Department of Health & Human Services
Health Care Financing Administration

NATIONAL MEDICAID FRAUD AND ABUSE INITIATIVE

REVIEW OF STATE MEDICAID PROGRAM INTEGRITY PROCEDURES

STATE OF ILLINOIS

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I.EXECUTIVE SUMMARY

The Health Care Financing Administration (HCFA) is committed to partnering with the States and other stakeholders in fighting fraud and abuse in the Medicaid program. In furtherance of that commitment and in HCFA's oversight role, a team of four Medicaid Fraud and Abuse Coordinators from four HCFA Regional Offices conducted a national review of program integrity policy and procedures in the Illinois Medicaid Program. Conducted during the week of January 24, 2000, the review explored current program integrity procedures and those under development by components of the Illinois Department of Public Aid (IDPA), which administers the Illinois Medicaid Program.

General purpose - The team's general purpose was to determine whether IDPA's program integrity procedures satisfy the requirements of Federal regulations at Title 42 Code of Federal Regulations (CFR) Parts 455 and 447.10 and applicable provisions of the Social Security Act. A related purpose of the review was to learn how the State Medicaid Agency and the IDPA Office of Inspector General (IDPA/OIG) identify, receive, use and network information about potential fraud and abuse involving Medicaid providers.

Team feedback - When the review team identified potential weaknesses based on its observations and interviews with IDPA staff members and its review of material that was submitted by IDPA, the team proposed suggestions to enhance Illinois' program integrity efforts. Equally important, policies and practices that the team identified as particularly innovative or effective were cited as "Best Practices." The review team also encouraged the State to identify any obstacles that hinder its fraud and abuse control efforts, which HCFA may be able to affect. These are referred to as "Hindrances" in this report.

PROPOSED ENHANCEMENTS

The review team is pleased to report that it did not find any instances of regulatory noncompliance. The team would like the State to consider several suggestions, however, which the team members believe can enhance the State's already impressive program integrity efforts. These proposed enhancements are organized around three functional areas:

- Excluded Providers,
- Provider Enrollment, and
- Provider Audit.

Excluded Providers - The State's current provider enrollment process does not fully utilize available information related to providers who are excluded from participation in Medicare, Medicaid and all Federal health care programs by the Department of Health and Human Services' Office of Inspector General (DHHS/OIG). The "sanction list" currently in use by State provider enrollment staff contains approximately 3,000 names. By contrast, the DHHS/OIG *List of Excluded Individuals and Entities* (LEIE) is a searchable, regularly updated database listing more than 17,000 providers nationwide who are in nonpayment status. The State's current practice of using the smaller, state-generated list

derived from the LEIE to screen potential Medicaid providers places it at risk of issuing Medicaid numbers and making payments to fee-for-service and managed care providers who are in nonpayment status.

A new sanctions database that the State hopes to begin using during 2000 should be a significant improvement in helping the State ensure that it does not begin to do business with excluded providers or continue to do business with them by failing to de-activate their Medicaid provider numbers. Its effectiveness may, in fact, qualify as a best practice. In the interim, however, the State should consider using the LEIE, which is posted on the Internet at **www.hhs.gov/oig/cumsan/index.htm**. Because the current procedure for screening excluded providers has been in place at the State agency for some time, the State also should search its provider records to determine if it may have issued provider numbers to excluded parties in the past.

Provider Enrollment - The State's provider enrollment process does not take full advantage of its authority to collect provider disclosure information. This type of information includes physician ownership and conviction information, as well as subcontractor and supplier relationship and transaction information for all provider types.

The State's provider enrollment application requires potential Medicaid providers to disclose and certify, in pertinent part, that they (and other involved parties) are not "… currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations." The State should consider modifying the language in its provider enrollment application for all provider types. The State should require applicants to disclose and certify whether they have ever been convicted of any felony offenses, not only that they are not "… currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations." Exercising its authority to more carefully screen provider applicants would allow the State to make more informed decisions about issuing Medicaid provider numbers, and would help ensure the quality of care provided to Medicaid beneficiaries.

Other proposed enhancements to the State's provider enrollment process include:

- Examining the contractual arrangement between a physician and any payee designated to receive payments for services performed;
- Routinely checking with licensure boards in other States to verify the validity of licenses presented to IDPA Provider Enrollment staff as evidence of provider applicants' professional standing; and
- Running criminal background checks on provider applicants.

Provider Audit - IDPA's current audit function does not target managed care providers. The selection of providers for analysis during the Surveillance and Utilization Review Subsystem (SURS) process for submission to the Narrative Review Committee (NRC) does not include managed care providers. To extend the reach of the State's oversight obligation to this currently uncovered provider population, a sample of managed care providers should be included in the State's audit process.

BEST PRACTICES

The State agency has taken many proactive measures necessary not only to identify abusive provider payments, but also to prevent them from occurring in the first place. Especially noteworthy is the weaving of "think-tank" mentality with exceptional internal and external interaction among entities dealing with program integrity issues. This environment creates a culture conducive to effectively fighting fraud and abuse by leveraging technology and tapping the collective experience of various staff members. This produces results such as trend development, the identification of problem providers, and the creation of policies designed for the prevention and collection of overpayments.

Excluded Providers

- The State plans to post State-imposed sanctions on an Internet website expected to go live in 2000. This will allow the community and other providers to see who is restricted from participating in the Medicaid program.

- The State also plans to automate the identification process by which excluded providers on the LEIE are automatically compared with the existing provider database and with new provider applications. The successful implementation of this effort will provide a solution to a vulnerability existing not only in Illinois, but also in many other States.

Provider Enrollment

- IDPA reported that it plans to re-enroll all of its approximately 60,000 active providers in the near future. The addition of seven new staff members to the Provider Enrollment Unit should assist the State's stated goal of re-enrolling all of its providers every five years. This will provide a timely opportunity for the State to include the additional disclosure information that we have proposed as enhancements.

- Providers are placed in a nonparticipating status when no billing is received for 12 months. If another 12-month period follows with no billing, that provider is then placed on inactive status and must re-enroll.

Provider Audit

- The State's planned case tracking system will allow access to all types of information about providers and beneficiaries that is derived from any IDPA/OIG activity.

SURS

- An expanded version, CS-SURS, is expected to be operational in 2000. Staff will be able to instantly select from their personal computers various combinations of Medicaid service parameters to manipulate and compare.

- A Narrative Review Committee (NRC) was established as a triage process to pare down thousands of exceptions determined by the SURS unit, to hundreds of cases presented for audit annually.

- A new, soon-to-be operative data warehouse ultimately will provide State staff with access to five years of paid claims data. The data warehouse will allow the State to overcome limitations inherent in diverse, fragmented data and allow better decisions to be made about the allocation of scarce program integrity resources.

- A "payment spike" report currently in use by the State is a means of preventing erroneous payments to Medicaid providers. Based on past billing patterns, it calls attention to unusual provider claims activity and allows the State to review the claims before they are adjudicated and paid.

