic investment in workforce development has resulted in measurable gains in operational efficiency and core skill advancement. These initiatives not only empower staff to perform their roles more effectively but also foster a culture of camaraderie, adaptability, and long-term success.

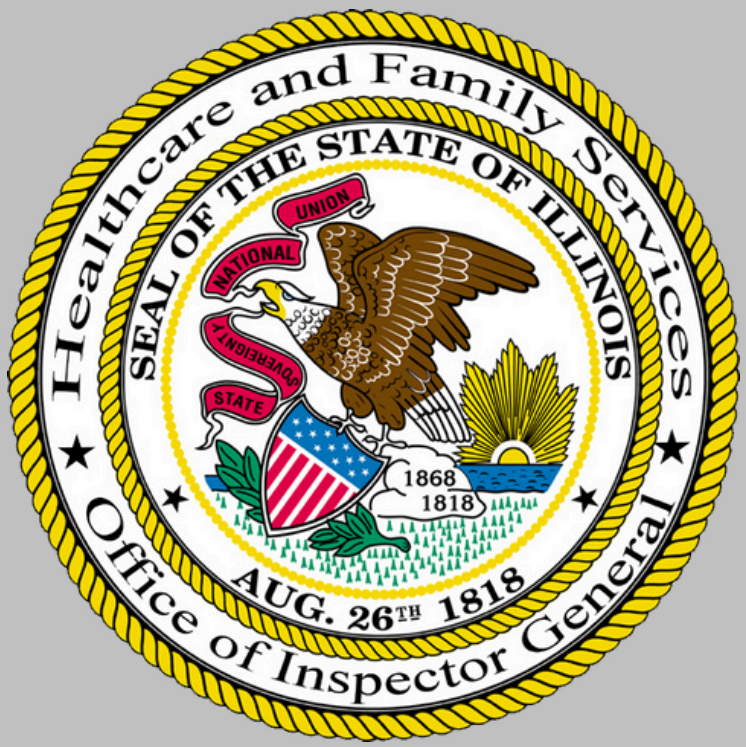
Internships: HFS OIG maintains its partnership with the University of Illinois Springfield's Graduate Public Service Internship (GPSI) Program, which connects graduate students with state agencies like HFS to offer hands-on experience in public service. At HFS OIG, each internship offers a distinct opportunity, with interns contributing to various bureaus and engaging in meaningful work that supports the agency's program integrity initiatives.

During FY2025, HFS OIG's nine interns worked on projects including social media content creation, development of a new MCO fraud reporting portal dashboard, social network and link analysis of specific fraud investigations, and provided valuable assistance in the LTC-ADI appeal hearing process.

Three interns assigned to BFST advanced the integration of Power BI dashboard technology into HFS OIG's existing inquiry online system. One PhD-level GPSI intern within MRA contributed to multiple high-impact initiatives, including creating a reverse geocoding model for BOI, developing a distance matrix tool using Google APIs in collaboration with BFST interns, and assisting with a new MCO Fraud Reporting Portal dashboard. This intern also was awarded the prestigious Brian T. Milbrandt Award, recognizing his outstanding academic and professional excellence in the GPSI program. In addition, GPSI interns assigned to BMI-Audit created new individualized audit plan documents, performed coding research, and conducted research for potential cost-saving changes documented in a draft whitepaper for management.

FY2025 marked OIG's fourth year participating in DePaul University's Jaharis Health Law Institute (JHLI) Summer Scholars Externship Program. JHLI connects first- and second-year law students with paid externships in health law agencies, offering hands-on experience, deeper legal skills, and valuable insight into public health policy. This year OIG welcomed two interns- one assigned to OCIG and the other to BMI.

Criminal Case Activity



CRIMINAL CASE ACTIVITY

HFS OIG investigations and audits can uncover alleged violations of state or federal criminal laws, which may be prosecuted by the U.S. Attorney's Office, the Office of the Illinois Attorney General, or various State's Attorney's offices throughout the State. The following table summarizes updates on criminal cases that arose from HFS OIG referrals to its law enforcement partners.[1]

OIG Case Number	Criminal Case	Summary	Status
1392853	*People v. Smith* DuPage County 23 CF 1682-01	Lateena Smith, a psychologist, was charged for submitting $2.46 million in false Medicaid claims for psychotherapy services she did not provide.	In August 2023, Smith was charged with 4 counts of theft, 1 count of managed health care fraud, and 1 count of forgery. In February 2025, Smith was sentenced following an agreed upon plea of guilty to Managed Health Care Fraud, a Class 2 Felony. The remaining counts of the indictment were nolle prosequi pursuant to the plea. Smith was sentenced to 3 years in the Illinois Department of Corrections and restitution in the amount of $2,247,647. A check for $1,506,662 was received by OIG at time of sentencing.
1370658	*People v. Sykes* Cook County 24 CR 01408 01	Monique Sykes, a Medicaid recipient, was charged with two counts of theft, one count of vendor fraud, and one count of forgery for submitting fraudulent timesheets and receiving a $4,710 overpayment.	Sykes was indicted in February 2024. Sykes plead guilty to Theft of Governmental Property in August 2024. Sykes was sentenced to 2 years Second Chance Probation, ordered to pay $1,000 restitution on date of plea, and restitution judgment order in the amount of $3,710 to DHS.

[1] Charges in indictments and criminal complaints are not evidence of guilt; defendants are presumed innocent and entitled to fair trials at which the government has the burden of proving guilt beyond a reasonable doubt.

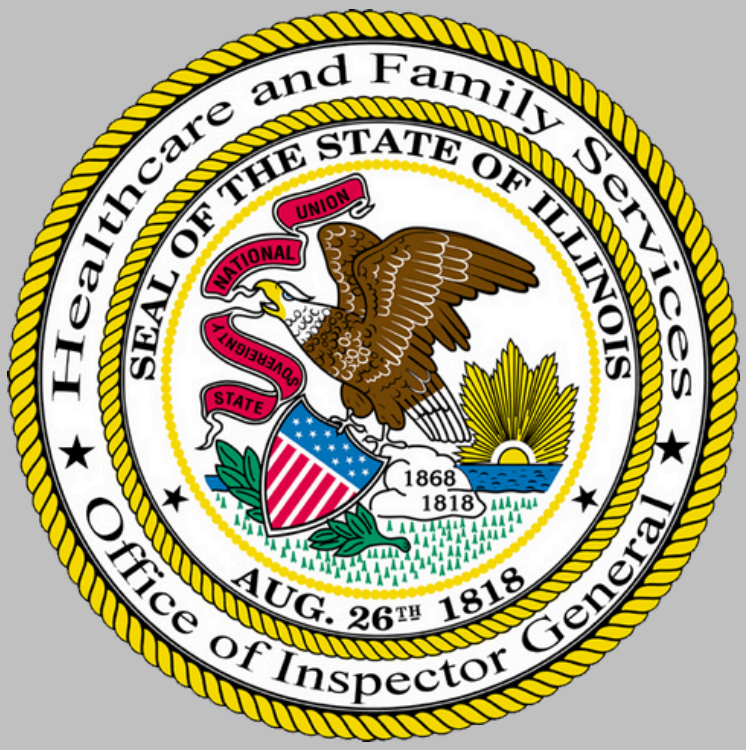
OIG Case Number	Criminal Case	Summary	Status
1400273	*People v. Carter* Cook County 24 CR 06203 01	Cynthia Carter, a home care aide with IDoA, was charged with billing over $10,000 in services while her client was inpatient and after the client was deceased.	Carter was indicted in June 2024 for Vendor fraud and two counts of theft. The case was continued until October 2025 for a status hearing.
1363001	*U.S. v. Ghosh* U.S. District Court, N.D. Ill. 23 CR 00140	Dr. Mona Ghosh was charged with 13 counts of healthcare fraud for submitting fraudulent claims for reimbursement for services that were not provided or for services that were not medically necessary.	Dr. Ghosh pleaded guilty in June 2024 to two counts of health care fraud, in violation of 18 U.S.C. § 1347. In June 2025, Ghosh was sentenced to 10 years imprisonment, ordered to pay restitution to insurance providers of $1.5 million, and ordered to pay restitution to victims in the amount of $605.[2]
1400277	*People v. Stewart* Cook County 24 CR 06418 01	Chelsea Stewart, a Homemaker for Urhai Community Services Center, was charged with one count of managed health care fraud and two counts of theft. Stewart submitted timesheets and clocked in when her client was admitted to an inpatient facility, resulting in an overpayment of over $10,000.	In July 2024, Stewart was indicted and charged with one count of managed health care fraud and two counts of theft. In January 2025, Stewart plead guilty to Theft and was sentenced to 24 months Felony Second Chance Probation and ordered restitution in the amount of $12,887. A check to OIG for $6,400 was remitted at time of sentencing.

[2]The judge explained that he could only impose restitution to patients based on actual losses for unnecessary and unwanted procedures under specific situations.

OIG Case Number	Criminal Case	Summary	Status
1250203	*People v. Stephen Akpan* Cook County 20 CR 0977201	Stephen Akpan, owner of a DME company known as Windy City Medical Supplies, allegedly billed for supplies recipients did not receive.	Akpan and Windy City Medical Supplies were charged with Vendor Fraud, Theft, and Forgery in October 2020. After a bench trial in July and August 2024, Akpan was found not guilty. The charges against Windy City Medical Supplies were dismissed as the company was dissolved.
1353998	*People v. Watson* Cook County 22 CR 13342 01	Easter Watson submitted over $240,000 in false Medicaid claims for psychotherapy services not rendered.	In May 2025, Watson pled guilty to managed health care fraud. Theft and forgery charges were *nolle prosequi*. Watson was sentenced to 60 days in jail, three years of probation, and ordered to pay restitution in the amount of $214,819.
1398381	*People v. Collier* Will County 2024 CF 1474 *People v. Tabb* Will County 2024 CF 1476	Johnny Collier, a DRS Personal Assistant, was paid over $10,000 for services allegedly not provided to Yohanna Tabb, a DRS recipient. Collier was residing in Texas; Tabb is a resident of Illinois.	Collier and Tabb were each indicted on 1 count Vendor Fraud, 2 counts Theft, 1 count Forgery in August 2024. In September 2025, both cases were continued to an undetermined date.
1373052	*People v. Jacobs* Cook County 24 CR 09011 01	Raheem Jacobs, a DRS Personal Assistant, submitted timesheets for services rendered while working for secondary employers and while residing out of state while the recipient resided in Illinois.	Jacobs was indicted for Vendor Fraud, Theft, and Forgery in September 2024. In April 2025, Jacobs plead guilty to theft, and the remaining counts were *nolle prosequi*. Jacobs was sentenced to 24 months Felony Second Chance probation and ordered to pay restitution in the amount of $9,307.

OIG Case Number	Criminal Case	Summary	Status
1405115	*People v. Thompson* Cook County 25 CR 02349 01	Phylicia Thompson, an Addus Healthcare Home Care Aide, submitted billing for dates of services after the recipient's date of death.	Thompson was indicted for Vendor Fraud, Theft, and Forgery in February 2025. Thompson did not appear at her March 2025 court date and a warrant was issued.
1398538	*People v. Brooks* Cook County 25 CR 02618 01	Melvin Brooks, a DRS Personal Assistant, submitted timesheets for services rendered while working secondary employment at an elementary school.	In February 2025, Brooks was indicted for Vendor Fraud, Theft, and Forgery. His next court date is September 2025.
1402345	*People v. Lynum* Sangamon County 2025-CF-842 *People v. Woods* Sangamon County 2025-CF-843	Kevin Lynum, a DRS recipient, and Xeana Woods (previously known as Sean Roberts) collected over $10,000 in payments for a provider who was not providing services to Lynum and did not sign up to be his PA.	In June 2025, Lynum and Woods were charged with identity theft, vendor fraud, theft, and forgery. Both have court dates scheduled in November 2025.
1396434	*People v. Geraline Williams* Cook County 25 CR 0122601	DRS Personal Assistant Geraline Williams allegedly billed for hours worked when her customer was hospitalized.	In January 2025, Williams was indicted with vendor fraud, two counts of theft, and forgery. Her next court date is in October 2025.

Bureau of Medicaid Integrity



BUREAU OF MEDICAID INTEGRITY (BMI)

AUDITS

BMI's Audit Section performs post-payment audits of Medicaid enrolled providers to ensure appropriate payments and to prevent and recover overpayments. The Audit Section approaches auditing using various audit methodologies, which are tailored to identify the risk of loss, based on changing trends. All enrolled providers are subject to audit. The selection of a provider for audit review is based on several factors, including, but not limited to data analysis, external complaints of potential fraud or improper billing, and provider risk scores and categories. Audits may use statistically valid random samples to allow its findings to be extrapolated. BMI audits hospitals, pharmacies, nursing homes, laboratories, physicians, transportation providers, and durable medical equipment (DME) suppliers. Where audits identify an irregularity in the billing practices of a provider, OIG may request that the provider conduct its own investigation and overpayment self-disclosure. Alternatively, an enrolled provider may also submit a self-disclosure based on findings identified pursuant to an internal investigation and review of the provider's billing practices.

The Audit Section has oversight responsibility for the Recovery Audit Contractor (RAC) and the Unified Program Integrity Contractor (UPIC). RAC reviews FFS paid claims for compliance with state rules and regulations. The UPIC conducts investigations and audits to reduce fraud, waste, and abuse in Medicaid programs. Audits conducted by BMI, RAC, and UPIC may result in the recoupment of identified overpayments, entry into a corporate integrity agreement, termination from Medicaid, or referral to MFCU for prosecution.

FY2025 AUDIT HIGHLIGHTS

In FY2025, BMI focused on continuing to improve effective audit outcomes, streamline audit processes, and decrease staff time spent on administrative tasks.

In-House Audits

Case Highlights: OIG issued the following audit reports in FY2025. These audits are for FFS claims only. Overpayments are based on direct Medicaid payments from HFS to the provider based on the fee schedule for the billed service on claims information. Provider types for this fiscal year consisted of Nursing Homes, DME, Physicians, and Pharmacies.

Audit Type	# of Audits	Overpayment total
Nursing Home	31	$836,983
DME	9	$3,537,039
Physician	3	$97,789
Pharmacy	2	$108,220
TOTAL	**45**	**$4,979,504**

Provider Self-disclosures: The federal Patient Protection and Affordable Care Act (ACA) require providers to timely identify and repay Medicaid overpayments. Under the ACA, providers are obligated to report, explain, and repay overpayments within sixty 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. In most circumstances, self-disclosure of overpayment will result in a better outcome for the provider than if OIG discovered the matter independently. In FY2025, there were 16 disclosures whereby OIG reviewed and accepted all 16. Highlights include a pharmacy vendor who repaid $3,107 when it was discovered that the pharmacist administered immunizations when they were not credentialed to do so and a vendor who repaid $58,082 upon discovery that they were paid at a rate that exceeded the contract rate.

Contractors

UPIC Program Improvements: UPIC, operating under a Joint Operating Agreement, works with both OIG and CMS to identify overpayments made to providers or entities receiving federal Medicaid funds and to determine if fraud, waste, or abuse occurred. For FY2025, BMI continued to enhance the process and relationship between OIG and Midwest UPIC contractor CoventBridge. Stronger communication, validation and vetting processes developed. CoventBridge provided proactive studies for OIG consideration. In addition to new studies started by UPIC, HFS OIG submitted two referrals that CoventBridge accepted.

UPIC Case Highlights: In FY2025, UPIC audited a variety of provider types, including DME companies, physicians, mental health providers, transportation companies, pharmacies, and hospitals. There was a collaborative effort between CoventBridge and BMI to establish audit criteria, tools, and supporting citations to enable CoventBridge to initiate pharmacy script audits for HFS. As a result of this collaboration, CoventBridge conducted regular pharmacy audits. Case Highlights include:

- Youthcare MCO Inpatient Psychiatric Audit: (Case No. 1439404). CoventBridge conducted a proactive data analysis to identify outliers in inpatient psychiatric claims for juvenile recipients (under 18 years of age). The audit review period covered dates of service from January 1, 2018, through March 31, 2022, and included both HFS FFS and YouthCare MCO claims. The audit resulted in minimal findings for FFS claims and identified MCO overpayment of $303,315 for YouthCare. These findings were forwarded to the YouthCare MCO for recovery.

RAC Program Highlights: The Medicaid RAC program was implemented pursuant to section 6411(a) of the Affordable Care Act, which amended and expanded section 1902(a)42 of the Social Security Act (the Act) to require States to establish Medicaid RAC programs by December 31, 2010. The final rule for Medicaid RAC was effective January 1, 2012, with States being required to fully implement RAC programs by April 1, 2011.[3] Health Management Systems, Inc. ("HMS"), a Gainwell Technology Corp., is the Illinois Medicaid RAC contracted by HFS OIG to conduct post-payment audits of vendors enrolled in the Illinois Medical Program.

FY2025 was the second year of implementation under a new contract. HMS performs two complex audit scenarios—Diagnosis Related Groups audits and Place of Service audits. Both complex audit scenarios involve an individual review of the medical record or other documentation submitted by the provider in support of the claim.

> Diagnosis Related Groups (DRG) – HMS audits DRG codes related to a medical procedure. The RAC performs a comprehensive medical coding review pursuant to Current Procedure Terminology (CPT) codes in effect at the time of service of all DRG coding claims for which an improper payment is identified. DRG audit findings contested by a provider are subject to clinical review by a contract physician.
>
> Place of Service Review (POS) – Medical records are closely examined by nurses and physicians in a post-payment review to ensure that claims for treatment furnished to an Illinois Medicaid Program recipient by an enrolled provider meet the Department's utilization review requirements for payment. Specifically, the audit determines whether services furnished on an inpatient basis could have been effectively furnished more economically in a setting other than inpatient.