Bureau of Fraud Research

The very existence of the Bureau of Fraud Research (BFR) constitutes a best practice. The BFR continues a long-standing tradition within IDPA/OIG of engaging in innovative fraud detection investigations in the Medicaid program. (Refer to Page 24 for discussion of the preventive and post-payment fraud and abuse detection that goes beyond the scope of SURS.)

II. BACKGROUND

In June 1997, HCFA's Southern Consortium assumed leadership of the National Medicaid Fraud and Abuse Initiative (Initiative). This Initiative was established with the primary goal of preventing fraud and abuse by assisting States in their efforts, identifying proactive strategies, and sharing information with other program integrity players. Through leadership, the Initiative strives to encourage participation and communication among State and Federal entities working to fight fraud and abuse.

Designing and conducting this review are important parts of fulfilling the Initiative's goals. HCFA staff who are part of the Initiative want to learn how States identify, use, coordinate and communicate fraud and abuse information. They also want to determine if States are in regulatory compliance with Federal laws and regulations dealing with fraud and abuse. Taking full advantage of HCFA's regional presence, a national review team was formed utilizing Medicaid Fraud and Abuse Coordinators from each of HCFA's 10 Regional Offices. The Illinois review was conducted by Coordinators from HCFA Regional Offices in Atlanta, Dallas, Philadelphia and Chicago.

During Fiscal Year 2000, members of the Initiative's national review team will review the program integrity efforts of a total of eight State Medicaid Agencies. When these reviews are concluded, a national report will be prepared by the Initiative.

III. INTRODUCTION

Since its 1966 inception, IDPA has administered the Medicaid program for medically needy individuals as authorized by the Illinois Public Aid Code and Titles XIX and XXI of the Social Security Act. Medically needy individuals are defined as those who qualify for Temporary Assistance for Needy Families (TANF); those who are aged, blind or disabled; and those with an income that does not exceed 133 percent of the TANF payment level for a family of the same size.

Illinois Medicaid Program - The most recent reports furnished by the State indicate that during Fiscal Year 1998, Illinois' Medicaid Management Information System (MMIS), one of the country's largest automated claims payment systems with hundreds of prepayment edits and safeguards, processed approximately 50 million Medicaid claims. FY 1998 Medicaid expenditures totalled approximately $6 billion. The Medicaid program provided medical care, through the services of approximately 60,000 providers, to a reported 1.5 million eligible beneficiaries, or one out of eight Illinois residents, during FY 1998. Of these medically eligible individuals, IDPA reported that 650,000 were children under the age of 19, and 60,000 were long-term care residents. Almost 50 percent of the State's public assistance clients, more than 600,000 individuals, received Medicaid as their only form of public assistance.

Illinois Program Integrity - The Illinois General Assembly in 1994 created the position of IDPA Inspector General, and charged IDPA/OIG with the prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct in IDPA-administered programs, including Medicaid. Prior to 1994, however, a predecessor position, Administrator of the Division of Program Integrity, existed for many years. Over the years, a number of organizational entities within IDPA have been charged with program integrity, with many of the functions of that mission having been conducted within IDPA for 20 years or more.

Currently, with an authorized staff of 311 employees and a $20 million budget, IDPA/OIG calls on the collective experiences gained from investigations, audits and reviews to develop fraud and abuse prevention strategies. IDPA/OIG staff members reported that they conduct many research projects and study the issues that affect the fiscal integrity of Medicaid and the other entitlement programs they monitor. These efforts are enhanced by participating in health care fraud task forces in three Federal districts in Illinois. One of the biggest challenges and successes that IDPA/OIG reported facing since its 1994 creation has been building and strengthening partnerships with Medicaid policy and program staff.

Payment Accuracy Review - In 1998, IDPA/OIG teamed with the Division of Medical Programs (DMP) to produce the first statistically valid study to measure payment

accuracy in a Medicaid fee-for-service program, *Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement* (PAR). The State characterized the PAR as the single most important effort in terms of both program integrity research, and IDPA/OIG partnering with DMP. Noting that the PAR project findings have provided substantial guidance in its continuing program integrity efforts, IDPA/OIG reported that the study determined that IDPA correctly spent 95.28 percent, plus or minus 2.31 percent, on its Medicaid provider payments. The report also identified 29 providers and seven beneficiaries who warranted further examination in the course of remedying an estimated $113 million in misspent Medicaid funds identified by the PAR.

Medicaid Fraud Prevention Executive Workgroup - Another activity that IDPA/OIG cited as an example of its success in partnering with Medicaid policy and program staff is the Medicaid Fraud Prevention Executive Workgroup (MFPEW) which was formed in 1996 and continues to meet monthly. Chaired by the Deputy Medicaid Administrator and the Deputy Inspector General for Operations, the workgroup includes 16 principal Medicaid program, IDPA/OIG and Bureau of Information Systems staff. Incorporating a broad base of disciplines including law and information systems, MFPEW participants work together to develop new techniques and strategies to prevent fraud, waste and abuse in Illinois' Medicaid program, and to evaluate payment practices and processes.

Continuing to treat payment accuracy and early fraud detection as priorities while developing innovative preventive strategies, IDPA/OIG also cites a successful relationship with the Medicaid Fraud Control Unit, discussed later in this report, as a contributing factor to successful program integrity functions in the Illinois Medicaid program.

IV. METHODOLOGY

Purposes of the review - The review team had three purposes in conducting this review:

- First, to determine if the State is complying with applicable laws and regulations;

- Second, to understand the program integrity operations in the Illinois Medicaid agency, and learn how potential fraud and abuse information is identified, received and used; and

- Third, to see how this information is shared with other fraud and abuse partners. We also encouraged the State to share hindrances to their mission, which HCFA perhaps could help alleviate.

Comment categories – The review team's comments fall into three categories: "Findings," "Proposed Enhancements," and "Best Practices**.**"

- Findings are defined as operations that are not in compliance with applicable laws and regulations, and are discussed in Section V, "FINDINGS."

- Proposed Enhancements are suggestions that the team believes would improve the State's program integrity efforts. They are discussed according to functional headings in Section VI, "OBSERVATIONS."

- Best Practices are State initiatives that reflect a high level of commitment to the short- and long-term success of fighting Medicaid fraud and abuse in Illinois. They are discussed in Section VI, "OBSERVATIONS."

Direction and Guidance – The review team used HCFA's *National Medicaid Fraud and Abuse Initiative Regional Office Review Guide* as the source of the review's direction and content. It is only a guide, however, designed to assist the reviewers and add consistency to the process. Team members relied heavily on interviews with staff. Operations were evaluated against Federal laws and regulations, listed in the review guide, which prescribe State requirements and outline additional authority that has been granted to the States to enhance their program integrity efforts. The predominant regulatory references are 42 CFR 455 and 447.10.

Scope of review - The scope was limited to the State's current projects and procedures for dealing with provider fraud and abuse issues. This includes the return of overpayments resulting from program integrity type audits. Although the team focused on fraud and abuse efforts for fee-for-service providers, many of the oversight rules that guided the team, as well as its observations, can effectively be applied in a managed care environment. A managed care review guide that is currently being developed by the Initiative will more effectively address program integrity efforts in a managed care setting.

V. FINDINGS

The review team found no areas of regulatory noncompliance.

VI. OBSERVATIONS

This discussion describes what the review team learned through its review of documents and conversations with management and staff. Most of the areas chosen for review are represented not only by a description of the area, but also how it relates to the purposes of the review. In the functional areas for which enhancements are proposed, the team has outlined the current condition, and has stated how the improvement can either alleviate a negative effect or add to a knowledge base that may help identify or prevent problem providers.

The team also has identified and discussed noteworthy best practices that enhance Illinois' program integrity efforts and should be shared with other States. The observations that follow are organized according to topical categories that may overlap various functional areas within the Medicaid Agency.

EXCLUDED PROVIDERS

The U.S. Department of Health and Human Services' Office of Inspector General (DHHS/OIG) was established to identify and eliminate fraud, waste and abuse in the Department's programs, and to promote efficiency and economy in Departmental operations. DHHS/OIG is authorized by the Secretary of DHHS to exclude from participation in Medicare, Medicaid, and other Federal health care programs parties, individuals and entities that have engaged in fraud or abuse.

Statutory Authority **-** Section 1902(a)(39) of the Social Security Act requires State Agencies to exclude any specified individual or entity from participation in the Medicaid program for the period specified by the Secretary, and to provide that no payment be made with respect to items or services furnished by that individual or entity during that period. Section 1903(i)(2)(A) of the Act prohibits the State Agency from making payment for any item or service by an individual or entity during any period during which the individual or entity is excluded from participation under Act Sections 1128, 1128A, 1156, or 1842(j)(2), or for such services provided at the medical direction, or on the prescription of, a physician who is excluded.

Under authority granted by Section 1128(d)(1) of the Act and delegated by the Secretary of DHHS, DHHS/OIG exercises its exclusion authority in a manner that results in an individual's or entity's exclusion from all programs under Medicare, and all State health care programs. Section 1128(d)(2) of the Act directs the Secretary to promptly notify each appropriate State agency of each exclusion, and the period of time that the State agency is directed to exclude the individual or entity from participation in the State health insurance program.

Section 4.30 of the Illinois Medicaid State Plan also prohibits IDPA from doing business with excluded providers.

Identification and Use of Fraud and Abuse Information

Interviews with Staff **-** The review team interviewed IDPA staff about their procedures related to excluded providers, and gathered documents related to the State's implementation of Federal exclusions. State provider enrollment staff related that they process an average of 150-200 provider applications each month. Staff told the team that they received from IDPA/OIG a "sanction list" of parties currently in nonpayment status. Provider enrollment staff informed the review team that they use only this state-generated "sanction list," and updates on exclusions, implemented under Federal or State law, that occur before IDPA/OIG issues its updated sanction list each month.

Staff provided the review team with their most current version of the State's sanction list, dated December 6, 1999. Provider enrollment staff related that they refer all requests for reinstatement to the Illinois Medicaid program to IDPA/OIG, to which the review team was directed with all questions about the State sanction list.

IDPA/OIG staff explained that the State sanction list contained, among other names, parties terminated by IDPA/OIG (for example, due to loss of licensure); parties reinstated to the Illinois Medicaid program after a State termination; and parties whose names appeared on the LEIE and whose addresses were in Illinois, or who had a provider number with the Illinois Medicaid program.

Assessing the Potential for Risk - The LEIE contained approximately 17,000 names of parties excluded as of January 2000. By contrast, the copy of the State sanction list that was provided to the review team contained approximately 3,000 names. The difference of approximately 14,000 excluded parties whose names were listed on the LEIE, but not on the State sanction list, raised a question for the review team as to whether the State's current procedure places it at risk of issuing Medicaid provider numbers to parties in nonpayment status. As noted in the discussion of **Managed Care** at Page 18, the State sanction list is also sent to the Bureau of Managed Care for similar purposes with managed care networks.

Concerned with this potential risk, the review team conducted a test that would give some indication whether the State can adequately protect itself from doing business with parties whose names may appear on the LEIE, but not on the State-generated sanction list. The team conducted this limited test by entering the Internet location of the LEIE and sorting it according to the State address of the excluded party. Thus, only parties with Illinois addresses were identified and searched by the team. This enabled the team to focus on parties who might be more likely to pose a threat to Illinois Medicaid by attempting to re-enter the program to obtain direct reimbursement, or to gain employment in the health care field in Illinois and thereby obtain indirect Medicaid reimbursement. Because the addresses were in Illinois, these exclusions also would be more likely to have occasioned DHHS/OIG to send exclusion notice letters for each party to the State Agency.

Results of Onsite Research - The review team found 600-700 names with Illinois addresses when it sorted the names on the LEIE in late January 2000. The review team quickly found, at random, five individuals listed on the LEIE whose names did not appear on the State's sanction list. These five parties were:

- Robert Wilson, a doctor of osteopathy excluded effective October 20, 1999;
- George Kouns, a medical doctor excluded effective May 20, 1999;
- Charles VanBibber, who was associated with a billing service company, excluded effective December 17, 1987;
- Ann Sheppard, a nurse (or nurse aide) excluded effective June 28, 1992; and
- Carol Turner, business manager of a skilled nursing facility, excluded effective August 19, 1999.

The team ended this test when it found the five parties mentioned above. The team believes it very likely, however, that there are other names on the LEIE with Illinois addresses that were not on the State sanction list. Further, this test did not compare the State sanction list against the thousands of parties on the LEIE whose addresses were not in Illinois.

Condition and Possible Effect - Because these five names were not on the State's "sanction list," the review team believed that IDPA provider enrollment staff would not have known that these five individuals were in nonpayment status. The State would therefore be at risk of issuing Medicaid provider numbers to them if they had submitted applications, or of not identifying them as excluded if the State learned of their association with individuals or entities that had Medicaid numbers in Illinois.

Additional Information - The review team discussed this test with IDPA/OIG staff and provided identifying information about the five parties. The team also asked IDPA/OIG to comment on the results of the test, which IDPA/OIG did by letter dated February 14, 2000 (received by the review team leader on February 23, 2000). In pertinent part, IDPA/OIG responded:

> "The Office of Inspector General (OIG) did not begin tracking non-medically licensed individuals, ineligible to participate in the Illinois Medicaid Program, on its sanction list until 3/3/94. Prior to this date, these individuals were tracked through the letters received directly from the Department of Health and Human Services.
>
> We reviewed the five individuals selected by William Hughes and found that Robert L. Wilson, M.D., had been terminated by the Department of Public Aid on October 21, 1999 and George Kouns, M.D. was not an enrolled provider. Apparently, the Provider Participation Unit had not received an update as of November 1999, which is the month of the list provided to you. None of the remaining three individuals are participating in the Illinois Medicaid Program and no payments have been made to them. As we discussed during your onsite review, this should not be an issue once our sanction database becomes operational in a few months."