HMS also added seven automated concepts. Automated concepts identify improper payments through verification of claim data elements against Illinois Medicaid Policies and rules.

[3] *See* final rule at: https://www.govinfo.gov/content/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

At the start of the fiscal year, HMS conducted a targeted outreach to providers. They began with email outreach to providers who had outstanding medical record requests. A total of 24,370 medical record requests were issued to providers. The response rate was exceptional, with 23,894 records received, reflecting a 99% compliance rate. According to HMS, Illinois had the lowest "Technical Denial" (audit findings based upon missing records) rate among all states they operate in. Following this, a total of 24,370 claims were selected and reviewed during the reporting period.

A high volume of claims were also identified whereby the provider failed to provide a request for dispute review (internal HMS review process of initial audit findings). A total of 218 claims were identified as having bypassed this initial step. BMI, in collaboration with HMS, conducted provider outreach to these providers. As a result of targeted follow up, there are only 58 remaining. Outreach to providers continued with a virtual presentation by HMS and OIG staff to the Illinois Hospital Association. The stakeholder engagement presentation included 135 attendees. Key takeaways related to improving communication on audit findings and promoting transparency in claims processing.

Overall, the data in FY2025 compared to prior years suggests a positive shift in Medicaid billing practices. The reduction in the number of providers audited and audit findings points to enhanced compliance, likely driven by improved training, system upgrades, and policy refinements. The increase in audit volume paired with fewer findings underscores the effectiveness of these improvements.

- **Complex Scenarios-** The data highlights key trends in provider compliance, audit volume, and outcomes, offering insights into the effectiveness of Medicaid billing practices particularly in the use of POS and DRG codes.
- **Decrease in Audited Providers**: FY2025 saw a reduction in the number of providers audited (193 vs. 198 in FY2024), suggesting improved accuracy in coding and billing practices.
- **Increase in Audit Volume**: Medical records requested rose by 4,409. Medical records received increased by 4,097. This reflects a more robust audit process and possibly broader audit coverage.
- **Improved Compliance Outcomes**: Records with findings decreased by 564, indicating fewer billing discrepancies. Records with no findings increased by 4,442, an improvement, reinforcing the trend toward better documentation and coding accuracy.

FY2025 AUDIT STATISTICS

In-House Audits

Initiated: 34
Completed: 45
Total Overpayments Identified: $4,979,511

Contractor Audits

RAC Complex Concepts (Place of Service and DRG)

Audits Initiated: 24,370
Total Findings: 9,123
Total Overpayments Identified: $76,002,661

RAC Automated Concepts

Total Findings:10,053
Total Overpayments Identified: $763,156

UPIC

Audits Initiated: 21
Audits Completed: 10
Total Overpayments Identified: $306,017

Self-Disclosure

Total number of self-disclosures reported and accepted: 16
Total overpayments identified: $74,832

PEER REVIEW

The Peer Review Unit (PRU) consists of nurses and physician consultants 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 (the medical care or lack thereof presents potential harm to the patient), excess of needs (medically unnecessary or excessive care), and grossly inferior quality of care (care that is below the minimum standards necessary to treat a patient). PRU cases originate from hotline complaints, referrals from internal units and/or external agencies such as IDFPR, IDPH, the Illinois State Police, or MCOs.

PRU's 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 physician consultants perform in-depth record reviews to determine if documentation meets acceptable quality guidelines and was medically necessary. When minor concerns are noted during this review process, OIG 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 includes 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.

In addition to reviewing complaint referrals, the nurse analysts frequently conduct joint interviews with BOI investigators to obtain additional clinical information needed to fully evaluate the referral and make clinical recommendations. 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.

FY2025 PEER REVIEW HIGHLIGHTS

Interagency Collaboration (Case No. 1421439): MFCU requested PRU's clinical expertise to review medical records on a case involving a deceased Medicaid recipient. The purpose of the review was to assess whether the patient's death was a direct result of caregiver neglect or abuse. Two nurse analysts spent several months reviewing voluminous medical records and photographs from multiple providers involved in the patient's care (physicians, several hospitals, home health agencies, wound care specialists and clinics, Adult Protective Services, EMS and coroner reports). The analysis identified significant concerns regarding the accuracy, consistency, and reliability of documentation across the continuum of care. Inconsistencies and conflicting reports regarding the patient's overall medical status and the quality of care delivered by both medical and non-medical providers were noted. The nurses opined that the death could not be attributed to the primary caregiver's care, or lack thereof.

Follow Up Reviews (Case Nos. 1177789, 1195263, 1190943, 1195267, 1196334): PRU conducted five subsequent reviews of providers who had previously received a Letter of Concern (LOC). A LOC identifies treatment concerns with the provider's care and recommends changes to come into compliance with HFS policies and appropriate standards of care. In some instances, OIG's medical consultants also recommend a subsequent review of the provider's care to assess compliance with prior recommendations. For each subsequent review, patient records were selected based on prior findings and were evaluated to assess compliance with recommendations and to determine the overall quality of care provided. From the subsequent reviews:

- Three providers demonstrated compliance with recommendations and rendered care that was found to be adequate and consistent with current standards. Each received a Letter of No Concern.
- Two providers showed substantial improvement in the quality of care provided. However, minor documentation issues were identified, and each received a Letter of Education to address these opportunities for improvement.

Special Projects: HFS Bureau of Professional and Ancillary Services (BPAS) requested assistance with a federally mandated compliance check on telehealth claims. BPAS sent 140 requests for records to providers. BPAS was unable to obtain records for 57. PRU was tasked with confirming accurate contact information and sending the records request letters and attestations to the providers who did not respond to the initial request. PRU confirmed payee information by searching the claim, running queries on the rendering and billing provider, and contacting the billing provider for accurate contact information. PRU successfully obtained records for 44 of the 57 cases.

FY2025 PEER REVIEW STATISTICS

Cases Reviewed: 27

Quality-of-Care reviews: 27
Reinstatement reviews: 0

Case Review Outcomes

Quality-of-Care reviews outcomes
- Letter of Concern: 1
- Letter of education: 2
- Audit referral: 2
- Letter of no concerns: 12
- Allegations unsubstantiated: 10

Reinstatements approved: 0

Recipient Verification Program

Letters mailed: 6,000
Responses received: 312
Services reported as received: 245
Services reported as not received: 0
Referrals to regional offices: 417

QUALITY CONTROL

Quality Control Review (QC) oversees the federally mandated Payment Error Rate Measurement (PERM) program and Medicaid Eligibility Quality Control (MEQC) review. In addition, QC conducts Independent Reviews of eligibility determinations and special projects designed to better identify error-prone medical eligibility factors, evaluate the effectiveness of eligibility policies and procedures when compared to federal regulations, and develop strategies to reduce medical eligibility errors across the state.

The PERM program, conducted every three years, measures improper payments in Medicaid and CHIP and produces error rates for each program. The intended effects of PERM are to identify errors and target corrective actions; reduce the rate of improper payments; and increase program savings at both state and federal levels. As part of the corrective action, states are required to return the federal share of overpayments and pursue recoveries according to law and regulation. QC conducts the eligibility reviews for MEQC and aids the coordination for PERM between the federal contractors and the state. QC is responsible for the coordination of the completion of questionnaires, data forms, contractor systems access, and identification of the universe of claims for federally contracted auditors.

The MEQC program focuses on improving the quality and accuracy of Illinois' Medicaid and Children's Health Insurance Program (CHIP) eligibility determinations through triennial reviews covering a span of one calendar year. 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.

In addition, Quality Control conducts internal audit projects aimed at further identifying issues related to potential fraud, waste, and abuse in error-prone areas. These projects are usually determined based on MEQC and PERM findings.

FY2025 QUALITY CONTROL HIGHLIGHTS

State errors reversed after dispute resolution (Case No. 1429179): During a PERM audit, CMS cited an eligibility case for failure to conduct the required 60-month lookback on a long-term care medical assistance application (ER2: documentation not done/collected at time of determination). The overpayment amount was $3,947 and the potential federal repayment was $2,016. The error was overturned after documentation was submitted confirming that HFS properly reviewed the lookback period, and the eligibility determination was correctly processed.

Projected cost avoidance of $17,028 for canceled benefits due to unverified Illinois residency of this beneficiary (Case No. 1411721): During a review for the Illinois Residency Review project, QC requested documentation of a beneficiary's current residency using possible addresses obtained through IES, CLEAR, and the PARIS Federal Interstate Match Report. The beneficiary did not respond to any requests. Because Illinois residency was unable to be verified, QC requested termination of medical benefits for the period of July 2024 through June 2025 (the end of beneficiary's current certification period).

Corrective Action Plan (CAP) Development: QC coordinates the development and monitoring of corrective action plans designed to eliminate or reduce errors utilizing various methods including training, system programming, and policy changes. A summary of the CAP highlights for Reporting Year (RY) 2022 and 2025 are as follows:

RY2022 for payments made beginning July 1, 2022, through June 30, 2023: This CAP addressed eligibility errors only. Illinois was required to complete bimonthly reports on the status of RY2022 corrective action implementations due to a continued error rate over the 3% federal threshold. QC has regularly submitted responses to CMS ahead of the due date for these reports. In FY2025, six bimonthly reports were submitted to CMS and accepted.

RY2025 for payments made beginning July 1, 2023, through June 30, 2024: This CAP addressed all three review type errors of eligibility, medical records, and data processing.

- Eligibility: QC collected and analyzed claims found to be in error and created a CAP proposal for HFS review. QC continues to work with HFS to finalize the PERM RY2025 CAP with a target submission of February 2026.
- Medical Records: Errors cited in Medical Records reviews were analyzed and the root cause for each was determined. A CAP has been agreed upon across several state agencies/departments. Most corrective actions are in the implementation process ahead of the required CAP submission due in February 2026.

- Data Processing: These errors were reviewed, and the root cause was identified throughout the review phase. At the conclusion of reviews, the corrective action necessary to address each error was determined and agreed upon across multiple state agencies and departments.

Highlight PERM Medical Records Overpayment Recoveries: QC identified Medicaid providers from the RY2022 and RY2025 PERM cycle whose failure to provide sufficient medical records for review led to overpayments that were now subject to recoupment.

Highlight MEQC RY2023: QC regularly monitored the status of one corrective action from the MEQC RY2023 CAP that was not yet implemented at the start of FY2025. The corrective action has now been implemented and the CAP was resolved in August 2024.

Illinois Residency Reviews: QC restructured residency reviews to access additional data sources and coordinate findings with other states when there is overlapping Medicaid eligibility.

FY2025 QUALITY CONTROL STATISTICS

Illinois residency reviews: 519

Unable to verify residency: 504
Verified residency: 15
Cost avoidance based on verifications: $1,696,276

PERM Medical Record Reviews: 926

Correct: 915
Error: 11

PERM Eligibility Reviews: 1629

Correct: 1542
Error: 87

PERM Data Processing Reviews: 1105

Correct: 1097
Error: 8

MEQC RY2026 Reviews (for cases processed as of 6/30/25): 174

Correct (closed): 139
Error (in payment review): 13
Technical Deficiency (closed): 21
Error and Technical Deficiency (in payment review): 1

LONG-TERM CARE – ASSET DISCOVERY INITIATIVE

The Long-Term Care – Asset Discovery Initiative Unit (LTC-ADI) conducts reviews of long-term-care applications with indications of the transfer or non-disclosure of assets. Undisclosed assets are resources not reported during the application process for long-term care services through the Medicaid program. If LTC-ADI identifies undisclosed resources, the applicant must spenddown those resources prior to Medicaid's payment for services. Transfers of assets for less than fair market value result in penalty periods during which the recipient is ineligible to receive long-term care services. LTC-ADI reviews applicants' financial documents, trusts, and other legal records 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 do not have the means to pay for their own care. Adverse determinations may be appealed in an administrative hearing. LTC-ADI provides expert testimony in appeals involving excess resources, penalties, denial of applications, and cancellation of ongoing eligibility. Most appeals are withdrawn by the client due to verifications received or adjustments executed. For those appeals that result in a hearing, the final determination is implemented by the local DHS Family Community Resource Center.

FY2025 LTC-ADI HIGHLIGHTS

Community Spousal Support Cases: Over recent years, an increasing number of long-term care applicants were submitting formal notices that their spouse living in the community was refusing to support them and assigning their support to the State. This meant that the spouse's resources could not be considered in determining the applicant's eligibility. HFS's recourse to these refusals under the law is to seek a spousal support order, a process that previously had not been implemented. Pursuant to 305 ILCS 55-4(b) and 89 Ill. Admin. Code 120.379, in May 2024, LTC-ADI in cooperation with OCIG began issuing support orders to community spouses, who had refused support. In FY2025, 31 support orders were issued with a total collection of $1,828,924. In addition to the funds received, some were resolved due to sufficient proof that resources had been depleted, and others were sent to collections. Since the implementation of spousal support orders, the submission of new spousal refusal notices has slowed significantly.

Undisclosed funds in annuities of $99,319 were discovered (Case Nos. 1444778 & 1444782): A husband and wife applied for long-term care services simultaneously. In these cases, the analysts discovered each having funds in annuity accounts. Both applications were denied after failure to comply with a request for information.

Multiple resources transferred to the daughter, resulting in $242,369 penalty (Case No. 1410069): An LTC-ADI analyst discovered multiple unreported financial assets, including several bank accounts, a safe deposit box, and a trust. The applicant's daughter used the applicant's debit card for personal expenditures and conducted Google Wallet transfers exceeding $100,000. Additionally, the daughter sold several pieces of jewelry from the safe deposit box for $25,000 without remitting the proceeds to the applicant. Further investigation revealed the closure of a certificate of deposit (CD), with the destination of the withdrawn funds remaining unknown. Funds were also gifted directly to the daughter as part of Medicaid planning efforts.

Life estate with excess resources of $2,643,327 applied toward cost of care (Case No. 1411997): LTC-ADI discovered that the applicant had been reinstated full ownership of a primary residence and 180 acres of farmland after a prior transfer to her children. The applicant was also conferred full ownership after their spouse passed away prior to the five-year Medicaid lookback period.

Disposal of resources led to a $342,327 sanction (Case No. 1438036): Although the applicant claimed not to have resources and reported no transfers in the past 60 months, LTC-ADI discovered she purposefully transferred funds to her children because she "wanted her sons to have the money." Transfers included $352,000 in investment accounts and $73,000 in real estate.

Couple divorces to qualify for Medicaid resulting in $125,570 penalty (Case No. 1414379): The applicant was in a LTC facility paying solely from his own resources. When those resources neared depletion, the applicant and their community spouse divorced, with marital resources in excess of $250,000, all which would be subject to a spenddown if married. The applicant was unrepresented in the divorce, and the decree awarded all resources to the community spouse. The applicant then applied for benefits. As a result, it was determined that the divorce was not fair or equitable, was done in an attempt to qualify for benefits, and was subject to a penalty on 50% of resources.

Unsubstantiated caregiving services, unreported property transfer, and missing funds lead to $160,068 penalty (Case No. 1415841): The applicant failed to report several transfers including payments to various family members for caregiving and other services with no proof of service delivery. The applicant's funds were also used to pay family members' credit card payments with no evidence the credit card purchases were used for the applicant's benefit. The applicant retained a life estate in real property that was liquidated during the five-year lookback period and did not receive the funds.

Transfer of property and funds result in $102,108 penalty and$83,668 spenddown (Case No. 1433852): The applicant only reported assets in a bank account, yet LTC-ADI discovered they owned four properties and oil rights. Three properties were valued at $92,916. The applicant transferred the fourth property to a family member with no compensation. The applicant's ex-spouse also transferred monies to themselves from the applicant's bank accounts.

Discovery of missing funds, accounts, and valuables lead to a $654,106 spenddown and $337,704 penalty (Case No.1419361): The applicant had unreported assets including bank accounts worth $90,204, investment and retirement accounts worth $202,431, and a valuables collection worth $504,222. The applicant sold real property during the five-year lookback period for $337,704 with an unknown destination of funds.

FY2025 LTC-ADI STATISTICS

Applications Reviewed: 2,413

LTC-ADI Recommendations on Applications Reviewed

Penalty and spenddown: 175
Penalty/no spenddown: 425
Spenddown/no penalty: 193
No penalty/no spenddown: 346
Denied: 1227
Withdrawn: 47
Rejected[4]: 183

Cost Savings From LTC-ADI Reviews

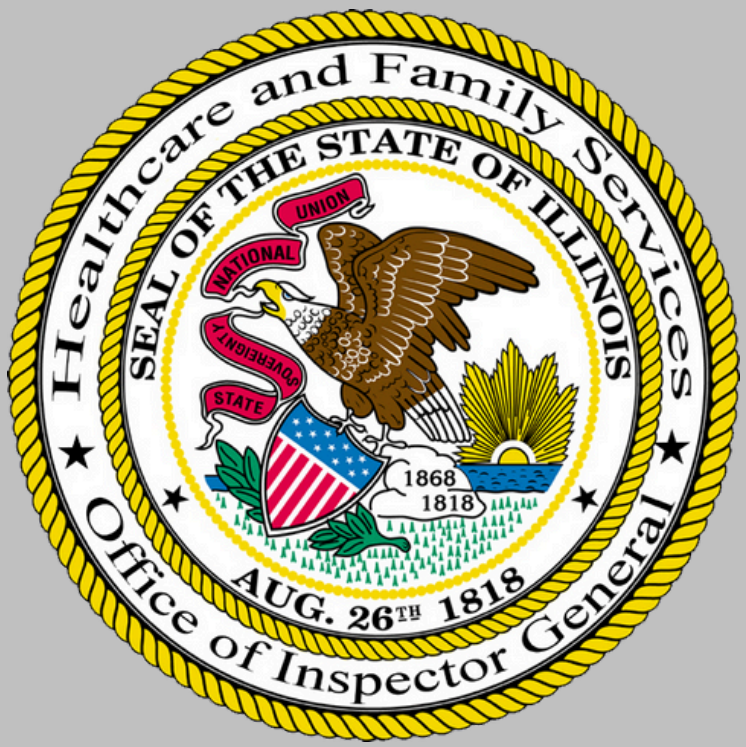
Value of unallowable transfers (penalties): $43,778,505
Value of excess resources (spenddowns): $27,797,338
Cost Avoidance (withdrawn application after review): $ 47,875,550

Spousal Support Orders

Value of Orders: $2,313,660
Collections on Orders: $1,828,924

[4] Application rejections occur if the client is deceased at the time of review.