As described above, State agencies are required by Federal law, regulation, and State Plan not to do business with excluded parties. The State's Provider Enrollment unit used a list of approximately 3,000 names when staff reviewed provider applications, rather than the LEIE or its equivalent. Thus, IDPA was at risk of issuing provider numbers, and making inappropriate payments under the Medicaid program, to parties in nonpayment status.

Additional Concerns – Because the additional information received by letter from IDPA/OIG did not address all of the team's concerns, it used the sanction list dated December 6, 1999, which was received from State staff during the onsite review, for further analysis.

- Although the State responded in its letter that it began "tracking" non-medically licensed individuals on March 3, 1994, the name of the business manager of the skilled nursing facility, excluded August 19, 1999, did not appear on the State's sanction list.

- The name of the party associated with the billing service company, who was excluded on December 17, 1987, did not appear on the State sanction list.

- Dr. Wilson, who was terminated by IDPA on October 21, 1999, was not on the State sanction list.

- Dr. Kouns was not an enrolled provider, but was not added to the State sanction list.

Risk Exposure - The five names provided to the State as the result of the team's random test serve only as examples, rather than a comprehensive list, of parties who are listed on the LEIE but not on the State sanction list. The review team had a limited amount of time to spend onsite at the State agency and therefore was unable to fully address the issue of whether the State is adequately reviewing its records to be sure that excluded parties do not obtain or have active Medicaid provider numbers. The team continues to believe that the State is at risk of paying excluded providers (directly or indirectly), and that it will remain at risk until it begins to use the more comprehensive information about excluded parties that is available to it. If there are any subsequent visits by a Network review team to Illinois, this issue should be considered for additional development.

Proposed Enhancements

Interim Measures - The State is in the process of implementing a permanent fix (see **Best Practices**) to its exclusion vulnerability. Until the process is in place and fully functional, however, the State should consider using the LEIE or its equivalent to be sure that it does not issue new Medicaid numbers to excluded parties, or continue to do business with excluded parties which already may have Medicaid provider numbers in Illinois.

Best Practices

Sanctions Website - The State of Illinois plans to post State-imposed sanctions on an Internet website that will be functional in the near future. This will allow the public and other providers to readily see which parties have been excluded.

Automated Sanction Database - The State plans to correct its exclusion vulnerability by creating a complete DHHS/OIG sanction database that is automatically compared to the existing provider database and searched prior to issuing new provider numbers. With implementation planned during 2000, this process should be a significant leap forward and help the State ensure that it does not begin or continue to do business with excluded parties. The new process will only be effective, however, if the database reflects the entire LEIE, whereby it may qualify as a best practice that would be well worth sharing with other State Agencies.

PROVIDER ENROLLMENT

The Provider Enrollment Unit is located within the Medical Operations Bureau of Administrative Support. Provider Enrollment staff determine which of the 150-200 providers who submit applications each month will be enrolled in the Illinois Medicaid program. The unit handles all provider types, with the exception of those who are processed by the Bureau of Long-Term Care. Enrollment information for long-term care providers is sent to Provider Enrollment for inclusion in the unit's records. This process begins by supplying applications to potential providers and ends with the unit either rejecting an application, or accepting the provider for participation in the Medicaid program. Applications are reviewed for completeness as well as for proper signatures, and are scanned into a storage and retrieval imaging system that can be accessed by provider number. Rejected applications are tracked for 15 days to expedite the process when the application is corrected and resubmitted.

Identification and Use of Fraud and Abuse Information

The Provider Enrollment Unit checks with the Illinois Department of Professional Regulation to ensure that a physician's medical license is valid. For out-of-state physicians requesting enrollment in Illinois, a copy of another State's license is used as sufficient proof of licensure. Other informational requirements for disclosing entities include the disclosure of ownership and criminal convictions. When an applicant's information is determined to be acceptable, it is compared to the exclusion list received from IDPA/OIG to make sure the entity has not been barred from participation. If a match is found, the application is pulled and sent to IDPA/OIG for review and follow-up.

Information Disclosure **-** IDPA's provider enrollment process does not take full advantage of the State's authority to collect provider disclosure information. While regulatory provisions at 42 CFR 455.104 do not require that the State gather it, this data can provide additional timely information that can be used not only in the enrollment process, but also by other State units that review providers. Similarly, the disclosure of certain subcontractor and supplier information also is not collected through the provider enrollment process as the regulations at 42 CFR 455.105 allow.

Criminal Background Checks **–** The review team was told that the State is not routinely running potential providers through a criminal background check as part of the enrollment process. The State's provider enrollment application requires potential Medicaid providers to disclose and certify, in pertinent part, that they (and other involved parties) are not "…currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations."

Designated Payee **–** Provider Enrollment Unit staff reported that most physicians select one or more payees in addition to themselves to receive payment for services rendered by the physician. The review team also was informed that the relationship or contract the physician has with the payee is not reviewed for appropriateness. Federal regulations

permit this type of an arrangement to groups and billing companies only under certain agent or employer circumstances as outlined in the regulations at 42 CFR 447.10.

Proposed Enhancements

To maximize disclosure during the enrollment process, the review team proposes that IDPA staff:

- Routinely contact out-of-state licensure boards to validate the license presented by a physician as evidence of the physician's professional status;

- Request ownership and conviction information from physicians;

- Review the permissibility of relationships between physicians and payees designated to receive Medicaid payments;

- Use the authority granted by provisions of the Balanced Budget Act of 1997 to refuse to do business with parties convicted under Federal or State law of a felony offense that the State determines to be inconsistent with the best interests of its beneficiaries;

- Request ownership information about a subcontractor with whom a provider has had business transactions totalling more than $25,000 during the past 12-month period. The State also can collect complete information about significant business transactions with a wholly owned supplier during the past five-year period;

- Consider modifying the certification language in its provider enrollment application to obtain information about all felony convictions, not just a Medicaid- or Medicare-related conviction for which the provider is currently serving a sentence or under sanction; and

- Consider running current and potential providers through a criminal background check as part of the enrollment process.

Best Practices

Non-participating and Inactive Status **-** Placing providers who do not bill Medicaid for 12 months into a non-participating status, and then inactive when an additional 12 months passes, is a good preventive measure. The proposed practice of automatically comparing the provider base to the LEIE and the State's sanction list is a proactive step that should help prevent sanctioned and terminated providers from Illinois and elsewhere from being enrolled in the Medicaid program.