Bureau of Investigations



BUREAU OF INVESTIGATIONS (BOI)

COMPLAINT INTAKE UNIT

BOI's Complaint Intake Unit (CIU) serves as the central intake unit for HFS OIG. CIU processes referrals and complaints received from MCOs, local DHS offices, members of the public, and other stakeholders alleging fraud, waste, and abuse by providers and recipients of Medicaid services and other government benefit programs. Referrals or complaints are received via phone hotline and online portals, as well as through direct communication with state and federal agencies and law enforcement entities.

CIU conducts thorough research on fraud, waste, and abuse allegations by reviewing internal Medicaid data and by accessing databases from a variety of sources, including, but not limited to open sources, DHS, the Illinois Secretary of State, IDPH, the Illinois Department of Employment Security, and HFS's Division of Child Support Services. HFS OIG then determines what further action to take on the allegation(s) in the referral or complaint based on factors and criteria such as OIG's jurisdiction and resources, financial loss amount, and quality of care/patient harm.

FY2025 CIU STATISTICS

Complaints Received: 1,966

Fraud Hotline: 237
MCO Fraud Reporting Referrals: 598
OIG Website: 928
Other (email, mail, fax): 203

Complaints Closed on Initial Review[5]: 483

Beneficiary: 218
Provider: 265

Complaints Accepted for Further Review[6]: 1,483

Beneficiary: 691
Provider: 792

[5] Complaints closed on initial review include matters that are duplicative, unintelligible, misdirected, or unrelated to OIG's jurisdiction.
[6] Some complaints reviewed in FY2025 were received in FY2024.

Provider Complaint Dispositions: 833

Opened: 293

Investigations: 204
Audits: 21
Peer Review and Provider Analysis: 14
FAE criminal referral: 12
OCIG Termination/Exclusion: 39
MCO Audit/Investigation: 3

Referred or declined[7]: 540

Beneficiary Complaint Dispositions: 662

Unfounded[8]: 573
Investigation Opened: 32
Referred to BMI LTC-ADI: 4
Referred to External Partners: 53

INVESTIGATIONS

BOI's Investigations Section conducts investigations into fraud, waste, and abuse in programs administered by HFS, DHS, and IDoA. BOI is divided into four regional units – Southern, Central, Northern, and Cook County. In its investigations, BOI may work with the Illinois MFCU, state and federal prosecutors, members of the law enforcement community, and other state and federal regulatory agencies. As the result of BOI's founded investigation into a provider, HFS OIG may refer the matter for criminal prosecution or seek administrative sanctions through OCIG. BOI also continues to investigate recipients alleged to have engaged in eligibility fraud or abuse of their benefits from Medicaid, TANF, or the Childcare Assistance Program. These investigations may result in the identification of overpayments, termination of benefits, or prosecution by state and federal agencies.

[7] Complaints are referred when OIG lacks jurisdiction, or another agency is better situated to investigate the matter. HFS OIG refers complaints to sister agencies like DHS and the IDoA, the MCOs, and other agencies as appropriate. Complaints are declined when, after OIG's review and assessment of the allegations, the complaint is found to be duplicative, no violation occurred or was *de minimis,* or factually does not warrant further investigation.

[8] Beneficiary fraud complaints are unfounded when, after CIU's review, OIG is unable to substantiate the allegation.

FY2025 INVESTIGATIONS HIGHLIGHTS

Medicaid Provider Cases

Department on Aging Home Care Aide billed while residing out of state (Case No. 1389205): An investigation established that a home care aide was living in Florida while continuing to get paid for providing services to the customer who resided in Illinois. BOI obtained Florida apartment leases and other records establishing the home care aide's Florida residency from approximately September 2019 through June 2022. The home care aide earned an estimated overpayment of $33,747. This case was referred to MFCU in April 2025 and accepted for investigation.

"Pop-up" Covid 19 testing lab suspected of false billing (Case No. 1410485): In early 2024, BOI received MCO referrals regarding an independent laboratory suspected of submitting fraudulent Medicaid claims for COVID-19 testing services that were not rendered. The lab was flagged as a potential "pop-up" provider, having begun billing Medicaid for COVID-19 in late 2022. Concerns were raised by SIUs following multiple complaints indicating that the lab was billing for tests that were never performed. OIG conducted an analysis of claims submitted through February 2025, identifying red flags including high-frequency billing, same-day billing patterns, and significant geographic distance between patients and the lab. Data analytics were used to identify members with unusual billing activity, which informed outreach efforts and patient identification. Surveillance was also conducted as part of the investigation. The total estimated amount billed was $2,545,478. The case was referred to MFCU and accepted in April 2025.

Anonymous tip leads to criminal referral of School Nurse (Case No. 1409849): In January 2024, HFS OIG received an anonymous allegation from HHS OIG. The complaint alleged that a school nurse was simultaneously providing care to a child enrolled in the DSCC program under the Medically Fragile, Technology Dependent (MFTD) waiver and billing Medicaid for one-on-one nursing services during the school hours. An OIG investigation found that from at least October 2021 to January 2025, the nurse was potentially paid by two separate entities – the public school and a home health agency – for the same services provided to the same patient. Medicaid program rules prohibit reimbursing for services already being provided by a school during instructional hours. The investigation identified an overpayment of nearly $48,525. The case was referred to MFCU and accepted in April 2025.

Department on Aging audit identifies inpatient billing by Home Care Aide (Case No. 1404950): An OIG investigation was initiated after a routine annual review by IDoA of its waiver program identified a home care aide employed by a home health provider allegedly fraudulently submitted claims for Community Care Program (CCP) services on behalf of a participant while the participant was living in a long-term care facility. Further investigation revealed that the home care aide allegedly forged documents, including the participant's signature, who is blind and unable to sign for himself. Between March 2022 and October 2022, the homecare aide billed for 175 days of services resulting in $11,225 in improper payments for services not rendered. In October 2024, OIG referred this case to MFCU. The Department on Aging is expected to recoup $8,848 in overpayments from the provider agency. The employee was terminated after the agency learned of the improper payments.

Additional OIG investigative work results in criminal referral of previously declined DRS case (Case No. 1351779): In December 2019, DRS made a direct referral to MFCU alleging that an Individual Provider (IP) was billing for hours while she was residing in another state. In June 2020, MFCU closed the case without prosecution and referred it back to DRS. OIG then opened its own investigation into the matter. OIG obtained employment and State of Wisconsin benefits records that revealed that the IP used several addresses of residency in WI from 2019 through 2024. Wisconsin benefit records revealed that the IP received SNAP/food stamp benefits in Wisconsin from August 2018 through June 2022. Additional evidence OIG obtained reflected that the IP was employed as a full-time employee in the State of Wisconsin from June 2022 through October 2024. Meanwhile, the DRS recipient resided in the south Chicago suburbs. Comptroller records show that the IP received payment in the amount of $64,785 for services from June 2022 through October 2024. Armed with this new information, OIG credibly alleged that the IP was paid for HSP services that she did not provide. The case was referred back to MFCU for consideration for criminal prosecution in May 2025 and was accepted.

DRS Individual Provider billed for HSP services while the customer was out of the country (Case No. 1410901): In December 2023, OIG received a referral from an unknown individual alleging that an IP was falsifying her timesheets by indicating she was providing care for the client, her uncle, when he was in Mexico. As a result of the referral, OIG opened an investigation into the matter. A review of U.S. Custom and Border Protection (CBP) Border Crossing Reports confirmed the times and dates that the DRS customer traveled to and from Mexico. There was no record of the IP ever leaving the country or going to Mexico. These documents were compared with DRS timesheets the IP submitted for the year of 2023, and WebCM payments. The evidence revealed that from August 2021 through April 2024, the IP falsely claimed she provided services on approximately 198 days, for a total of 1,218 hours, when the client was out of the country in Mexico, which resulted in an overpayment of $20,572. This case was referred to MFCU and accepted for consideration for criminal prosecution in January 2025.

DRS Individual Provider billed while customer was incarcerated (Case No. 1415273): In April 2024, OIG received a referral from an unknown individual alleging that an IP was falsifying her timesheets by indicating she was proving services for the client while he was incarcerated. As a result of the referral, OIG open an investigation into the matter. A review of the Illinois Department of Correction and Cook County Department of Correction records revealed that the DRS customer was incarcerated from June 2023 through September 2024. DRS records revealed that the IP submitted time sheets and clocked in daily, claiming to have worked 2,606 hours providing services to the client during the time he was incarcerated, which resulted in in overpayment of $46,408. This case was referred to MFCU for consideration for criminal prosecution and accepted in February 2025.

Identity theft scheme results in DRS customer being criminally charged as part of National Health Care Fraud Takedown (Case No. 1402345): A completed investigation involving a DRS customer revealed that the customer stole an identity and used it to falsely submit an application as an IP to provide HSP services to the customer. The false information submitted by the customer caused the paychecks for the purported IP to be mailed to the customer's address for services that never were provided. An overpayment of services was established totaling $28,783 from December 2021 through December 2022. This case was referred to MFCU. This case was included as part of a National Health Care Fraud Takedown. On June 30, 2025, the customer was charged with identity theft, vendor fraud, theft, and forgery. The case remains pending in criminal court.

Transportation provider's false claims result in criminal referral and payment suspension (Case No. 1424510): An investigation found that the owner of a transportation company allegedly submitted false billing to the Medicaid program. OIG's analysis of records determined that between January 2022 and October 2024, nearly 4 out of every 5 of the billed trips were potentially fraudulent and had no corresponding medical documentation or appointment. The highest number of false claims involved trips allegedly provided to the transportation company's owner's parents. The total overpayment was $208,424. The case was referred to MFCU in May 2025 and a payment suspension was placed on the provider in June 2025.

Trips to Nowhere (Case Nos. 1417068, 1415681, 1447582, 1415277, 1416107, 1447581, 1416932, 1416286, 1416844, 1415687, and 1415290): An SIU identified a fraud scheme involving gas mileage reimbursement for private auto transportation for medical appointments that never occurred and brought this matter to the attention of OIG. After review of transportation broker data, OIG identified numerous Illinois Medicaid Recipients and family members with familial and other connections who allegedly conspired to obtain gas mileage reimbursement payments from the transportation broker that never occurred. By exploiting loose controls, the fraudsters were able to generate approximately 5,626 trips for medical appointments from August 2022 through March 2025 that never occurred. This resulted in an approximate overpayment of over $475,000. This scheme identified 11 payees' using 54 assumed aliases and 87 Payee ID's who were paid for 78 Illinois Medicaid recipients. In June 025, MFCU accepted this case as a criminal referral.

Mother of child allegedly received kickbacks from nurse who was billing for services not rendered (Case No. 1411904): In March 2025, OIG completed an investigation on a registered nurse employed by a home health agency to provide in-home care for a child as a part of the MFTD Medicaid waiver program. OIG's investigation found that the nurse was working secondary employment at a hospital during times that she had reported to the home health agency that she was providing in-home nursing services to the child. Moreover, bank records obtained by OIG showed regular transfers of money from the nurse to the mother of the child. The transfers corresponded in time to wages the nurse was paid from the home health agency. OIG found the agency was paid approximately $173,636 in misspent Medicaid dollars for the services the nurse reported she provided for the client that allegedly did not occur. The case was referred to MFCU and accepted in March 2025.

DRS Individual Provider billed while incarcerated (Case No. 1411508): In December 2024, an investigation was completed on a DRS IP. OIG's investigation revealed that the IP was incarcerated during times that she reported providing HSP services to her customer. Additionally, it was found that the IP was assisted in the scheme by the customer and the customer's mother. OIG's investigation included obtaining phone recordings from the jail in which the IP, the customer, and the customer's mother discuss the scheme to defraud the HSP. OIG found the IP was paid approximately $25,202 in misspent Medicaid dollars. In January 2025, MFCU accepted the case.

Individual Provider is indicted by local State's Attorney Office for State Benefits Fraud and Forgery (Case No. 1399922): In September 2024, OIG completed an investigation on a DRS IP. OIG's investigation revealed that the IP allegedly misrepresented her daughter's medical condition in order to qualify for HSP services. The IP also allegedly billed for HSP services that were not rendered due to overlapping secondary employment. The investigation also determined that, from May 2023 through July 2023, the IP was suspended due to overtime violations. During this time, the back-up IP, who was the IP's father, billed as if he was providing HSP services to the customer. However, when interviewed by OIG, the father denied providing the services or signing the HSP timesheets. When the father received his DRS paycheck for back-up IP services, he would sign the check, cash it, and then give the IP the money. The back-up IP provided no HSP services. OIG estimated that the IP was paid approximately $58,008 in misspent Medicaid dollars. In November 2024, the IP was indicted for State Benefits Fraud and Forgery by the Union County State's Attorney's Office.

DRS Individual Provider is indicted for Vendor Fraud based on secondary employment (Case No. 1423681): During an investigation, OIG determined that an IP submitted claims for HSP services that were not provided. OIG obtained evidence that the IP worked secondary employment at a restaurant while billing for HSP services. OIG calculated approximately 493 hours of secondary employment that conflicted with the IP's HSP hours resulting in a fraudulent payment of approximately $8,625. In February 2025, MFCU accepted the case for criminal prosecution and in July 2025, the IP was charged with Vendor Fraud, two counts of Theft, and Forgery.

Client Eligibility Cases

OIG investigation into customer eligibility for HSP services results in referral for possible civil prosecution (Case No. 1404624): In its investigation of a DRS customer, OIG found that the customer was receiving DRS Personal Assistant services from his mother and sister; however, he was not eligible for services because his assets exceeded the limit for the program. The customer had significant financial assets that were not disclosed as part of his eligibility determination; including an annuity from a large legal settlement and real estate. The customer's IPs were paid approximately $131,365 in Medicaid funds for which the customer was not eligible. The case was referred to MFCU in December 2024 where it is under review for potential civil recovery.

Mother did not report spouse/father of her three children as being in the home or his income (Case No. 1367046): An investigation found that the recipient improperly received SNAP and Medicaid benefits for herself and her three children from January 2014 through October 2022 and May 2023 through September 2023. The investigation determined that the recipient had not reported her spouse/father of her three children was residing in the residence, their joint assets (real estate, autos and bank account) and their employment income. OIG submitted the results of its investigation to the DHS local office with an estimated overpayment of $39,795.

Mother failed to report marriage and cohabitation with children's father resulting in Childcare Assistance Program overpayment (Case No. 1403651): In June 2023, OIG received a referral alleging that a recipient misrepresented her household composition to obtain state benefits. The referral stated that the recipient had been claiming to be a single mother when, in fact, she had been married for the past seven years. OIG determined that the subjects were married and resided together while the recipient received assistance from the DHS Bureau of Childcare. Based on the recipient's failure to disclose truthful information about her family composition, OIG established a $35,687 overpayment for childcare assistance, covering the period from July 2021 through April 2023. OIG referred the case in October 2024 to DHS. The recipient has appealed the overpayment determination.

FY2025 INVESTIGATIONS STATISTICS

Outcomes of Investigations Completed

- Provider Cases: 226
  - Medicaid Cases: 220
    - Substantiated: 103
      - Referred to MFCU: 64
      - Referred to OCIG: 31
      - Referred to BMI: 1
      - Referred to Prosecution: 1
      - Referred to Other State Agencies 6
    - Substantiated/Financial Loss Threshold Not Met: 6
    - Unsubstantiated: 111
  - Childcare Cases: 6
    - Substantiated: 3
      - Referred to Law Enforcement/Prosecuting Authority: 3
    - Unsubstantiated: 3

- Beneficiary Cases: 58
  - Medicaid Cases: 52
    - Substantiated: 42
    - Unsubstantiated: 10
  - Childcare Cases: 6
    - Substantiated: 2
      - Referred to Law Enforcement/Prosecuting Authority: 1
      - Referred to DHS: 1
    - Unsubstantiated: 4

- Established Provider Overpayments: $55,782,979

- Established Client Overpayments: $316,930
  - Childcare program cases: $191,065[9]
  - SNAP overpayments: $125,865

Open Investigations at Close of FY2025

- Provider Cases: 174
  - Medicaid cases: 154
  - Childcare cases: 20
- Beneficiary Cases: 19
  - Medicaid cases: 14
  - Childcare cases: 5

[9] This is the amount of childcare overpayments that DHS processed this fiscal year as a result of OIG fraud referrals for childcare providers and recipients. The total includes OIG cases that were referred in the previous fiscal year.

FRAUD ABUSE EXECUTIVE

The Fraud Abuse Executive (FAE) coordinates communication between HFS OIG and law enforcement entities and collaborates with the MCOs on data requests for criminal and civil investigations. Specifically, FAE coordinates the referral of substantiated BOI provider investigations to MFCU or other prosecutorial agencies. FAE responds to law enforcement data requests and assists with the review and approval of global settlement agreements generated by the National Association of Attorneys General, HHS OIG, and the Department of Justice. HFS OIG supports federal law enforcement and oversight counterparts including HHS OIG, CMS, FBI, U.S. Attorney's Offices, and the National Association of Medicaid Fraud Control Units. 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 audit reviews, PRU reviews, and administrative sanctions, including payment suspensions, overpayment recoupments, and termination from the Illinois Medicaid program.

FY2025 FAE STATISTICS

Referrals to MFCU[10]: 82

Accepted: 80
Not accepted: 2

Responses to Requests for Information: 176

Law enforcement data requests: 106
Law enforcement information requests: 70

[10] FAE refers some cases to MFCU directly without BOI's involvement. These can be cases where the MCO SIU has already developed evidence of the fraud or if the matter is related to an ongoing MFCU case.

NEW PROVIDER VERIFICATION AND MONITORING

The New Provider Verification (NPV) Unit reviews new applications, application modifications, and revalidations for all high-risk Medicaid providers, including transportation, durable medical equipment (DME), pharmacy with DME, and home health providers, as well as providers of concern due to past convictions or sanctions. NPV reviews applicant information, such as background checks, licenses, insurance, and corporate records. Based on NPV's findings, OIG determines whether to grant or deny an applicant's enrollment.

NPV also monitors new providers that are designated as high risk for fraud (based on provider type) for one year after enrollment. Provider billing activities and claims are analyzed several times during a provider's conditional enrollment, and the NPV analyst contacts the provider to offer guidance and answer questions they may have regarding serving as a Medicaid provider. If no concerns are identified after a year of monitoring, the provider becomes a fully enrolled Medicaid provider. If problems are identified, OIG may decide to extend the provider's conditional enrollment or to disenroll the provider.

FY2025 NPV HIGHLIGHTS

NPV Identifies Forged Insurance Record (Case No. 1429059): On September 10, 2024, Provider Enrollment Services referred a transportation provider ("Transportation Co. A") and its owner for OIG to review. With their enrollment application the provider submitted a proof of insurance. Transportation Co. A's proof of insurance appeared to be modified, and the covered entity was not correctly centered on the form. NPV collaborated with the National Insurance Crime Bureau to verify whether the provider was covered by this insurance policy. Results reflected that the insurance policy number was for a different company, Transportation Co. B. The insurance company associated with this policy indicated that Transportation Co. A. falsified their insurance coverage and issued a cease-and-desist notice. Based on this, OIG denied the enrollment. The owner of Transportation Co. A also had another transportation company currently enrolled, Transportation Co. C. Transportation Co. C was also referred to OCIG for termination due to the false insurance documentation that was supplied with Transportation Co. A's enrollment application. Upon further review of Transportation Co. B, it was discovered that the owner is the mother of the owner of Transportation Co. A. As a result of this one false document three separate reviews and investigations were initiated. Transportation Cos. A has appealed its enrollment denial. Transportation Co. B has been identified for substantial compliance issues and NPV will continue to monitor it throughout the year to ensure they stay in compliance.

FY2025 NPV STATISTICS

Provider Enrollment Referrals Received: 2,369

- New applications opened: 663
- Modifications opened: 742
- Re-enrollments/reinstatements opened: 14
- Revalidations: 950

Applications Reviewed and Outcomes[11]: 2,394

- New applications: 689
  - Approved: 599
  - Denied: 40
  - Withdrawn: 0
  - Returned to DRS/PES: 50
- Modifications: 749
  - Approved: 713
  - Denied: 8
  - Withdrawn: 0
  - Returned to PES: 28
- Re-enrollments/Reinstatements/Revalidations: 956
  - Approved: 915
  - Denied: 8
  - Withdrawn: 2
  - Returned to PES: 31

Applications/Modifications Pending: 76

On-Site Reviews Performed: 444

Providers Monitored

- Monitoring term ended: 161
  - Enrolled: 158
  - Disenrolled: 3
- Monitoring term ongoing at end of FY2025: 292

[11] Some applicants reviewed in FY2025 were received in FY2024.

PROVIDER ANALYSIS UNIT (PAU) / RECIPIENT ANALYSIS UNIT (RAU)

The Provider Analysis Unit consists of analysts with clinical expertise who review provider claims and records for indications of fraud, waste, or abuse. The PAU analysts conduct in-depth reviews of billing records to determine if claims and services are appropriate. They investigate external and internal referrals by reviewing billing patterns, research aberrant billing practices, determine business inter-relationships, and collaborate in active investigations. Upon completion, the analysts share their findings with other OIG components such as CIU, BOI investigators, and OCIG attorneys. Analyst findings assist in deciding 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.

RAU is composed of analysts, with the oversight of medical consultants. RAU manages 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, ensuring the recipient receives coordination of all medical and pharmaceutical services (including referrals to specialists). 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" program, is designed to promote optimal recipient safety through care coordination. Recipients who may benefit from lock-ins are identified based on risk criteria programmed into OIG's selection algorithm and from external complaints received by OIG.

FY2025 PAU HIGHLIGHTS

Internal Referral Process Development: PAU now plays a crucial role in the initial review of potential internal leads for provider fraud, waste, abuse. PAU will review known national fraud schemes for Illinois billing outliers. Once PAU obtains and reviews billing data, it can send any providers with aberrant findings to Complaint Intake for determination on whether to open a case. To better process these internal referrals, PAU can enter referrals into OIG's complaint portal creating a centralized entry point and ensuring accurate processing.

PAU case assistance: To continue to maximize PAU's clinical expertise, a formal process was developed for PAU analysts to assist multiple areas of OIG during investigations. This process allows an OIG case to be forwarded to a specific PAU analyst to research, review, and document work as a consultant.

Provider sentenced for Medicaid fraud (Case No. 1353998): In 2021, a PAU analyst reviewed Medicaid provider Dr. Easter Watson as an outlier for billing of services and uncovered potential fraudulent billings. These findings and the analyst's report were communicated to OCIG and were subsequently used in charging Dr. Watson. In May 2025, Dr. Watson plead guilty to Illinois Medicaid fraud for billing for services not rendered. She was sentenced to 60 days in the department of corrections, 3 years of felony probation and ordered to pay HFS $214,819.

FY2025 PAU STATISTICS

Complaint Intake Referrals Researched and Presented: 257

Case Consultations Provided: 14
HFPP Review: 2
BOI Assistance: 12

Presentations for Interdisciplinary Committee[12]: 4

Legacy Cases Completed: 3
Presented to Provider Review Committee[13]: 2
Closed no further action: 1

Case Open at End of FY2025: 1

FY2025 RAU HIGHLIGHTS

Criteria Revision and Improvement: The Recipient Analysis Unit saw continued evaluation and analysis of the selection list criteria to maximize accuracy and efficiency of the cases reviewed. In addition, a new internal referral process was developed so that patterns of potential provider fraud, waste, or abuse identified within Recipient Analysis Unit are reviewed in Complaint Intake. Conversely, external recipient referrals received by Complaint Intake now have a pathway to be reviewed by the Recipient Analysis Unit.

Recipient on Restriction Charged (Case No. 1437322): After RAU placed recipient Latresha M. Brooks on a dual restriction for excessive use of Medicaid benefits, they were later indicted for diverting their prescriptions of hydrocodone and tramadol. The recipient was charged with unlawful acquisition and possession of controlled substances.

[12] The Interdisciplinary Committee is comprised of BOI and BMI and reviews complicated cases that might have overlapping audit and investigation tracks.
[13] The Provider Review Committee is comprised of representatives from different components of OIG. The committee reviews provider conduct and makes decisions whether to take actions such as educate, peer review, audit, investigate, or terminate.

FY2025 RAU STATISTICS

Cases Completed: 1650

MCO: 930

Recommended Restriction: 108

No Recommended Restriction: 822

FFS: 537

Restriction: 8

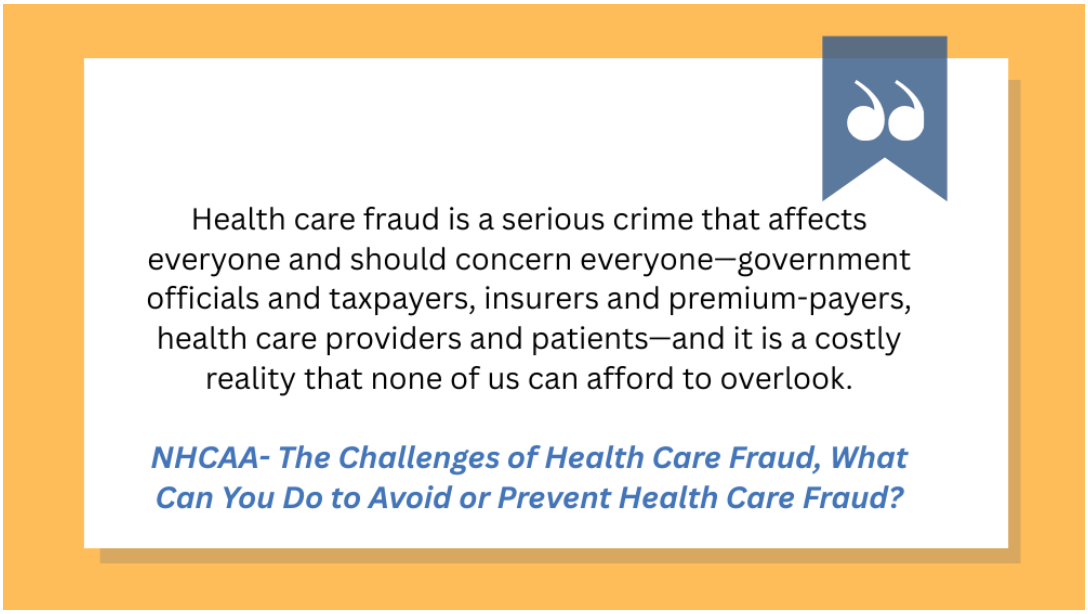
No restriction: 529

Deceased/Eligibility Canceled/TPL[14]: 183

MCO Restrictions[15]: 1451

Cost Avoidance[16]

MCO: $ 11,787,265

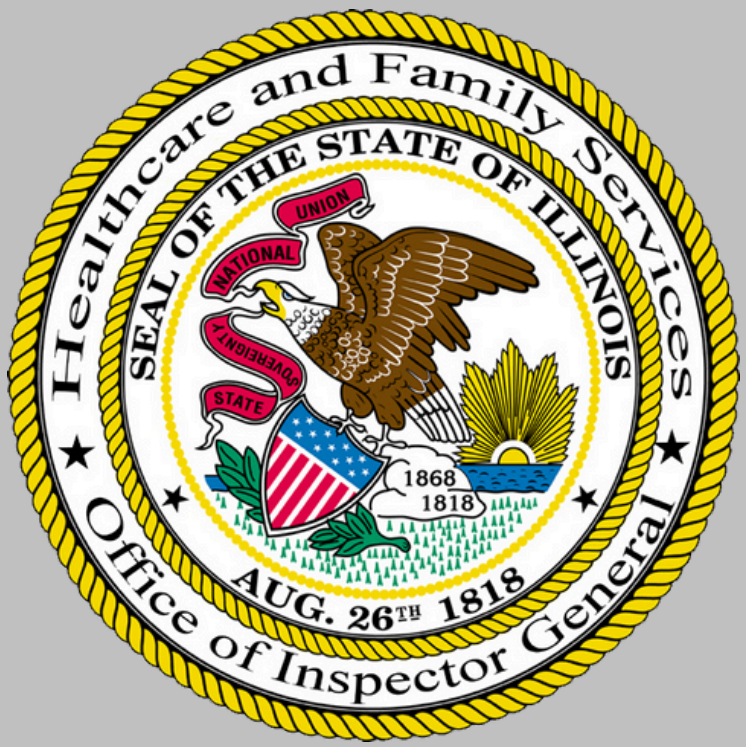


[14] In these situations, there is nothing for PAU to enforce or recommend due to the type of insurance category. This means a recipient's primary insurance is through either Medicare or a Private Insurance Plan and Medicaid is the Secondary payer. Recipients are exempt from RRP. PAU has no way to evaluate all claims, recommend and enforce a restriction as the claims are first paid through the TPL.

[15] MCO Restrictions is an unduplicated count of beneficiaries restricted by MCOs and includes a) any beneficiaries newly restricted during the fiscal year, and b) any beneficiaries whose restriction continued into the fiscal year.

[16] Cost Avoidance is an estimation of prevented expenditures based on past reimbursed services for the restricted beneficiaries. Restricted beneficiaries not receiving past reimbursed services are not included in the Cost Avoidance calculation.

Bureau of Internal Affairs



BUREAU OF INTERNAL AFFAIRS (BIA)

BIA investigates allegations of misconduct by HFS and IDoA employees, contractors, and vendors. BIA gathers facts by interviewing witnesses and subjects, conducting surveillance, and reviewing documents. At the conclusion of BIA's investigative activities, BIA prepares a report with findings for the appropriate Department's division administrators.

FY2025 BIA HIGHLIGHTS

Former HFS Employee Violated the Illinois Procurement Code (Case No. 1442561): In February 2025, BIA received a referral from the Office of Executive Inspector General (OEIG) alleging that HFS's former Agency Procurement Officer (APO) violated the Illinois Procurement Code by not seeking or receiving Illinois Independent Chief Procurement Office-General Services (CPO-GS), State Purchasing Officer (SPO) approval when he made several changes to an HFS contract. BIA reviewed the two contracts executed by the vendor in July 2023 and September 2023 and confirmed changes were made to the original document dated in July 2023 after it had been reviewed and approved by the SPO. The unapproved contract with the former APO's changes was subsequently sent to vendor and was executed. The changes made by the former APO granted the vendor terms that were not in the SPO approved contract. These unauthorized changes placed HFS at potential liability if the vendor claimed additional lines items that were not initially awarded/approved but were subsequently added. When interviewed, the former APO didn't recall information related to his actions involving the contracts and would not provide an explanation as to why he made the changes or failed to seek approval from the CPO-GS SPO as required by agency policy and state law. Based on the evidence identified and the testimony of the witnesses involved, BIA found evidence that the former APO violated the Illinois Procurement Code, the Illinois Admin. Code and HFS policy. Because the APO was no longer employed by HFS, BIA referred the matter back to the OEIG for further action.

FY2025 BIA STATISTICS

Total Cases Opened: 105

Total Cases Completed: 98

Findings in Misconduct Investigations

Substantiated: 1
Unsubstantiated: 16
Administratively closed[17]: 1
Declined: 21
Referred: 59

Outcomes in Substantiated Investigations

Pending: 1
Resignations/terminations: 0
Suspensions: 0

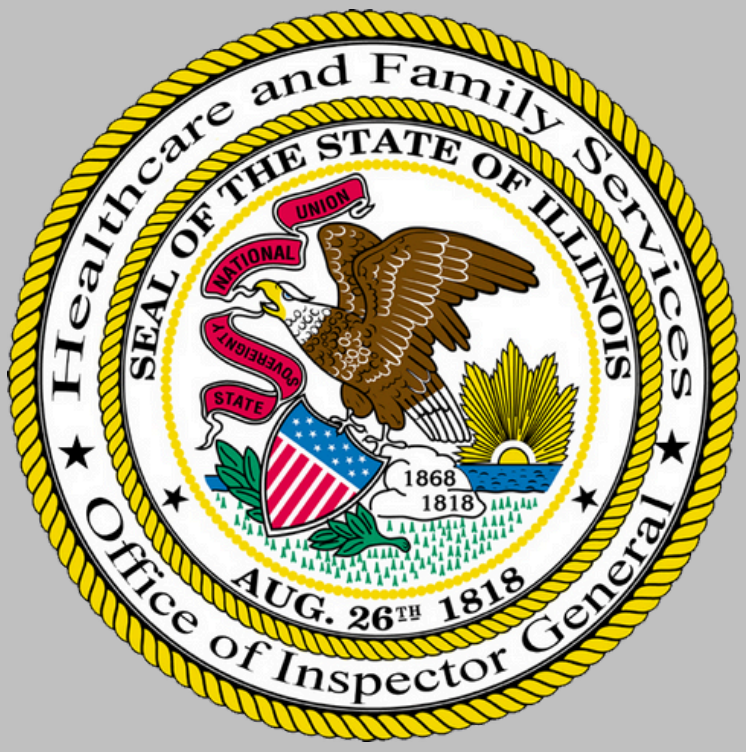
Regarding the February 5, 2025 sentencing of LaTeena Smith, of Bolingbrook, Illinois, for defrauding the state of Medicaid funds. Smith was sentenced to three years in prison and ordered to pay over $2.2 million in restitution to the state, $1.5 million of which she paid after being sentenced. The investigation was conducted by MFCU with HHS OIG, HFS OIG and ISP.

This sentence is thanks to the effective, collaborative efforts with our law enforcement partners to safeguard public healthcare funds. Fraudulent Medicaid claims undermine the program, and recovering this money is critical to protecting the program's integrity.

Elizabeth Whitehorn, Director, HFS

[17]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 handled by another entity, the matter was consolidated with another investigation or, in rare circumstances, BIA determined that further action was unwarranted.

Office of Counsel to the Inspector General



OFFICE OF COUNSEL TO THE INSPECTOR GENERAL (OCIG)

OIG attorneys in the Office of Counsel to the Inspector General (OCIG) have many responsibilities, including providing legal support to OIG bureaus, units, and internal committees; analyzing legislation that impacts OIG and HFS; administering OIG's responses to Freedom of Information Act (FOIA) requests and subpoenas; and coordinating with the HFS Office of General Counsel during external litigation matters. OCIG's primary responsibilities, however, lay with its representation of HFS before the department's administrative tribunal during actions brought against enrolled providers and non-enrolled individuals associated with providers. Those actions generally take three forms: (1) actions by which HFS seeks to impose punitive sanctions against individuals and corporate entities that, OIG determined, have engaged in fraud or misconduct; (2) actions by which HFS seeks to recover overpayments of Medicaid funds from enrolled providers, as identified by OIG or external auditors; and (3) actions taken to defend HFS's decisions to deny applications for enrollment as Medicaid providers or payment for medical-transportation services.