Provider Re-enrollment **-** Having already re-enrolled all of its participating dentists within the past year, IDPA reported that it plans to re-enroll all of its approximately 60,000 active providers in the near future. The addition of seven new staff members to the Provider Enrollment Unit should assist the State's stated goal of re-enrolling all of its

providers every five years. The re-enrollment process also provides a timely opportunity for the State to consider including the additional disclosure information that we have proposed as enhancements.

AUDIT

The Audit Section is located under the Bureau of Medicaid Integrity within the Office of Inspector General. There are 30 auditors located in Chicago and five in Springfield. Cases presented for audit come from the NRC, which analyzes more than one hundred narratives monthly and recommends 20 or 30 for audit. The cases selected for audit do not include managed care providers unless the provider is selected for review based on fee-for-service issues.

Identification and Use of Fraud and Abuse Information

When cases are received, they are entered into an audit queue and assigned to audit staff. Some cases that are referred from outside entities bypass the NRC and go straight to the audit queue. The auditor reviews a provider claim detail representing a statistically valid sample of claims. The provider who is subject to audit is notified and asked to pull the client records for the sample of claims selected. Provider financial and related organization records also are reviewed. Audit staff evaluates this information to determine if the medical records support the services billed; if there is an overpayment; and if there are possible violations of anti-kickback law.

The review team randomly selected and reviewed five cases from the open and closed audit queues. The cases were well developed, with substantial supporting documentation, indicating that the SURS function, NRC process and audit staff all contribute to a quality audit program.

Coordination and Communication With Other Entities Involved in F&A

The Medicaid Fraud Control Unit (MFCU) participates in the NRC and can take a case to review for civil or criminal fraud before it gets to the audit staff. Cases also can be sent to the MFCU at any time during the data gathering and audit process if it is felt that a likelihood of fraud exists. Auditors assist the MFCU with data and information for cases that are referred.

Proposed Enhancements

Managed care providers should not be exempt from audit consideration. Since shadow claims exist within the MMIS, they could be considered for possible inclusion in the exception reports generated in the SURS. The audit unit could review a small sample of managed care providers to establish an oversight foothold. This would provide IDPA with a way to evaluate this type of provider that currently does not exist.

Best Practices

Case Tracking System – The review team was told that a case tracking system under development will allow auditors to access all types of information on providers and clients derived from any IDPA/OIG activity, such as audits, peer reviews or investigations. Auditors' ability to access narratives, audit reports and work papers, in particular, promises to be a valuable time saver and a boost to the development of audits and case information.

MEDICAID FRAUD CONTROL UNIT

The Illinois State Police is the grantee for the Medicaid Fraud Control Unit (MFCU), which has been in existence since 1978. The Illinois State Police is responsible for the investigators and auditors. The prosecutors report to the the Illinois Attorney General's (AG) office, which is a separate constitutional office in the State. The current director has been with the MFCU since 1991 and has served as director since August 1999.

Settlements and Convictions **-** The MFCU obtained 17 convictions and settlements in 1997; 21 convictions and settlements in 1998; and 19 convictions and settlements in 1999. Approximately 90 percent of the matters on which the MFCU works originate with IDPA/OIG.

IDPA is a signatory to all settlements entered into by the MFCU as a result of their investigations. IDPA receives full restitution in the cases which the MFCU investigates alone. In cases that involve Federal and State violations that are investigated by the MFCU and a Federal agency (*e.g.,* DHHS/OIG or the Federal Bureau of Investigation (FBI)), funds collected are split by the IDPA and the Federal agency involved. Most of the cases investigated by the MFCU contain civil as well as criminal issues.

Coordination and Communication with Other Entities Involved in Fraud &Abuse

The relationship between a MFCU and a State agency can sometimes suffer due to inherent tensions that exist between the law enforcement function of a MFCU and the administrative function of a Medicaid agency.The MFCU's relationship with IDPA is generally good, however. Both the MFCU and IDPA/OIG report directly to the Illinois Governor's Office, reducing the likelihood of conflicts between them.

Information Sharing **-** The MFCU gets information about all of the audits done by IDPA/OIG in the form of a "cover sheet" that provides summary information on each audit. The MFCU participates in the NRC and considers it important. Among other things, it allows the MFCU to learn of State activities early in the process. The MFCU's participation in the NRC also allows it to suggest that IDPA do post-payment computer reports which, in the MFCU's opinion, are likely to indicate that fraud has been committed. The MFCU returns cases to IDPA/OIG that it closes without investigation, and also provides a summary quarterly report of these cases. The MFCU has access to

MMIS reports through IDPA. It takes several weeks, however, for the MFCU to get the information needed, either in paper format or otherwise. The MFCU does have online access to MMIS data through a terminal in its own office.

Working Relationships **-** The MFCU reported that it has a good relationship with the United States Attorney's Office. Joint cases are common in the Central and Southern Districts of Illinois. Some of the MFCU's staff attorneys are cross-designated as both Federal and State prosecutors.

IDPA/OIG reported having equally good working relationships with both the MFCU and the State AG. IDPA has been receptive to the MFCU's comments concerning State policies that the MFCU believes should be changed to better protect Medicaid funds. The MFCU and IDPA/OIG speak on a weekly basis, and more often as needed. IDPA/OIG has a staff person on site with the MFCU, and this facilitates communication between them. The FBI also has an agent onsite at the MFCU.

IDPA/OIG's relationship with the MFCU allows the MFCU to better utilize its investigative resources. By sharing information with the MFCU so readily (*e.g.*, as demonstrated by the MFCU's participation in NRC meetings), IDPA and IDPA/OIG help protect the integrity of the State Medicaid program. Information sharing is equally and as freely shared with the health care fraud prosecutors assigned by the AG.

Proposed Enhancements

None were identified during the review.

Best Practices

Onsite Presence **–** Having a DHHS/OIG staff member onsite with the MFCU facilitates communication between them.

MANAGED CARE

The National Medicaid Fraud and Abuse Initiative is in the process of developing comprehensive guidelines to assist the states and other stakeholders in their efforts to identify, prevent, investigate and report Medicaid fraud and abuse in a managed care setting. Although the primary focus of this review was the fee-for-service environment, the review team was interested in learning about managed care operations and any provider oversight. This information is reflected in this report because it represents timely input into our developing efforts to assist the states with their program integrity efforts in the managed care environment.

Managed care options and penetration **-** Staff from IDPA's Bureau of Managed Care (BMC) reported that currently, a total of eight managed care organizations (MCOs) participate as contractors in the State's voluntary Medicaid managed care program serving 150,000 eligibles. Six of the MCO contractors are Medicaid Health Maintenance

Organizations (HMOs) and the other two are Managed Care Community Networks (MCCNs). The number of health care organizations offering Medicaid HMOs in Illinois dropped by half in 1999, from 16 contractors in 1998 to the current six. Medicaid MCOs currently are active in two Illinois counties: Cook, which includes the Chicago metropolitan area, and St. Clair, which encompasses East St. Louis.