Any individual or entity subject to an administrative action brought by OCIG is generally afforded the right to an evidentiary hearing before the HFS administrative tribunal, and the assertion of that right initiates what can be protracted litigation. On the other hand, the failure to request an evidentiary hearing or otherwise advance a defense before the tribunal results in a default judgment in favor of HFS. Except where otherwise noted, litigation in each of the cases discussed below resulted in such default judgments, as ordered by the HFS Director through final administrative decisions.

FY2025 OCIG HIGHLIGHTS

OCIG Initiates Largest Number of Administrative Actions in Six Years. This fiscal year, OCIG attorneys filed 229 actions with the HFS administrative tribunal, an increase of nearly 50% over the 154 cases that the bureau brought in FY2024. The 229 actions are also the most initiated since FY2019, falling short of that fiscal year's total of 233 by only four. Even more, the significant jump represents a 194% increase over the nadir of that six-year period, which occurred in FY2021 when only 78 actions were filed due, in part, to statewide work slowdowns related to the Covid-19 pandemic.

The marked increase in the number of administrative actions filed is all the more notable when it is considered in the context of the entirety of OCIG's work throughout FY2025. As detailed below, OCIG imposed 31 payment withholds against providers where credible evidence or allegations showed that they had engaged in fraud — a 121% increase over FY2024. And, as touched upon in the following highlight, OCIG attorneys submitted ten briefs in highly contentious and complicated matters that include issues of first impression that directly impact OIG and the Illinois Medicaid Program, alike.

OCIG Attorneys Play Integral Role in Defending OIG's Initiative to Collect Unpaid Spousal Support for Long-Term Care Recipients: Throughout FY2025, OCIG attorneys prevailed in multiple matters before the DHS administrative tribunal that tested the ability of OIG to recover financial support that spouses of Medicaid applicants owe to those applicants. As highlighted in this report's earlier section presenting the work of BMI, beginning in May 2024, that bureau's Long-Term Care Asset-Discovery Initiative took steps to address Medicaid applicants' increasing use of an estate-planning tool known as "spousal refusal" to obtain full Medicaid coverage for long-term care with little to no financial contribution to that care. When relying on spousal refusal, an applicant's spouse affirms that he or she refuses to commit his or her portion of the marriage's community assets to support the applicant, which he or she would have otherwise been obligated to do under Illinois law. The disavowal of that support then decreases the applicant's assets below the upper asset threshold for Medicaid coverage, thereby allowing the applicant to receive full coverage for his or her care regardless of the refusing-spouse's ability to provide support.

However, Illinois law provides that, in instances where a spouse refuses to support an applicant, the applicant automatically assigns to the State of Illinois his or her right to seek that refused support. As such, the State may recover directly from the refusing-spouse the amount of support owed, including costs associated with the applicant's long-term care. OIG, therefore, now issues orders to refusing-spouses that require them to pay to HFS the amount of financial support that they were liable to provide to applicants so as to ensure that the spouse and applicant, together, properly contribute to the cost of the applicant's care.

In seven instances, the spouses to whom OIG issued orders sought appeals before the DHS administrative tribunal, advancing complicated and novel legal arguments to challenge the office's legal authority to recover owed spousal support. And in each of the appeals — where a collective approximate total of $740,000 of support was at issue — OCIG attorneys obtained either favorable settlements or decisions from the tribunal, confirming that Illinois law authorizes OIG to collect support owed by refusing-spouses. Nevertheless, one spouse asked the Illinois Circuit Court of Cook County to review the DHS tribunal's ruling against her; that matter is now pending.

Generally, the Office of the Illinois Attorney General (OAG) represents State agencies in matters litigated in circuit courts. But because the spouse's appeal presented sophisticated legal questions of first impression, OAG took the rare step to appoint OCIG attorneys as Special Assistant Attorneys General to tap their expertise when defending the DHS tribunal's decision. The Circuit Court is expected to issue its decision in FY2026, and that decision will play a large role in shaping OIG's continued efforts to collect owed spousal support to defray Medicaid expenditures related to long-term care.

After a Full Evidentiary Hearing, OCIG Secures an Important Victory in a Termination and Recovery Action Against a Medical Transportation Provider: In September 2024, the HFS Director issued a final administrative decision ***In re PAL Transportation, Inc.*** **(Case No. 1183706)**, finding that OCIG had successfully proven that medical-transportation provider PAL Transportation had defrauded the Illinois Medicaid Program of approximately $147,000. The Director also agreed with OCIG that the company's enrollment as a Medicaid provider should be terminated for engaging in the fraudulent scheme and that its president, Martha Anderson, should be barred from the program for her role in the wrongdoing. The decision concluded a highly contested administrative action that took nearly eight years to reach a final resolution.

PAL Transportation's prohibited billing practices were identified by a comprehensive BMI two year audit of the company's billing records, which identified three categories of discrepant billing claims submitted for payment: (1) claims for purported transportation of Medicaid recipients who were, in fact, receiving inpatient care at the time; (2) duplicate claims for the same services; and (3) claims based on loaded mileage, which inflated the amount that HFS ultimately paid the company.[18] The audit also found that PAL Transportation had failed to maintain complete and correct records detailing transportation services, in violation of Illinois law. Based on these findings, the audit concluded that PAL Transportation defrauded the Medicaid program of $146,982 and that Ms. Anderson, in turn, oversaw the scheme. OCIG subsequently took administrative action to recover the identified audit amount, seek the termination of PAL Transportation's Medicaid enrollment, and bar Ms. Anderson from the program. The case culminated in a three-day evidentiary hearing where OCIG attorneys introduced extensive documentary evidence and the testimony of several members of OIG staff, including the BFST Bureau Chief, Fiscal Manager, and BMI audit supervisor.

In December 2023, the administrative tribunal released a 44-page recommended decision recommended that HFS be allowed to recover the full amount identified by the BMI audit, terminate PAL Transportation's Medicaid enrollment, and bar Ms. Anderson from the program — a recommendation that the HFS Director adopted in its entirety the following September, over the company's extensive objections. PAL Transportation declined to challenge the Director's final administrative decision before the Illinois Circuit Court of Cook County, bringing the long-running matter to a close.

[18] Billing by using loaded mileage artificially inflates the miles driven by a medical-transportation provider when transporting more than one Medicaid recipient simultaneously. Instead of billing for the mileage of one trip, as HFS regulations require, the provider will claim that the recipients were each transported that distance separately. For instance, a properly submitted claim for a ten-mile joint trip for recipients A and B will reflect only the ten miles driven. But if the provider were to bill by using loaded mileage, it would claim that recipients A and recipient B were each transported ten miles separately, resulting in a false total of 20 miles driven.

ACTIONS SEEKING PUNITIVE SANCTIONS CONCLUDED IN FY2025

Investigations undertaken by BOI and OIG's investigative partners often uncover evidence that individuals and corporate entities enrolled in the Illinois Medicaid Program as providers violated Illinois law and HFS regulations. In such cases, OCIG is empowered to seek the imposition of punitive sanctions against those individuals and entities, including: (1) the termination of the providers' Medicaid enrollment; (2) the barrment of appropriate personnel related to terminated corporate providers; and (3) the revocation of corporate entities' eligibility to act as terminated providers' billing payees. OCIG is also authorized to bring actions to exclude non-enrolled individuals who are determined to have been involved in fraud or misconduct in connection with the Program from the class of individuals who may provide care to Medicaid recipients.

Most administrative actions brought by OCIG seek the imposition of punitive sanctions. In FY2025, those actions fell into nine categories:

(1) Terminations of enrolled providers, and exclusions of non-enrolled employees of Medicaid-enrolled entities, who received Medicaid-paid wages for services not rendered
(2) Terminations of medical professionals whose professional licenses to practice in Illinois were suspended, revoked, or otherwise terminated
(3) Terminations of providers who have criminal records that include disqualifying criminal convictions
(4) Terminations of providers who failed to satisfy debts owed to HFS
(5) Terminations of providers who were sanctioned by other state or federal healthcare programs
(6) Terminations for fraud or misconduct where recoveries of Medicaid funds were also appropriate
(7) Terminations of corporate providers or revocations of billing payees where management-group members were previously sanctioned by healthcare programs or committed crimes
(8) Terminations of long-term or intermediate-care facilities when HHS, CMS, or IDPH revokes certifications to operate
(9) Summary terminations of providers who breached corporate integrity agreements or settlement agreements, as well as providers whom HHS excluded from Medicare or any other state healthcare program

Terminations and Exclusions of Individuals Who Received Medicaid-Paid Wages for Services Not Rendered

A significant portion of OCIG's termination and exclusion actions focus on individuals who directly or indirectly bill the Illinois Medicaid Program for services that they did not, in fact, perform. Although such actions are not limited to any one type of provider, a disproportionate number are those who provide personal-assistance care to homebound Medicaid recipients as (1) Medicaid-enrolled providers who render care through the DHS Home Services Program or the DHS Division of Developmental Disabilities; or (2) non-enrolled caregivers employed by privately owned, and Medicaid-enrolled, homemaker agencies that provide Medicaid-covered in-home personal care. 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, but for the Personal Assistants' ability to provide care. Because Personal Assistants serve a vulnerable population, OIG is particularly vigilant when identifying and investigating potential instances of fraud or misconduct, including where the Personal Assistants commit billing fraud by submitting timesheets that falsely reflect that they provided services that were not rendered.

OIG and DHS often refer incidents of billing fraud to law enforcement for potential criminal prosecution. But in instances where law enforcement declines to prosecute, OCIG may initiate administrative actions to terminate the offending individuals' enrollment as Medicaid providers or exclude them from participating in the Program as care-rendering providers. In FY2025, OCIG successfully sought such terminations and exclusions in 23 matters where individuals were found to have engaged in billing fraud. That fraud, in turn, resulted in providers and non-enrolled employees fraudulently obtaining a total of $265,077 in Medicaid-paid wages, which are now subject to recovery though additional legal action.

Although Personal Assistants who engage in billing fraud employ a variety of schemes, the patterns of misconduct largely fall into two categories: secondary-employment fraud and inpatient fraud. Personal Assistants also occasionally employ other, less common ploys when attempting to defraud the Program, as summarized below.

SECONDARY-EMPLOYMENT FRAUD

First, Personal Assistants will purport to have rendered services at times when they were instead working elsewhere, what is known as "secondary-employment fraud." Twelve actions resolved in FY2025 resulted in termination of enrolled Personal Assistants who were found to have engaged in secondary-employment fraud. The following three cases are notable because of the high dollar amounts at issue and the Personal Assistants' secondary employment was with governmental entities or companies in positions of public trust:

***In re Floyd Batteast* (Case No. 1348516):** Floyd Batteast fraudulently obtained $36,638 in Program funds by billing for personal-assistance services that he falsely claimed to have provided from August 2018 through January 2020, when he was instead working at General George S. Patton Elementary School in Riverdale, Illinois. In so doing, he received a total of $36,638 in undeserved payments.

***In re Melissa Moore* (Case No. 1401945):** Melissa Moore falsely claimed to have provided personal-assistance services from May 2017 through March 2019 when she was, in fact, working at Southern Illinois University; Community Unit School District No. 1 in Carlyle, Illinois; or Kids Before and After, a daycare in Rochester, Illinois. As a result, Ms. Moore fraudulently obtained $25,499.

***In re Tyuss Love* (Case No. 1290441):** Tyuss Love worked at natural-gas provider Peoples Gas at the same times that he falsely claimed to have provided personal-assistance services between April 2016 through January 2018. As a result, he received $16,254 for services that he never rendered.

Other examples include the following matters involving high dollar amounts defrauded:

Case Name OIG Case Number	Period Over Which Fraud Occurred	Wages Fraudulently Obtained
In re Barbara Shaw (Case No. 1289580)	July 2014 – January 2018	$34,007
In re Brandon Swan (Case No. 1367522)	January 2019 – March 2020	$21,329
In re Qiana Paul (Case No. 1402456)	October 2018 – March 2020	$15,369

In one case — ***In re Pankti Patel* (Case No. 1373443)** — OCIG took action to exclude Pankti Patel, a non-enrolled caregiver employed by an enrolled homemaker agency who engaged in secondary-employment fraud, through which she was paid $24,488 for services that she falsely claimed to have performed from March 2019 through April 2021.

INPATIENT FRAUD

The second fraudulent scheme is known as "inpatient fraud," where Personal Assistants bill for services that could not have been rendered because the recipients under their care were, in fact, hospitalized or residing in a long-term care or similar facility at the times of the claimed services. OCIG prevailed in two termination actions where evidence established that enrolled Personal Assistants had committed inpatient fraud, one of which is of interest given the large dollar amount that was defrauded: ***In re Ashley Dyson*** **(Case No. 1401048)**, in which Personal Assistant Ashley Dyson obtained $17,035 by billing the Program for services that she claimed to have provided from August 2018 through July 2019, when the recipient under her care was, in fact, hospitalized.

OCIG also took administrative action in four cases to exclude non-enrolled caregivers employed by enrolled homemaker employees who engaged in inpatient fraud:

Case Name OIG Case Number	Period Over Which Fraud Occurred	Wages Fraudulently Obtained
In re Carolyn Bonner (Case No. 1391648)	November 2021 – May 2022	$8,780
In re Kristi Bradford (Case No. 1389522)	December 2021 – May 2022	$6,483
In re Devonna Alexander (Case No. 1404877)	December 2021 – Mar. 2022	$6,408
In re Lamont Nichols (Case No. 1410407)	November 2022 – January 2023	$3,827

OTHER SCHEMES

In four additional cases, OCIG prevailed in actions involving fraudulent schemes that did not involve either secondary-employment or inpatient fraud:

> ***In re Kendra Wooden*** **(Case No. 1368211):** Personal Assistant Kendra Wooden's enrollment was terminated when the recipient under her care stated she had never received the services that Wooden claimed to have provided from April 2020 through September 2020. Wooden was paid $7,482 through her fraud.

***In re Sylvia Cordorva-Elliot* (Case No. 1416321) / *In re Chelsea Glover* (Case No. 1419200):** Sylvia Cordova-Elliot and Chelsea Glover, both non-enrolled caregivers employed by enrolled homemaker agencies, never performed the services that they claimed to have provided. Ms. Cordova-Elliot was paid $4,459 for services that she falsely asserted to have provided from December 2023 through January 2024. Ms. Glover, in turn, was paid $3,524 for services that she fraudulently claimed to have provided from December 2023 through April 2024. Both Ms. Cordova-Elliot and Ms. Glover were excluded from participating in the Program as care-rendering providers.

***In re Jacqueline Matthews* (Case No. 1395874):** An enrolled homemaker agency that employed non-enrolled caregiver Jacqueline Meyers paid her $14,953 for services that she falsely claimed to have provided from April 2019 through May 2020 when the recipient under her care had, in fact, passed away. Consequently, she was excluded from participating in the Program as a care-rendering provider.

Terminations Resulting from Professional Sanctions

The Illinois Department of Financial and Professional Regulation (IDFPR) is the State of Illinois's agency that regulates the medical profession by, among other things, ensuring that competent professionals are properly licensed to provide services to the public. In its role, IDFPR has the authority to revoke, suspend, terminate, or otherwise sanction medical professionals' licenses to practice in Illinois when those professionals engage in misconduct or provide substandard care. When IDFPR sanctions Medicaid providers, OIG must take action to terminate their enrollment in the Illinois Medicaid Program. In FY2025, OCIG successfully sought the termination of 21 Medicaid providers upon the imposition of IDFPR sanctions. The matters involving the most severe provider misconduct are identified below:

IDFPR Sanction and Underlying Bases
License to practice as a physician and surgeon indefinitely suspended for engaging in: (1) immoral conduct in the commission of an act of sexual misconduct; and (2) unprofessional, unethical, or dishonorable conduct of a character likely to deceive, defraud, or harm the public
License to practice as a physician and surgeon suspended pending criminal charges, including: (1) soliciting child prostitution; (2) pandering of a child; (3) patronizing a prostituted child; and (4) attempting to commit sexual assault of a child
License to practice as a physician and surgeon placed on permanent inactive status for engaging in a pattern of inappropriate conduct with multiple patients of his pediatric practice, including conduct sexual in nature
Temporary medical permit suspended pending criminal charges, including: (1) traveling to meet a minor for the purpose of engaging in criminal sexual abuse; and (2) aggravated criminal sexual abuse of a minor
License to practice as a physician and surgeon permanently revoked after having been convicted of criminal sexual abuse

Terminations Based on Criminal Convictions

HFS regulations allow for the termination of providers' enrollment in the Illinois Medicaid Program where they "engaged in practices prohibited by applicable federal or State law or regulation." In addition, providers' enrollment can be terminated if they have been convicted in state or federal court of certain disqualifying offenses.[19]

In FY2025, OCIG prevailed in 25 termination actions that were based on providers' previous criminal convictions. Three notable examples follow:

> ***In re Sargon Audisho*** **(Case No. 1360031):** Physician Sargon Audisho was convicted in the U.S. District Court for the Northern District of Illinois of one count of healthcare fraud. In pleading guilty to the crime, he admitted that he had participated in a scheme to defraud the Medicare program of over $54.6 million by generating fraudulent physician orders so that the program would cover the cost of medically unnecessary durable medical equipment and genomic testing.