MCCNs **-** BMC staff described MCCNs as provider-based organizations that were integrated into IDPA's Medicaid managed care program beginning in July 1999 as authorized under 1998 state law. For contracting purposes, MCCNs are treated similarly to HMOs, but are subject to different licensing standards and financial solvency requirements, the level of which increases with an MCCN's time in the program. Being IDPA entities, MCCNs are not subject to oversight by the Illinois Department of Insurance.

Provider Participation Requirements. BMC staff related that providers who participate in the Medicaid managed care program must:

- Be Medicaid-enrolled;
- Remain in good standing; and
- Provide notice of any changes.

Identification and Use of Fraud and Abuse Information

Database Access – Illinois reported that it makes information on enrolled providers available to its MCOs through Electronic Data Interchange (EDI). With respect to the approval process for new primary care providers in an MCO's network, the State used a manual, paper process at the time of the review. Under a proposed new automated system, BMC would move beyond the current system, in which IDPA Provider Participation staff performs "lookup" of provider information on the database and provides that information to the MCOs, to allow the MCOs database access. Lookups will no longer be required, and a provider's status will be verified automatically by IDPA. Approvals or denials of provider participation in the MCO network will be reported back to the MCO.

Tollfree Fraud and Abuse Hotlines – Provider- and client-oriented fraud and abuse reporting hotlines are maintained by IDPA, with a primary focus on eligibility fraud. IDPA agreed to furnish a report detailing the number of referrals received via hotline calls, either from or about Medicaid MCOs, for future follow-up.

Coordination and Communication with Other Entities

Communication with Contracting MCOs **-** BMC staff members reported that they maintain constant interaction with the six HMOs and two MCCNs currently participating as contractors in the State's managed care program. That interaction includes quarterly meetings, which BMC holds with each participating MCO. A second set of quarterly meetings also is held with the MCOs as a group to discuss topics of general interest. A third set of quarterly meetings is held with the quality assurance directors and medical

directors from all participating MCOs. IDPA also meets regularly with MCOs and their behavioral health subcontractors on issues related to behavioral health. Ad hoc meetings are scheduled with the MCOs as a group, or individually, as needed.

Reporting and Monitoring **-** Contracting MCOs must notify the State immediately of any provider/site terminations. Providers who move from one health care plan to another retain the same Illinois provider number, but are assigned new site numbers.

Coordination to Ensure Access to Care **-** Although some providers are paid on a capitated basis by the Medicaid MCOs with which they contract, a substantial number of Medicaid providers under such contracts are paid on a fee-for-service basis. BMC staff related that in November 1999, one of its MCO contractors with enrollees in Cook County issued a public statement that it would defer all medical necessity determinations for covered services to its network providers, effectively granting its physicians final approval and autonomy concerning decisions to cover treatment that they deem medically necessary. This action was seen by BMC as a positive indicator of the MCO's commitment to, and coordination with, IDPA's goal of ensuring that Medicaid beneficiaries have appropriate access to care.

Interaction with IDPA/OIG **-** BMC staff reported that they interact with the IDPA/OIG on a monthly basis and have a standing meeting for that purpose. The meeting also is attended by IDPA General Counsel, as well as representatives from the State Department of Insurance and the MFCU. BMC noted that it works particularly closely with IDPA/OIG on eligibility fraud issues.

Excluded Providers **-** IDPA/OIG shares its sanction list with BMC, which in turn forwards it to MCO contractors. The State's sanction list is checked against monthly Provider Affiliation Reports (PARs) filed by participating MCOs, generally with a one-week turnaround time. An error report is generated on any sanctioned provider names that appear on a plan's PAR. BMC staff reported that these error reports are retrieved electronically by MCO contractors.

Contractual Fraud Control Provisions **-** Federal program integrity regulations at 42 CFR 455.13(a), address the methods and criteria used to identify suspected cases of fraud. Exhibit A of the State's contract for HMO services specifies that the contracting MCO must fully implement a quality assurance program which, in addition to monitoring health care services quality, provides for fraud control. (The oversight role of the State's contract external quality assurance organization is detailed below.)

- ***Fraud and Abuse Reporting Requirements*** **–** At the time of the review, according to BMC staff, new contracts with an effective date of April 1, 2000 would be substantially similar to contracts that were in effect at the time of the review but scheduled to expire on March 31, 2000. The contract addressed fraud and abuse procedures in Article V(y), which required that MCO contractors properly report suspected fraud and abuse, appoint a liaison to IDPA, and ensure that policies and procedures are in place internally and at all subcontractors.

Although the State did not anticipate at the time of the review that the next round of contracts would be substantively changed, the State subsequently reported that actual changes to the fraud and abuse reporting requirements have strengthened the contract.

- ***Other Fraud and Abuse-Related Contract Terms -*** In addition to these reporting procedures, BMC staff pointed to other fraud and abuse-related provisions in Article V of IDPA's managed care contract. These provisions prohibit fraudulent marketing, credentialing and reporting practices.

Quality Assurance Oversight - In compliance with the program integrity regulations at 42 CFR 455.13(a), BMC staff detailed the functions of the State's external quality assurance contractor (QAO). BMC works routinely with the QAO as an external entity that engages in medical review activity. BMC staff reported that the QAO is charged with, and effectively accomplishes, the following functions:

- ***Onsite review activities -*** These activities typically involve attending quality assurance (QA) and peer review committee meetings, reviewing minutes of such meetings, looking at MCO contractors' QA plans, reviewing their objectives, monitoring emergency and telephone logs, and reviewing provider credentialing, ensuring contractor compliance with the HMO Federal qualification regulations at 42 CFR 417.106.

- ***Medical record review*** - Monitoring plan compliance with 42 CFR 417.106(a)(3), encounter data is used by BMC to pull samples that are passed on to the QAO for review. The QAO then shares that information with the MCO, which pulls supporting records for the QAO to review at site offices. The sample size is based on enrollment and other factors.

- ***Oversight of plan QA functions -*** QAO reviews plans requiring prior IDPA approval, as well as annual QA plans as required under 42 CFR 417.106(a).

- ***Technical assistance -*** In response to the receipt of complaints or the identification of issues and the process for addressing them with MCO contractors, as addressed at 42 CFR 455.14, BMC sends in the QAO to assist MCO contractors. This also entails supporting MCO contractor compliance with 42 CFR 417.106(a)(4), which requires appropriate remedial action as determined under a QA program. BMC staff reported experiencing few difficulties with the QAO's documentation or coordination with IDPA.

Proposed Enhancements

None were identified during the review.

Best Practices

None were identified during the review.