[19] These offenses include murder; class X felonies under the Illinois Criminal Code; 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; crimes of fraud or willful misrepresentation related to healthcare programs, including the Illinois Medicaid Program, or the provision of healthcare services; and other crimes of financial misconduct related to healthcare programs, also including the Illinois Medicaid Program.

***In re LaTeena Smith* (Case No. 1392853):** Psychologist LaTeena Smith submitted over $2.2 million in fraudulent billing claims to HFS for psychotherapy services that she had falsely claimed to have provided from June 2021 through February 2023. As detailed in this report's earlier section presenting the work of BOI, that bureau referred the matter to law enforcement after developing evidence of Ms. Smith's fraud. The DuPage County State's Attorney's Office later charged Ms. Smith with, among other crimes, managed healthcare fraud, to which she later pleaded guilty.

***In re Brian Weinstein* (Case No. 1405008):** Brian Weinstein owned Apollo Health, an Illinois company that arranged for medical providers to perform home visits to Medicare recipients. In his role, he defrauded the Medicare program of over $757,300 by directing the company's billers to submit, on behalf of unwitting medical providers under the company's employ, over 12,500 billing claims to the program for medical services that those providers had never rendered. Federal authorities subsequently charged Mr. Weinstein with several crimes including healthcare fraud, to which he pleaded guilty before the U.S. District Court for the Northern District of Illinois. As a result of Mr. Weinstein's conviction, HFS also revoked Apollo Health's eligibility to serve as a billing payee in the Program.

In addition to the 22 Personal Assistants identified earlier in the report as having engaged in billing fraud, 21 Medicaid-enrolled Personal Assistants were terminated from the Program after having been convicted of various crimes premised on the types of billing fraud discussed earlier, secondary-employment and inpatient fraud. Four cases are notable for the high dollar amounts at issue:

Case Name OIG Case Number	Type and Time Period of Billing Fraud(s)	Crime, Sentence, and Ordered Restitution
In re Forlicia Williams (Case No. 1416389)	Services not rendered October 2014 – October 2019	Felony theft 100 hours' community service $47,339 restitution to DHS
In re Dornita Mack (Case No. 1327424)	Inpatient Fraud April 2018 – April 2019	Felony vendor fraud 90 days' incarceration $34,028 restitution to DHS
In re Barbara Shaw (Case No. 1289580)	Secondary-Employment Fraud July 2014 – January 2018	Felony vendor fraud 24 months' probation $34,007 restitution to DHS
In re Paula Abdullah (Case No. 1377232)	○ Secondary-Employment Fraud September 2019 – November 2021 ○ Inpatient Fraud December 2020 – November 2021	Felony vendor fraud 20 months' probation $30,738 restitution to DHS

Terminations for Failures to Repay Debts to HFS

Providers enrolled in the Illinois Medicaid Program can incur debts to HFS in several ways, such as through final administrative decisions ordering them to repay money to the department or by the terms of settlement agreements. In those instances where providers are delinquent in repaying debts, OCIG can take action to terminate their Medicaid enrollment. Where corporate entities are the delinquent debtors, OCIG can take additional action to bar personnel associated with those entities from participating in the Program.

In FY2025, OCIG prevailed in two actions seeking the termination of providers who owed HFS a total of $138,887, along with the barrment of personnel associated with the providers:

Matter Name OIG Case Number	Unresolved Debt Amount and Administrative Actions Taken
In re Lincoln Yellow Cab (Case No. 1168094)	o $72,290 debt established by final administrative decision enforcing audit findings o Enrollment of provider Lincoln Yellow Cab terminated o Owner Vito Antonacci barred from participating in the Program further
In re Nicholas Stamat (Case No. 1169578)	o $66,597 debt established by final administrative decision enforcing audit findings o Enrollment of provider Nicholas Stamat terminated

Terminations of Providers Who Were Sanctioned by Other State or Federal Healthcare Programs

Federal law mandates that HFS must terminate providers' enrollment in the Illinois Medicaid Program when those providers are terminated from, or otherwise sanctioned by, another state or federal healthcare program. In seven matters, OCIG successfully sought the termination of providers' enrollment based on information provided by CMS:

Matter Name OIG Case Number	Sanctioning Agency and Program(s)
In re Modern Laboratory Incorporated (Case No. 1423573)	HHS (Medicare and all Medicaid programs)
In re Advanced Biomedical Inc. d/b/a Pathology Laboratory (Case No. 1421876)	o CMS (Medicare) o Louisiana Department of Health (Medicaid)
In re Total Diagnostix III d/b/a CQuentia Labs (Case No. 1404468)	o CMS (Medicare) o Louisiana Department of Health (Medicaid)
In re Perry Rudich (Case No. 1414267)	CMS (Medicare)
In re Ren F. Durate Psy D, Inc. (Case No. 1411534)	CMS (Medicare)
In re Kim Anderson (Case No. 1405640)	Nevada Department of Health and Human Services (Medicaid)
In re All American Medical Supplies (Case No. 1414528)	Michigan Department of Health and Human Services (Medicaid)

Terminations for Fraud or Misconduct Where Recoveries of Medicaid Funds Were Also Appropriate

In certain instances, OCIG can simultaneously seek to impose punitive sanctions on Illinois Medicaid providers who engaged in fraud or misconduct and recover the resulting Medicaid funds. In addition to its victory in *In re PAL Transportation, Inc.* — which is discussed above — OCIG obtained a favorable final administrative decision in consolidated matter *In re Vee Enterprises* (Case Nos. 1404855 & 1375121), in which the office's attorneys sought to enforce two BMI audits of medical-transportation provider, Vee Enterprises. While conducting the audits at issue, BMI personnel made multiple attempts to obtain from Vee Enterprises the thirteen categories of records to be audited; the company, however, refused each of those requests. The company's refusal to cooperate served as grounds for the termination of its enrollment as a Medicaid provider. In addition, the absence of records resulting from the company's lack of cooperation led the auditors to identify 243 instances where it failed to substantiate billing claims for the supposed provision of transportation services from January 2019 through December 2021. As a result, the two audits together concluded that Vee Enterprises received $473,410 in identified overpayments of Medicaid funds, which it was required to repay.

Terminations of Corporate Providers and Entities Where Management-Group Members Were Sanctioned by a Healthcare Program or Engaged in Illegal Acts

Under Illinois law, certain bad acts of an enrolled corporate provider's management group — its owners, corporate officers, investors, and managing employees — are imputed to the corporate provider itself. As a result, a provider's Medicaid enrollment may be terminated where members of its management group (1) were previously terminated, excluded, or barred from the Illinois Medicaid Program or another state or federal healthcare program; or (2) engaged in practices prohibited by state or federal law. Corporate entities' authorization to act as billing payees for enrolled providers can likewise be revoked on the same grounds. In eight actions, OCIG successfully argued that the enrollment of corporate providers should be terminated, and the ability of corporate entities to act as payees revoked, based on the bad acts of its management group. Notable cases include:

Matter Name OIG Case Number	Underlying Bad Acts of Provider's Management Group and Administrative Actions Taken
In re Cal's Medical Enterprises (Case No. 1263240)	○ Owner James Calhoun convicted in federal court of engaging in a conspiracy to commit healthcare fraud, mail fraud, and wire fraud ○ Owner Betty Calhoun convicted in federal court of making of false statements relating to healthcare matters ○ Enrollment of Cal's Medical Enterprises terminated ○ Mr. and Mrs. Calhoun barred from participating in the Program further
A&Z Home Healthcare Inc. (Case No. 1296833) ***Dominion Home Health Care Inc.*** (Case No. 1403515)	○ Felix Omorogbe, co-owner of both providers, convicted in federal court of money laundering ○ Owner Patricia Omorogbe, co-owner of both providers, convicted in federal court of engaging in a conspiracy to commit healthcare fraud ○ Enrollment of A&Z Home Healthcare terminated ○ Enrollment of Dominion Home Health Care terminated
In re Luna Labs LLC (Case No. 1409487)	○ Owner Baqar Hussain Razv Syed convicted in federal count of healthcare fraud ○ Enrollment of Luna Labs LLC terminated ○ Mr. Syed barred from participating in the Program further

Terminations of Facilities upon CMS or IDPH Decertification

Although not common, the HFS Bureau of Long-Term Care (BLTC) will notify OCIG that either CMS or IDPH determined that a long-term or intermediate-care facility is out of substantial compliance with federal regulations governing Medicare and Medicaid programs' participation requirements. In either case, the facility is afforded several opportunities to return to compliance but, if it does not, CMS or IDPH will terminate the provider agreement with the facility. OCIG, in turn, will file an administrative action to terminate the facility's provider agreement with HFS.

In FY2025, BLTC notified OCIG that CMS and IDPH had scheduled to decertify one long-term care facility. And although OCIG responded by filing an action to terminate that facility's provider agreement, neither that matter, nor any other pending matter, was resolved through a final administrative decision.

Summary Termination and HHS-Mandated Exclusion Actions

As noted earlier, providers subject to administrative actions are generally afforded the right to an administrative hearing. There are, however, limited circumstances in which a provider's enrollment in the Illinois Medicaid Program may be terminated without first necessitating a hearing. One such instance is when a provider breaches a corporate integrity agreement (CIA) into which he or she had entered with HFS. A CIA is an agreement into which the provider will enter in lieu of termination where grounds for termination exist. The terms of a CIA generally require the provider to repay any overpayments of Medicaid funds that OIG identifies, institute corrective action to address acknowledged improprieties or shortcomings, and provide OIG with regular reports detailing the results of that corrective action. By entering into a CIA, the provider also (1) agrees that its enrollment may be summarily terminated should it fail to meet any requirement outlined in the agreement; and (2) waives its right to an administrative hearing to challenge that termination.

In FY2025, no provider was terminated for its breach of a CIA.

- Coming into this fiscal year, OCIG continued to monitor two CIAs that carried over from FY2024; OCIG monitored those CIAs throughout FY2025 and took no further administrative action with regard to the providers who are parties to the agreements.

- OCIG also entered into two new CIAs during the year. One of those new agreements closed without further action because the provider who was party to that agreement fulfilled the agreement's terms; OCIG continues to monitor the second CIA. As a result, OCIG will continue to monitor three CIAs into FY2026.[20]

[20] Confidential investigations, audits, and reviews continue while OIG monitors CIAs. Therefore, the matters underlying CIAs will not be detailed. Similarly, the matters that underlie CIAs that have expired will not be detailed because, in those instances, no punitive action was taken against the providers.

In addition, OIG may summarily terminate a provider's enrollment upon the breach of a payment agreement or settlement agreement that includes provisions allowing for immediate termination upon the agreement's breach. In FY2025, no providers were terminated for breach of agreement.

OIG also immediately terminates the enrollment of any provider that the HHS excludes from the Medicare program or any other state healthcare program. In FY2025, OIG imposed summary exclusions of this type in 13 matters.

ADMINISTRATIVE APPEALS CONCLUDED IN FY2025

OCIG defends administrative appeals taken by (1) applicants to become enrolled providers in the Illinois Medicaid Program whose applications were denied; and (2) medical transportation providers to challenge HFS's denials of payment for services. OCIG's efforts regarding those appeals are detailed below.

Defense of Denials of Applications for Enrollment

Providers must apply to become enrolled Medicaid providers, and applications may be denied where the applicant is found to have engaged in activities that would constitute grounds for an otherwise-enrolled provider's termination from the Program. When an application to enroll is denied, the applicant has the right to appeal the determination to the HFS administrative tribunal. In such cases, OCIG represents HFS to defend the decision. In FY2025, OCIG successfully defended the denial of applications in two matters:

Matter Name OIG Case Number	Reason for Application Denial
In re Redacted (Case No. 1403852)	Previous IDFPR action to suspend applicant's license to practice as a physical therapist remained in effect, thereby preventing him from rendering services as a Medicaid provider
In re Redacted (Case No. 1411518)	Previous conviction of a crime of violence that may subject Medicaid recipients to an undue risk of harm, specifically, felony aggravated battery upon a police officer

Defense of Denial of Payment for Medical Transportation

Medical-transportation providers' administrative appeals of decisions to deny payment for transportation services were placed on hold from 2019 to late 2022 in response to legislation that resolved providers' challenges outside of the appeals process. Relying on that legislation, in FY2023, OCIG attorneys successfully worked with attorneys for transportation providers to withdraw nearly 1,200 unadjudicated appeals. These efforts continued throughout FY2025, with an additional 78 appeals being withdrawn by agreement.

OCIG also continues to work with providers' counsel and the HFS administrative tribunal to ensure that appeals taken after the effective period of the legislation are promptly addressed. Notably, OCIG engaged the HFS Bureau of Professional and Ancillary Services to help institute a revised payment-review process intended to preempt the involvement of the administrative tribunal. This revised process has resulted in determinations authorizing payments in 82 of the 126 appeals filed since 2022. In addition, the revised process helped to decrease the number of appeal filings in FY2024 from hundreds in years past to only two.

FY2025 FINANCIAL RECOVERY ACTIONS

Illinois law charges OIG with the recovery of overpayments of Medicaid funds identified by audits performed by BMI. OIG is further authorized to recover Medicaid funds identified by audits performed by OIG's external Recovery Audit Contractor (RAC), CMS's Unified Public Integrity Contractor (UPIC), or private accounting firms retained by OIG.

In FY2025, OCIG attorneys obtained final administrative decisions in recovery actions where the HFS Director determined that HFS is allowed to recover a total of $833,049 in overpayments.[21] In addition, OCIG collected $127,910 from providers who opted to remit full audit amounts before administrative actions concluded. As a result, OCIG secured the repayment of $960,959 through recovery actions (a 114% increase over FY2024).

Audits Completed by BMI

In FY2025, OCIG successfully advanced 17 cases enforcing audits completed by BMI — including *In re PAL Transportation* and *In re Vee Enterprises* — yielding a total of $880,842 in monetary awards for HFS. In six cases in addition to *In re PAL Transportation* and *In re Vee Enterprises*, OCIG obtained favorable judgments through which the providers were ordered to repay a total of $154,013 in Medicaid funds. Two notable cases follow:

[21] This amount is in addition to the favorable decisions obtained in *In re PAL Transportation* and *In re Vee Enterprises*, where OCIG successfully sought both the termination of providers' enrollments and recoveries of $146,982 and $473,410 in Medicaid funds, respectively.

***In re Samir Sayegh* (Case No. 1366827):** A BMI audit of physician Samir Sayegh identified 139 discrepancies in billing claims for goods and services that he asserted to have provided from January 2019 through December 2021, which resulted in the overpayment of $106,487 in Medicaid funds.

***In re Sudhir Bhatia* (Case No. 1358354):** After auditing dental provider Sudhir Bhatia, BMI concluded that he had failed to substantiate a one billing claim with proper documentation. As a result, he erroneously received $21,250 in Medicaid funds that he was required to repay.

In nine additional matters, and after OCIG initiated recovery actions, the providers opted to repay the identified overpayments in full instead of proceeding to hearing. In all, the providers remitted $106,437.

Audits Completed by the RAC and UPIC

In FY2025, OCIG obtained a total of $227,098 in overpayments through RAC audits. Three RAC matters were resolved through the administrative-hearing process, where the tribunal concluded that HFS was entitled to recover $205,625 in total Medicaid funds:

***In re Symphony of Lincoln Park* (Case No. 1401486):** RAC auditors identified 145 instances where long-term care facility Symphony of Lincoln Park's resident accounts for July 2016 through December 2018 included incorrect patient credits, claim overpayments, and estate referrals. As a result, the facility received $103,979 in overpayments of Medicaid funds.

***In re Ryze on the Avenue, LLC f/k/a Symphony of Bronzeville Park* (Case No. 1401479):** RAC auditors found that long-term care facility Ryze on the Avenue kept faulty resident accounts for October 2016 through March 2019 that improperly utilized 106 patient credits, ten claim overpayments, and 28 estate referrals. The facility received $81,778 in overpayments in Medicaid funds.

***In re Metropolis Rehabilitation & Health Care Center* (Case No. 1401490):** HMS concluded that long-term care facility Metropolis Rehabilitation and Health Care Center's resident accounts for March 2016 through August 2018 incorrectly included 24 improper claim overpayments and one incorrect estate referral. The facility erroneously received $19,868 in Medicaid funds.

In three additional matters, providers remitted payment to satisfy identified overpayments before the issuance of any final administrative decision; those payments totaled $21,473.

In FY2025, no recovery action based on a UPIC audit resulted in a final administrative decision or the recovery of a full overpayment amount.

WITHHOLDINGS OF MEDICAID PAYMENTS IN FY2025

Under certain circumstances, OIG is authorized to direct HFS and MCOs to withhold all Medicaid funds to be paid to providers for services rendered before any administrative action is taken against the providers:

- When a provider, or a member of a corporate provider's management group, has been indicted or charged with a crime that is based on alleged fraud or willful misrepresentation related to (1) the Illinois Medicaid Program; (2) another state or federal healthcare program; or (3) the provision of healthcare services.
- When OIG receives from a law enforcement agency, from a federal oversight agency, or through the results of a preliminary OIG audit, credible evidence that a provider, or a member of a corporate provider's management group, engaged in fraud or willful misrepresentation related to the Program.
- Upon the initiation of an audit of a provider, a quality-of-care review of a provider, or an investigation in which there are credible allegations of fraud on the part of a provider or a member of a corporate provider's management group.
- When a provider, or a member of a corporate provider's management group, demonstrates a clear failure to cooperate with HFS.