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM

The Medicaid agency's Surveillance and Utilization Review Subsystem (SURS) Control unit is located in the Bureau of Information Technology (BIT) within IDPA/OIG. The actual SURS function is part of the Medicaid Management Information System (MMIS) mechanized claims processing and information retrieval system, which States are required to have unless waived by the Secretary of DHHS. A typical MMIS has several subsystems that maintain information on, for example, beneficiary eligibility, provider billing, claims processing, and third party liability. As one of the core subsystems of MMIS, the SURS is designed to help identify inappropriate care and services by creating beneficiary and provider profiles for program management and utilization review purposes.

SURS Capability **-** SURS derives most of its data from adjudicated claims, so the emphasis is on a retrospective review of beneficiaries and providers. Through the use of automated exception reporting techniques, the relatively few potential misutilizers are isolated for further review. SURS can establish a statistical profile of health care delivery and utilization patterns established by providers and beneficiaries. These profiles can establish norms and calculate averages and standard deviations by peer group.

For example, Management Summary Reports can be produced for each class group and reported item of service provided, establishing a normal range of values as the average plus or minus some standard deviation. Profile Reports can show, for each provider or beneficiary, a set of statistical indicators describing utilization patterns, so that exceptional utilizers can be reviewed more closely.

Identification and Use of Fraud and Abuse Information

IDPA/OIG's BIT combines SURS and other State systems functions. The State currently uses the NOMAD system, which operates as part of BIT. Additional claims payment information is added to NOMAD on a monthly basis, and it contains approximately two years of paid claims history. At present, approximately 80 percent of claims are submitted electronically to the State.

SURS Unit Activities **-** SURS produces monthly and quarterly reports based on paid claims data that is arrayed so that aberrant providers can be identified. Notably, all provider groups are reviewed, and all have some chance of being identified as exceptional. Providers are assigned to different groups (*e.g.*, rural or urban, specialists or generalists) and compared against the practice patterns of their peers. SURS staff identify about 350 providers for further review each quarter, and these initially selected providers are assigned to analysts in the SURS area. These analysts, who do not do field work, gather additional information in-house about the provider under review and present it to the monthly meeting of the Narrative Review Committee (NRC). Members of the NRC include the Audit Manager of IDPA/OIG, the SURS chief, the MFCU, staff from Medical

Programs staff and the Bureau of Long-Term Care, and staff members from other program areas, as warranted by the cases to be reviewed each month.

Postpayment Activities - Current State SURS staff have regularly produced significant overpayments for the Illinois Medicaid program each year. They also have produced significant numbers of case referrals to the Medicaid Fraud Control Unit for consideration of further investigation.

Prepayment Activities - In addition to their post-payment efforts, the State makes significant efforts to prevent erroneous payments before they occur. The State reported having avoided paying $16 million in inappropriate Medicaid claims during State Fiscal Year 1998 due to the Recipient Restriction Program. More significant savings were realized from the State's claims processing prepayment edits, which saved the State $25.2 million in SFY 1998.

The State has also recently begun using a "payment spike" report produced by SURS. This report allows the State to determine if a provider has had an unusual increase in Medicaid payments that might warrant further review. The State is currently using the report to review services of nonemergency medical transportation companies. (The Spiked Payment project is discussed as a Best Practice at Page 23.)

Data Analysis-Based Reviews - Prior to the NRC meeting each month at IDPA/OIG offices in Springfield, that office mails material related to each case that will be reviewed to all members so they can prepare to discuss the approximately 100 cases on that month's agenda. After the presentation by the assigned IDPA/OIG analyst, NRC members then cast their individual votes to decide how these cases should proceed. The State is currently seeking additional funding from HCFA to implement a case tracking system that it already has designed.

Complaint-Based Reviews - In addition to conducting data analysis reviews, the State also performs reviews on the basis of complaints received. These "tips" sometimes are referred directly to the NRC, without assignment to analysts. Once the NRC process is completed, IDPA/OIG keeps track of any referrals made to other agencies (*e.g.*, MFCU, DHHS/OIG) via a card file system. Other complaints generate audits, peer reviews or investigations without ever being reviewed by the NRC.

Data Mining – A new data warehouse will allow the State to analyze data from different perspectives and summarize it into useful information, a process commonly known as "data mining." Data mining will allow the State to look for patterns among the claims it receives from Medicaid providers and determine whether patterns are benign, or perhaps malignant. (The State's new data mining capability is also discussed under **Bureau of Fraud Research** at Page 24.)

Proposed Enhancements:

None were identified during the review.

Best practices:

Spiked Payment - The "payment spike" report currently in use by the State is a means of preventing erroneous payments to Medicaid providers. It calls attention to unusual claims activity of providers based on past billing patterns, and allows the State to review claims before they are adjudicated and paid.

NRC Meetings - The practice of holding an NRC meeting each month to discuss provider information is a very good way to identify the best cases for audit. SURS, IDPA/OIG, Medical Programs, MFCU management, and the State Departments of Public Health, Professional Regulation and Human Services review the narrative case information developed to that point. Cases can be picked for criminal investigation by the MFCU or selected for audit based on the thoughts of the group.

Client Server-SURS - IDPA/OIG is nearing implementation of an expanded version of SURS, CS-SURS, because of the application of personal computers to the fraud detection process. Expected to be up and running in 2000, CS-SURS offers many advantages over the old methods of doing business. Individual employees will be able to sit at their computers and select any desired combination of Medicaid service parameters to manipulate and compare.

New Data Warehouse - NOMAD will be replaced in 2000 with the State's data warehouse, which is a collection of integrated, subject-oriented databases designed to support State decisions. The data warehouse will provide the State with better information; merge operational, informational, departmental and beneficiary data; and make it readily available to State staff. Because the warehouse ultimately will contain five years of paid claims data, it will provide the State with the data it needs for analytical processing over a long, historical perspective. (Further detail of the data warehouse follows under **Bureau of Fraud Research** on this page.)

BUREAU OF FRAUD RESEARCH

The Bureau of Fraud Research (BFR), located within IDPA/OIG, is a fraud and abuse "think tank," considered by the review review team to be a Best Practice in itself. BFR's staff of six investigators, whose backgrounds range from analysts in the SURS unit to former quality control reviewers, is headed by a staff member with nearly 25 years of experience in program integrity and quality control.

Although BFR has been in operation as a separate entity for only one year, its predecessor, Loss Prevention Analysis and Research, existed since 1995 with essentially the same staff and mission as BFR. The think-tank mentality that drives the unit has sparked innovative efforts on the part of IDPA/OIG. Certain projects that may have had their inception prior to the formal creation of the unit are attributed here to BFR. This Bureau's charter is to "develop or acquire fraud detection routines." In general terms, BFR looks for fraudulent service patterns that are beyond the scope of SURS.

Identification and Use of Fraud and Abuse Information

***Data Warehouse* -** BFR currently uses a Statistical Analysis System (SAS) that selects data and analyzes it for patterns indicating possible abuse. The system presently contains three years of data, but that capacity will be expanded as a new data warehouse is fully implemented. The fully developed data warehouse, a joint project of IDPA/OIG and the Division of Medical Programs (DMP), will include:

- all claims history for the past five years,
- provider and recipient information, and
- relational databases (Social Security numbers, rent paid, *etc*.).