OCIG attorneys review allegations and evidence before recommending that the imposition of a payment withhold is appropriate. Attorneys also work 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 FY2025, OIG directed HFS to impose 31 payment withholds.[22]

FY2025 SETTLEMENT AGREEMENTS

As part of OIG's ongoing effort to ensure that HFS resources are preserved, including HFS's time and money, OCIG is empowered to negotiate settlement agreements to bring matters to a quick resolution. In FY2025, OCIG attorneys successfully negotiated a total $638,168 in settlements in eight matters, including the following to notable cases:

Settlement of $375,000 in Recovery Action Brought Against Long-Term Care Facility (Case No. 1317873): An auditor retained by OIG reviewed the resident accounts of a long-term care facility and concluded that it had received $473,356 in overpayments of Medicaid funds. The facility subsequently agreed to resolve the matter by paying $375,000.

[22] Confidential investigations and audits continue after the imposition of payment withholds. Therefore, the matters in which payment withholds were imposed, and the legal basis for those payment withholds, will not be detailed in this report.

Settlement of $207,565 in Recovery Action Brought Against Medical-Supply Company (Case No. 1393073): After auditing a medical-supply company's billing claims for its provision of durable medical equipment from July 2018 through June 2021, BMI personnel concluded that the company received $244,195 in Medicaid funds for supplies that were not ordered by physicians. The company agreed to repay $207,565 of those funds to avoid responding to an administrative recovery action.

FY2025 OCIG STATISTICS

Total Administrative Actions Initiated: 229

- Termination Actions: 153
  - Actions seeking owner barrment: 7
- Exclusion Actions: 35
- Summary Terminations and Exclusions from Medicaid: 8
  - Terminations based on violations of settlement or payment agreements: 0
  - Exclusions mandated by HHS: 8
- Defense on Appeal: 7
  - Denials of enrollment applications: 7
- Recovery of Overpayments: 26
  - OIG audit recoupments: 14
  - RAC audit recoupments: 11
  - UPIC audit recoupments: 1

Final Actions: 140

- Termination Decisions: 82
  - Actions seeking owner barrment: 9
- Terminations Where Recovery Was Also Appropriate: 2
- Exclusion Decisions: 13
- Summary Terminations and Exclusions from Medicaid: 13
  - Terminations based on violations of settlement or payment agreements: 0
  - Exclusions mandated by HHS: 13
- Defenses on Appeal: 2
  - Denials of enrollment applications: 2
- Recovery of Overpayments: 20
  - OIG audit recoupments: 17
  - RAC audit recoupments: 3
  - UPIC audit recoupments: 0
- Matters Resolved by Settlement Agreement: 8

Payment Withholds: 31

Corporate Integrity Agreements

Ongoing at start of FY2025: 2
Newly entered during FY2025: 2
Total monitored: 3
Total closed: 1
Ongoing at end of FY2025: 3

Financial Impact: $1,599,127

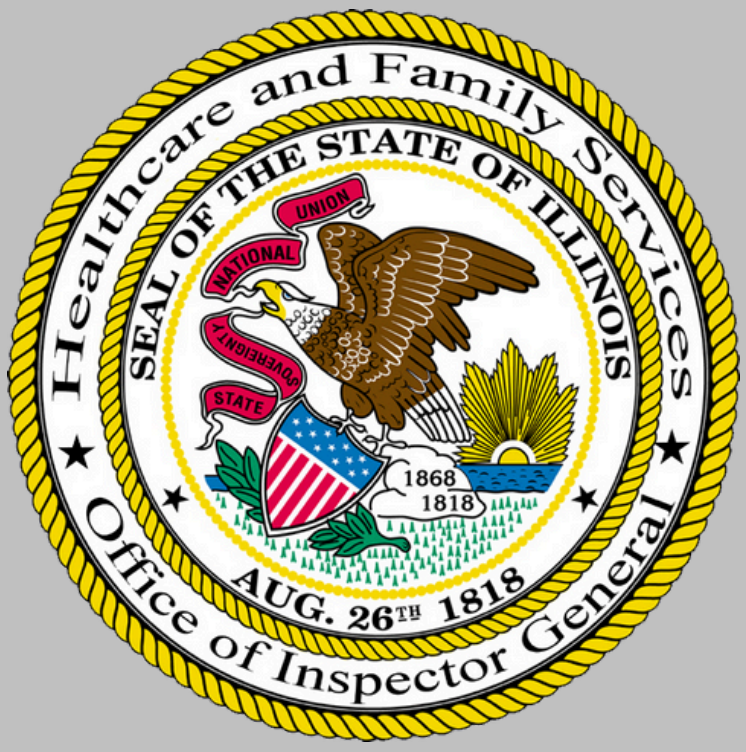
Overpayments Established by Final Administrative Decision: $833,049
Overpayments Established by Settlements: $638,168
Overpayments Repaid After Filing Notices of Recovery: $127,910

Regarding the June 9, 2025 sentencing of Dr. Mona Ghosh, of Hoffman Estates, Illinois, for billing Medicaid and private insurers for nonexistent and unnecessary services. Ghosh was sentenced to ten years in prison and ordered to pay approximately $1.5 million in restitution.

Physicians and other medical professionals who place profits ahead of patient care do so at the expense of the very people they swore an oath to protect. The sentence imposed in this case reflects the severity of the defendant's crimes and the harm inflicted on numerous patients. This investigation underscores our agency's commitment to aggressively pursuing those who fraudulently submit claims to federal health care programs and put patients at risk.

Mario Pinto, Special Agent-in-Charge, HHS OIG- Chicago Division

Bureau of Fraud Science and Technology



BUREAU OF FRAUD SCIENCE AND TECHNOLOGY (BFST)

BFST is composed of the Fraud Science Team (FST) and the Technology Management Unit (TMU). FST and TMU 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's Data Warehouse along with other third-party data sources.

In FY2025, the DNA Framework remained a critical analytic tool for OIG staff to support program integrity and combat Medicaid fraud, waste, and abuse (FWA). OIG staff viewed 64,800 pages in DNA, a 31% increase compared to FY2024, and requested 19,100 reports, a 36% increase over the prior fiscal year.

BFST prioritized enhancements of user experience, process efficiencies, and increased data accuracy for DNA's model maintenance and development. In alignment with management guidance and user priorities, BFST added functionality and module development.

FY2025 BFST HIGHLIGHTS

Post-Mortem Capitation Payment Advisory: Over several years BFST conducted an analysis of HFS's payment of capitation rates for deceased recipients. In particular, BFST analyzed the information in the Integrated Eligibility System (IES)[23] and the claims adjudication system, Recipient Database (RDB)[24], that was causing these post-mortem payments. In FY2025, OIG issued an advisory notice to HFS recommending capitation recovery based on BFST's analysis.

In the past BFST has reported on post-mortem capitation payments based on death dates established by Illinois Department of Public Health data. To improve the accuracy of recipients' dates of death, BFST began compiling data from the federally maintained Death Master File (DMF)[25]. BFST also compiled additional data sources to identify inconsistent death data across systems that may merit further investigation.

[23] Integrated Eligibility System (IES) is the Illinois Medicaid eligibility system of record maintained by Department of Human Service (DHS).
[24] Recipient Database (RDB) is a copy of the eligibility system kept in sync with IES eligibility system of record with periodic back-feeds. Illinois Medicaid claims are adjudicated using eligibility status from RDB in the HFS Medicaid Management Information System (MMIS).
[25] Death Master File (DMF) is a comprehensive database created by the Social Security Administration that includes information about individuals whose deaths have been reported to the agency. OIG uses the DMF bulk search utility to search all Illinois Medicaid recipients on a monthly basis and stores results locally for analytics use.

HFS has a process to recoup capitation overpayments when it is determined they were made after a recipient's death. If the payments were made within the past 18 months, the recoupment is automated, and if the payment was made more than 18 ago, the process requires a manual review. With these recovery processes in place, BFST focused its analysis on identified capitation overpayments going back to 2019 which remained unchanged month after month increasing the likelihood that there were no void and recovery actions. BFST identified total post-mortem capitation exposure of approximately $106M, of which $5.7M in payments were made for recipients who had a documented date of death that matched across all HFS systems and supporting resources including: DMF and the Illinois Department of Public Health Vital Records death data.

In August of 2024, OIG requested HFS take action to recover the $5.7M in overpayments, as the system data supported a finding of post-mortem payment with no conflicting information. Of this $5.7M, approximately $3.7M fell into the automated 18-month lookback period and $2M fell outside that period. While HFS disagreed with OIG's recommendation, by Spring 2025 it had recovered the $2M in overpayments and agreed to look into the broader data issues giving rise to the unrecouped post-mortem capitation payments.

As of June 2025, the total value of post-mortem capitation overpayments was $135M. To better focus resources and solutions on this issue, BFST grouped questionable post-mortem payment data into three categories:

- Missing or inaccurate death status in IES
- Lack of agreement on death date between IES and RDB
- Inconclusive death status data across systems

The recovery value for each area above is: $80M for missing or inaccurate information in IES, $3M for differing data in IES and RDB, and $52M for inconclusive death information across source systems. At the closure of the fiscal year, BFST is working with both DHS and HFS to correct systems data and ensure appropriate recovery of post-mortem capitation payments. At the end of FY2025, HFS had recovered $16,319,426 in capitation payments as a result of this project.

New DNA Report Development and Implementation: In FY2025 BFST worked with OIG program staff to develop a number of new data analysis reports to support various office operations, including:

- MCO Report Development: BFST developed automated reporting in DNA based on information submitted through the MCO Fraud Reporting Portal. This fraud portal supports efficient communication between MCO Special Investigative Units (SIUs) and OIG. The DNA interface for the MCO reporting portal allows users to filter data by MCO organization and record creation date, allowing an efficient monitoring of FWA activities and response patterns across managed care entities. The report consolidates and organizes key metrics of the MCO's records including record status, allegation source, allegation type, identified overpayment, and recoupment requested. This module strengthens the DNA system's ability to monitor external stakeholder performance while improving accountability and transparency in Medicaid fraud prevention efforts.

- Provider and Recipient Analysis Section (PRAS) Report Implementation: The PRAS report was developed and integrated into the DNA system to enhance claim analysis and improve investigation efficiency. The report supports focused, recipient-level claim investigations by providing the Same and Similar Report and Rejection Report. The Same and Similar Report enables users to identify paid claims for the same recipient and overlapping, or identical, procedure codes. This feature aids discovery of duplicate billing, service overutilization, or upcoding. Conversely, the Rejection Report allows users to examine denied claims within a defined time range for the same recipient, supporting isolation of common rejection patterns, eligibility discrepancies, or coding-related errors.

- Quality Control (QC) Payment Report Development: The QC payment report was added to the DNA system to support Medicaid Eligibility Quality Control (MEQC) efforts to investigate payment activities against a recipient's eligibility status in determining whether Medicaid payments were appropriate during a selected benefit period. Required report parameters include recipient ID, case ID, begin date, and end date.

- National Drug Code (NDC) Inquiry Report Implementation: The NDC Inquiry Report was implemented to enable targeted drug analysis. The report is designed to assist auditors and investigators in examining Medicaid prescription drug use patterns, detecting prescribing anomalies, and evaluating pharmacy-prescriber dynamics in a geographic region. Users enter an NDC code, select a begin and end date, and choose a geographic region to generate a report. The report includes a drug's brand name, generic name, label name, therapeutic class information, and ranked lists for the top 25 prescribers and top 25 pharmacies based on total payment.

- Claims Void Inquiry Report Implementation: The Claims Void Inquiry Report provides insights on claims that have been voided or rebilled. Using a Document Control Number (DCN) as a search key, users can determine whether a claim was adjusted, voided, or rebilled. This report extracts both the original and adjusted voucher information, including payment amounts before and after the adjustment. Additional report fields include adjustment voucher date, adjustment reason, process type, and claim void indicator.

Recipient Restriction Program (RRP) Revision: The RRP or "lock-in" program is a Medicaid initiative aimed at reducing service misuse and overutilization by restricting high-risk recipients to designated providers or pharmacies. A structured monitoring program was developed to identify individuals exhibiting concerning use patterns. In FY2025, BFST revised program algorithms that flag recipients for review to ensure policy accuracy and analytic rigor.

Statistical Revision of Recoupment Calculation:
In FY2025, in support of OIG's audit team, BFST focused on applying tailored statistical methods based on sample characteristics to ensure accuracy and compliance with audit best practices. Specifically, for samples with fewer than 300 units, a mean estimator was adopted as the preferred method for projecting recoupment amounts. For samples with 300 or more units, a ratio estimator was applied to align with standard statistical guidance for large sample extrapolations. Different statistical formulas are used based on the sample unit type, dependent on service-level or recipient-level, ensuring confidence intervals are appropriate for the sampling structure. These revisions provide a consistent and standardized validation framework, enhance the reliability of projected recoupment amounts, and support defensible audit conclusions.

Drug Utilization Review (DUR) Report Enhancement: BFST refined its opioid-related metrics, primarily around morphine milligram equivalents (MME), in alignment with best practices recommended by CMS. Key metrics include total MME dispensed in a 12-month reporting period, total MME dispensed per covered individual, total MME dispensed per covered individual receiving an opioid prescription, and average daily MME dispensed per opioid prescription. These enhancements improve data transparency, strengthen the program's ability to monitor controlled substance use, and mitigate inappropriate utilization of opioids, stimulant ADHD medications, and sedative benzodiazepines across age groups in the Medicaid population.

Reference Code Quick Lookup Module Development: BFST added this utility module to the DNA system, to improve operational efficiency and data consistency during claims review. The module allows for searches by provider type, category of service (COS), and error code. New provider types were added, including Family Support Program (100), Crisis Stabilization Unit (101), Diabetes Prevention Program Organization (102), Pharmacist (105), Acupuncturist (106), and Genetic Counselor (112). Additionally, COS codes, previously three-digit numeric values, now include alphabetic entries such as CS (Counseling for Medically Fragile Children), EA (Utilities), EM (Access to Home or Vehicle), FT (Family Training), and ME (Specialized Medical Equipment/Supplies). The Error Code Lookup allows searches of over 2,000 unique error codes and supports bi-directional search by code or description, allowing users to quickly retrieve definitions for analytic needs.

DNA Architecture Enhancements: BFST made enhancements to DNA on both front-end development and back-end infrastructure while maintaining robust security measures across existing systems. One key area involved vulnerability patching. A standardized schedule and simplified procedures were set up to monitor dependencies, find outdated packages, and prioritize updates based on severity. These enhancements support reduction of security problems and fixing identified issues sooner. Another critical enhancement involved the authentication processes. More specifically, BFST added an extra layer of security for user-facing authentication and service-to-service communication for client credentials without disrupting the user experience.

FY2025 BFST STATISTICS

DNA Reports Generated: 19,145

DNA Pageviews: 64,827

Help Desk Inquiries: 572

Data Requests Completed: 143

Management, Research, and Analysis Section

MANAGEMENT, RESEARCH, AND ANALYSIS (MRA) SECTION

The Management, Research, and Analysis (MRA) Section facilitates professional development opportunities for all HFS OIG staff, including the creation and refreshing of in-house training sessions for new employees' onboarding and existing staff's continuing education. MRA staff also serve as enterprise-wide liaisons, ensuring effective communication and collaboration on HFS OIG work product and investigation initiatives.

FY2025 MRA HIGHLIGHTS

Communications and Outreach: MRA launched a monthly internal office-wide newsletter in FY2025 to keep OIG connected and informed. Each issue highlights training opportunities that strengthen our efforts to prevent fraud, waste, and abuse, along with educational resources and important updates about OIG's work. The newsletter also shines a light on staff successes and team accomplishments, celebrating the people who make a difference every day. By combining professional development, recognition, and education, the newsletter helps ensure our staff stay informed, motivated, and united in our mission to protect Medicaid and the communities that rely on it.

HFS OIG leverages social media to enhance transparency, raise public awareness of its mission to combat fraud, waste, and abuse in Illinois Medicaid and other government programs, and reinforce its prevention and deterrence efforts. In FY2025, OIG increased its social media posts across all platforms, highlighting successful convictions and settlements, employment opportunities, staff participation in conferences, and health awareness initiatives. This represents a notable increase from OIG's first social media post in 2024. Engagement continues to grow, with monthly increases in followers across all platforms. As of July 1, 2025, OIG reached 285 followers on LinkedIn and 159 followers on Instagram—metrics that reflect the expanding reach and impact of OIG's communications strategy.

Documenting Impact of IMPACT Core: MRA participates in regular meetings with external partners on behalf of OIG, including meetings on enrollment, managed care, data quality, and new provider and policy development. MRA also participates actively in federal CMS Technical Advisory Group (TAG) calls. One notable project involving internal and external stakeholders this year was working with the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) Core development team assigned to HFS to support the migration of the MMIS system into the IMPACT functionality. OIG's use of MMIS was outlined and documented, step by step, in order for the development team to ensure needed features in MMIS will migrate over to the IMPACT Core system. This 10-month long project culminated in formal documentation provided to HFS and the development team.

Study Design Collaboration with Healthcare Fraud Prevention Partnership (HFPP): HFPP is a voluntary collaboration between public and private organizations aimed at detecting and preventing healthcare fraud. Its members include federal and state agencies, law enforcement, private health insurers, and anti-fraud associations. HFPP's main goal is to shift fraud-fighting efforts from being reactive to preventative. By sharing data and information, partners can develop broad, practical strategies that each organization can use to better identify and address healthcare fraud, waste, and abuse.

In June 2024, HFPP launched Study Collaboration Meetings – an innovative and interactive partner resource. OIG is one HFPP partner taking advantage of this unique collaboration opportunity. Held following the release of each HFPP study, these meetings provide partners with an opportunity to collaborate and exchange information on unscrupulous providers identified in the accompanying study.

In February 2025, OIG accepted HFPPs offer to become a Partner Champion state. Partner Champion states collaborate with HFPP during the initial design phase of HFPP studies, providing input on data analysis, fraud scheme specifics, and Medicaid-related issues. In FY2025, OIG assisted with one Partner Champion study.

OIG's collaboration with HFPP was highlighted in HFPP's article "Taking Advantage of HFPP Resources." Inspector General Dunn noted "Our collaborative process of triaging HFPP alerts, notifications, and studies permits us to promptly open cases for investigation and audit, as well as relay valuable information for any open and active investigations."

Training and Professional Development Initiatives: Ongoing internal trainings strengthen organizational performance by enhancing staff efficiency, morale, and collaboration. Targeted instruction equips employees with the knowledge and tools needed to complete tasks with accuracy and timeliness, improving overall workflow efficiency. In FY2025, MRA's overall internal training sessions increased by 124%. MRA began hosting weekly Team Talk sessions, allowing staff a dedicated virtual space to drop in with questions and discuss general Medicaid topics. MRA also designed custom one-on-one sessions and hands-on exercises and demonstrations for all OIG staff to increase skill sets in a variety of areas. Working together with BFST, educational opportunities are provided to staff in addition to identifying and resolving any technical issues that may arise with the systems or reporting. These opportunities demonstrate OIG's investment in its workforce, fostering confidence, engagement, and job satisfaction. Additionally, shared learning experiences promote collaboration across units, ensuring staff operate with a common understanding and work collectively toward advancing OIG's mission.

FY2025 MRA STATISTICS

Office-wide Trainings

MRA-presented sessions: 121
HFS OIG Learning Series sessions: 7
Sessions shared from external sources[26]: 64

Newsletters Published: 11

HFPP Activities:

Cases created: 18
- Cases routed for OIG investigation or audit: 4
- Cases closed no further action after review: 11
- Partner Champion Study Review: 1
- Cases pending at end of FY2025: 2

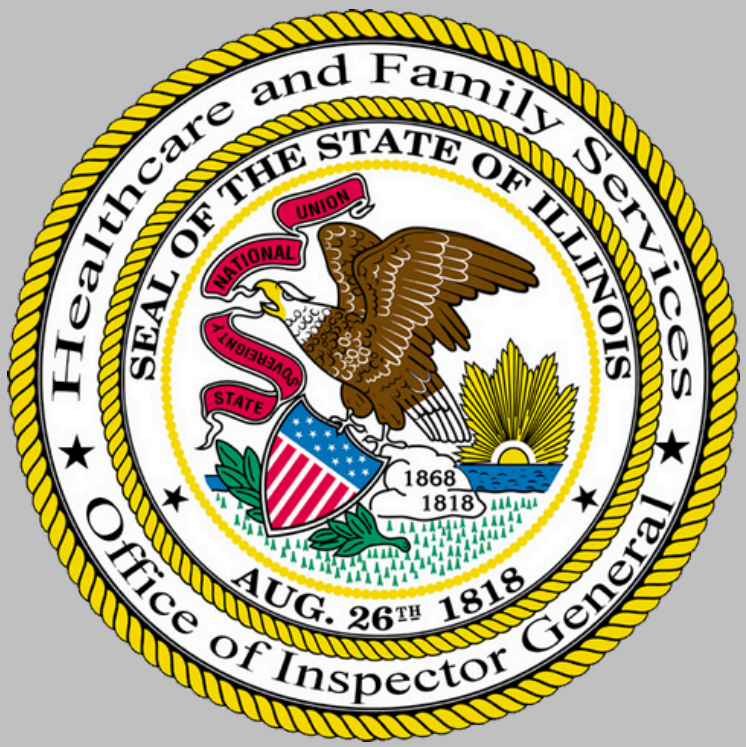
Regarding the June 30, 2025 announcement of the US DOJ "Health Care Fraud Takedown", in which thirteen defendants in Illinois are now facing federal criminal charges as part of the largest national health care fraud enforcement action in DOJ history– and the largest ever in the Northern District of Illinois.

Every fraudulent claim, every fake billing, every kickback scheme represents money taken directly from the pockets of American taxpayers, who fund these essential programs through their hard work and sacrifice. And when criminals defraud these programs, they're not just committing theft — they're driving up our national deficit and threatening the long-term viability of health care for seniors, disabled Americans, and our most vulnerable citizens.

Matthew R. Galeotti, Principal Deputy Assistant Attorney General, US DOJ- Criminal Division

[26] These sources include organizations such as NHCAA, IAMHP, HFPP, NAMPI, AIG, MFCU, and MII.

Fiscal Management Unit



FISCAL MANAGEMENT UNIT

The Fiscal Management Unit handles budget, general collections, bad debt recovery, vendor invoicing and procurement matters for OIG. Fiscal Management maintains and updates OIG's operations budget and handles OIG's procurements and intergovernmental-agency agreements. It processes and tracks overpayments resulting from OIG audits of Medicaid providers, provider settlements and court-ordered restitutions. Fiscal Management 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.

FY2025 FISCAL MANAGEMENT HIGHLIGHTS

Budget: OIG's FY2025 Operations budget was $7.0 million. General Revenue Fund expenditures constituted 0.07% of this amount while Part F – Public Aid Recoveries Trust Fund expenditures totaled 99.93%. The breakdown of the Operations budget follows, with percentages based on the total Operations budget.

62%	HMS, OIG's RAC vendor, is paid on a contingency-fee basis.
28%	Other professional contracts, including for Northern Illinois University analytics, audio transcription services, public records access and search services, IT consulting services and personal services contracts.
6%	1 statistical and 12 medical consultants.
4%	Employee travel, conference fees and license reimbursements.

Collections: Fiscal Management handles the recovery of overpayments established by a final audit determination, a final administrative determination, a provider settlement agreement, or a provider/client restitution agreement. Once an overpayment is finalized, Fiscal Management staff will establish an account receivable for the amount owed to HFS. If a provider fails to make a payment, Fiscal Management will send the provider an initial payment-reminder letter. If the provider does not comply with the initial reminder letter, Fiscal Management 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 OCIG for termination and barrment of the provider from the Medicaid program. In FY2025, Fiscal Management processed and maintained 5,931 accounts receivables. FY2025 collections by audit type and provider type were as follows:

Audit Type	Provider Type
RAC audits – 86%	Hospital – 91%
Field audits – 4%	Long-term care – 4%
Desk audits – 8%	Physician – 1%
Self-disclosure audits – 0%	Transportation – 0 %
UPIC Audits – 2%	Other – 4%

Demand Letters: In FY2025, the Fiscal Management Unit sent out ten fifteen-day demand letter for ten audits establishing $678,501 in overpayments. Three letters were sent to individual practitioners, two to Long Term Care Community Spousal Support program individuals, one letter to a Recipient for a Restitution case, one letter to a hospital, and three letters to long-term care facilities. In response to these letters, Fiscal Management collected $176,309. The collections received are fifteen times more than what was collected in FY2024 due to increased communications with the delinquent providers.

Bad Debt: When Fiscal Management has exhausted all attempts at collection and a debt is still outstanding, HFS OIG seeks to have the debt deemed uncollectible. Fiscal Management staff determine whether the case will go to an outside collection agency, to the HFS Director's office for write-off, or to OAG for write-off. This determination depends on various factors, including whether the providers or owners have assets and income to cover the debt owed. Bad debt cases finalized in FY2025 include the following:

Convicted Fraudster with $16M judgement: Heavenly Interventions was a payee owned by Debra Gaines. Ms. Gaines was billing Medicaid using a physician's credentials without the physician's knowledge. The case was referred to MFCU, who conducted the investigation. Between 2007 and 2010, Ms. Gaines billed Medicaid in the amount of $276,000 for physiological services allegedly provider to Medicaid recipients, claiming the services had been provided by a Medicaid provider. The physician in question testified that he had not provided the services and Ms. Gaines had fraudulently utilized his credentials after he had applied and interviewed for a job at Heavenly Interventions.

The defendant was convicted of Vendor Fraud in July 2015 and sentenced to six years in an Illinois Department of Corrections facility. The judge imposed a final judgement on the defendant of $16,027,030. The judgment included $257,010 or the overpayment amount, $514,020 for treble damages and $15,256,000 for Civil Monetary Penalties.

After OIG attempted to collect the debt, the case was sent to OAG in April 2021. OAG also failed to collect the debt and approved the write off in June 2025.

Community Spouse Subject to Withhold: As the result of a long-term care asset discovery review, OIG determined that a community spouse owed $12,669 in community spousal support to pay for their spouse's long-term care needs. The community spouse signed a spousal support order in July 2024, agreeing to make monthly payments of $2,167. Nonetheless, the spouse failed to make any payments.

After OIG's Collections unit staff attempted to collect the debt, the case was routed on to OIG Bad Debt unit. In May 2025, a judgement order was issued requiring the community spouse to pay $300 per month until the debt is paid in full. OIG Bad Debt unit placed a withhold in the Illinois Office of the Comptrollers Debt Recovery database and a total of $956 has been collected via the offset with a balance owed of $11,713.

Liens Placed on Transportation Provider Owners with $200k Debt: OIG audited W and W Transportation in 2005-2006 and established $200,091 in overpayments due to improper documentation and lack of prior approvals. The owners entered into a payment agreement in November 2006 but stopped making payments in 2008. OIG continued to seek collection of the debt and terminated the provider from Medicaid. In 2009, OIG Bad Debt staff entered a withhold in the Illinois Office of the Comptrollers Debt Recovery database in the amount of $164,900 and subsequently referred the case to OAG After collection efforts and failed attempts at settlement, OAG filed a formal complaint against the owners in March 2024.

In September 2024, the defendants appeared in court to testify that due to their age, lack of employment and medical issues they were unable to pay back the debt. The court entered a summary judgement against the company and the two owners in May 2025 and a lien on their personal properties was imposed.

Procurement: During FY2025, the Fiscal Management Unit processed 21 contracts, 3 intergovernmental agency agreements, and 1 joint operating agreement. These 21 contracts included 12 medical consultant contracts; 6 audio, data and information services contracts; a statistical consultant contract, a personal services contract, and a Recovery Audit Contractor. Fiscal Management also helped oversee OIG's 19 intergovernmental agreements, 4 data sharing agreements, and 1 joint operating agreement with federal, state, and local partners.

FY2025 FISCAL MANAGEMENT STATISTICS

Collections

Account receivables: 5,931
New account receivables: 5,701
Outstanding account receivables: 230
Value of new account receivables established: $37,178,580
Collected account receivables: $30,355,755
Open account receivables: $40,231,921

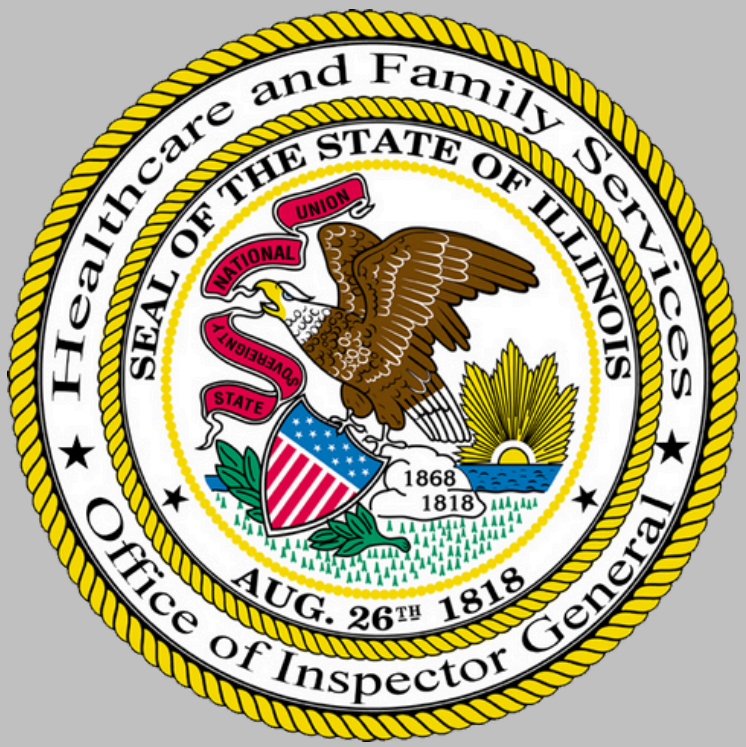
Bad Debt

Bad debt cases established: 3
Value of established bad debt cases: $171,090
Cases sent to collection agency: 8
Value of cases sent to collection agency: $382,034
Total bad debt cases written off: 6
Value of bad debt cases written off: $16,262,476

Procurement

Contracts: 21
Value of contracts: $5,606,906
Interagency agreements: 19
Value of interagency agreements: $700,000
Joint Operating Agreements: 1
Data Sharing Agreements: 4

Managed Care Program Integrity



MANAGED CARE PROGRAM INTEGRITY

As the majority of Medicaid beneficiaries are enrolled in Medicaid managed care, OIG has continued to prioritize its commitment to managed care program integrity (PI) in FY2025. This commitment is evidenced by OIG's engagement with internal and external stakeholders, which has served as a catalyst to key managed care initiatives in FY2025.

FY2025 MANAGED CARE PROGRAM INTEGRITY (PI) HIGHLIGHTS

MCO Contract Amendment Allows for OIG Recover of Provider Overpayments: OIG's managed care PI authority underwent meaningful growth as a result of a 2025 amendment to the Health Choice Illinois (HCI) contract. The amendment allows the recovery of overpayments identified by OIG which have not previously been identified by the MCO. OIG recoveries will be made directly from MCO capitated payments. The MCO may in turn recover the overpayment from network enrolled providers' billings of claims of service. Prior to the HCI contract amendment, only MCOs could recover and retain identified overpayments. OIG is currently operationalizing its newly acquired authority, working with both internal and external shareholders to ensure seamless processes are in place in the undertaking of recovery actions. OIG expects the expanded recoupment authority will enhance oversight of the managed care program.

OIG Collects FFS Overpayments Through MCO Offsets: For the first time OIG capitalized on its Health Choice Illinois contractual authority to recover debt owed to HFS through an MCO withhold on a Medicaid provider. As Illinois Medicaid continues to shift client enrollment from traditional FFS to managed care, there has been a correlating decrease of FFS billing and increase in provider billing through managed care. OIG coordinated with two MCOs to initiate recoupments from two providers that had stopped billing FFS but were actively billing MCOs. The coordinated effort resulted in a recoupment in one instance and a negotiation of an installment payment agreement with OIG's Fiscal Management Unit in the other. Given the success of the initiative, OIG will continue to use this contractual authority to seek recoupment of FFS overpayments.

MCO Program Integrity Oversight Activities: HFS OIG utilizes an interdisciplinary approach to MCO program integrity oversight activities. Each of its bureaus played an active role, having worked both independently and collaboratively, in OIG's oversight endeavors during FY2025.

- BOI - Monitors and conducts investigations based on referrals submitted by the MCOs' Special Investigation Units (SIU) via the MCO fraud reporting portal.
- BMI - Refers cases to MCOs based on FFS fraud, waste, and abuse trends and schemes identified during audits conducted by the bureau and its UPIC.

- BFST - Spearheads data analysis of MCO paid claims and encounters, identifying outliers and anomalies in billing practices and innovating and improving HFS OIG's managed care PI data analysis capabilities.
- Fiscal Management Unit - Identifies providers who have received FFS overpayments for which OIG will require recovery from an MCO.
- OCIG - As HFS OIG's legal department, OCIG has been critical to the Office's managed care program integrity efforts by taking administrative action to suspend, sanction, and terminate bad actors from Medicaid including managed care.

MCO Fraud Portal: The portal serves not only as an interactive referral tool for SIUs to report incidents and investigations of fraud, waste, and abuse, it also functions as a tracking tool. In FY2025, OIG continued to improve portal functionality with the goal of maximizing utility for both SIUs and OIG. For example, adding additional reporting fields and notification options have improved case management and tracking.

Subcommittee Meetings: OIG continued to meet monthly with representatives of the MCOs' SIUs and MFCU to address MCO PI matters including, but not limited to, education and information sharing promoting collaboration among Medicaid PI partners. These meetings facilitate proactive identification of potential provider fraud and abuse issues and ensure coordination with law enforcement on active fraud cases. In FY2025, OIG also dedicated time to one-on-one quarterly meetings with each SIU. These meetings provide an intimate setting to discuss not only general, but also SIU specific issues, and help to generate program integrity initiatives. Most importantly, quarterly one-on-one meetings have proven beneficial in fostering communication and collaboration between SIUs and OIG.

FY2025 MANAGED CARE PROGRAM INTEGRITY STATISTICS

MCO Fraud Portal

MCO Audits and Investigations Opened: 483
MCO Referrals to OIG: 474
MCO Overpayment Recovery Requests: 392
MCO Overpayment Recovery Request Value: $55,278,261
MCO Overpayment Recovery Approvals by HFS OIG[27]: 346
MCO Overpayment Recovery Value Approved by HFS OIG: $28,467,027
MCO Overpayments Recovered[28]: $4,116,762

MCO Subcommittee Meetings

Subcommittee meetings held: 11
Leads OIG provided to the subcommittee: 39

[27]Requests for overpayment recoveries may have been submitted to HFS OIG prior to the start of FY2025.
[28] Monies recovered may include recovery request made prior to the start of FY2025.

FY2025 ANNUAL REPORT

401 South Clinton Street
Chicago, IL 60607

2200 Churchill Road
Springfield, IL 62702

Medicaid Fraud Hotline:
1-844-ILFRAUD

www.illinois.gov/hfs/oig

Twitter: @HFSOIG
Instagram: @HFSOIG
LinkedIn: /company/hfsoig
Bluesky: @hfsoig.bsky.social