Staff reported having found more than 400 specific schemes and techniques for data gathering. The group anticipates being able to further expand its work in that area when the data warehouse is fully implemented.

***Data Mining* –** At the time of the review, a contractor, the Triada Company, was developing data mining software for BFR that utilized correlations and other probability trees to compare many variables simultaneously, seeking unusual patterns in data that are not readily apparent. The State subsequently reported that Triada had been replaced by Innovative Software Solutions, Inc. Data mining, which can "drill down" to claims level data, finds correlations that are evident only from an analysis of years of data. (See also the discussion of data mining under **SURS** at Page 24.)

***Executive Analysis* –** BFR reported that it also will be using another software package, Executive Information Systems (EIS) by Medstat. The new EIS, a joint project of IDPA/OIG and DMP, will provide information involving health care outcomes and trends, utilizing graphs and pie charts. Managers will have access to this system, which is described as user-friendly.

***Claims Analysis* –** State staff reported on a number of claims analysis projects jointly developed by IDPA/OIG and DMP. Staff utilizes commercial code analysis, which is a more sophisticated method to edit submitted claims for incongruous billing code combinations. BFR staff related, for example, that this capability has been effective in detecting inappropriate billing by non-emergency transportation companies. BFR devised a system of prior approval linking medical transportation claims with other medical service invoices, improving the State's detection of false transportation claims. BFR reported that the State has issued a Request for Proposal to proceed to the next step of automating the prior approval process. Bureau staff also reported similar success in detecting a scheme in which false claims were submitted by a third party billing contractor that had inflated its billings by a factor of ten.

BFR reported having examined its Medicaid managed care expenditures once, without finding any significant problems. Managed care is not a big factor in the State's Medicaid program, with only 150,000 enrollees, or 10 percent of the current total client population

of 1.5 million, currently enrolled. (See Page 18 for discussion of the State's managed care program.)

New CS-SURS – IDPA/OIG has been instrumental in the development of a new CS-based SURS system that is expected to be up and running early in 2000. (See **SURS** at Page 24.)

Beneficiary Eligibility Cards – DMP and IDPA/OIG are moving jointly to a plastic "swipe" eligibility card, which is intended to reduce the incidence of Medicaid "card sharing." Long-range plans include the establishment of alternate methods of identity detection, such as retinal scanning, which would eliminate the need for Medicaid identification cards altogether.

Fraud Science Team - The creation of the FST, which is funded by IDPA and resides within BFR, is a recent and laudable development. The team is charged with developing cutting-edge program integrity software.

Random Claim Selection - Each month, BFR selects for review a statistically valid, random sample of claims that have not been associated with an unusual service pattern. Thus, every Medicaid claim processed has a chance of being reviewed. This is a criterion for spotting fraud espoused by Malcolm Sparrow of Harvard University's John F. Kennedy School of Government, who continues to advise the State following his participation in a 1997 educational symposium on fraud and abuse that was organized by IDPA/OIG--and which, in itself, the review team cited as a best practice for its value in staff education.

Specially Designed Edits and Reports - In its role as a participant in the MFPEW, IDPA/OIG was instrumental, along with DMP, in developing the innovative "spiked payment" program designed to detect a sudden rise in the level of a provider's service delivery. The use of these monthly reports, which alert the State to examine provider invoices, was cited separately as a best practice of the SURS unit. (See Page 24.)

Through the use of other specially designed computer edits and monthly reports developed by BFR, MFPEW can identify billing patterns that vary from the norm, listing such providers for further study.

Other success stories include:

- An early project that involved a clinical laboratory, which had been billing routinely for a few thousand dollars every month. When claims billing accelerated rapidly to $1.3 million in less than four months, prompt follow-up investigation uncovered fraudulent activity that resulted in the subsequent conviction of the lab's proprietors.

- A medical transportation invoice edit to determine whether an additional Medicaid invoice is in the system when a transportation claim is found. The theory is that the latter cannot exist without the former.

- BFR initiated a project to monitor pharmacy practices that include a consistent pattern of early prescription renewal; excessive numbers of one-day drug supplies; and multiple prescriptions for the same recipient, on the same day, for drugs from the same therapeutic class.

Nursing Home Liabilities - BFR was instrumental in IDPA/OIG efforts that resulted in a recently passed Illinois law. Fines and penalties levied against nursing homes now accrue to the new owner of any nursing home that declares bankruptcy and immediately re-opens under new ownership. The new law has effectively halted the practice of nursing homes incurring, and then ignoring, Medicaid fines.

Other Projects - BFR staff detailed a number of other proposed IDPA/OIG plans and projects that are in various stages of joint development with DMP:

- A proposed electronic payment project would allow providers to be paid over the Internet.
- A project to uncover ineligible applicants for nursing home services, the Long-Term Care Asset Discovery Initiative (LTC-ADI), identified client assets that should have been counted in the Medicaid application process. With nearly $2 million in Medicaid program savings, IDPA/OIG has asked IDPA to expand the project statewide.
- Biometric screening has been employed to eliminate "phantom" children. This process involved rescreening, which was described as less than successful, and fingerprinting, which has been more successful Statewide.
- Although a fraud investigation project involving neural networking was not previously successful, it will be attempted again when the data warehouse is in place.

Coordination and Communication with Other Entities Involved in F&A

LTC Project Expansion - After two successful rounds of the LTC-ADI project (described above) saved the Medicaid program nearly $2 million, IDPA/OIG plans to expand the project statewide to realize projected savings in the range of $9 million. This expansion will entail coordination between IDPA, in which the Medicaid program and IDPA/OIG reside, and the Illinois Department of Human Services, which determines eligibility for medical assistance, including long-term care.

Project CARE – IDPA/OIG has performed projects that aid the cash assistance side of IDPA, as well as the Medicaid program. One such project focused on detecting $300,000 in cash assistance overpayments to families fraudulently claiming "phantom" children. The Children-at-Risk Evaluation, or Project CARE, studied fraud indicators that included nonstandard or questionable birth certificates, and all Medicaid-certified children who had ever had services billed in their name.

VII. HINDRANCES

An important part of the team's review is to restate situations that, in the opinion of IDPA, hinder the State's ability to most effectively fight fraud and abuse. IDPA/OIG told the review team that it has regularly referred State Medicaid termination file material to DHHS/OIG for consideration of nationwide exclusion under Federal law (see Section 1128(b)(5) of the Act). IDPA/OIG also stated that DHHS/OIG rarely, if ever, implements a Federal exclusion based on the State's termination action. IDPA/OIG believes that State-imposed terminations should routinely be given reciprocal effect by DHHS/OIG via exclusion of such parties from nationwide participation in Medicare, Medicaid, and all Federal health care programs.

VIII. CONCLUSION

The review team found that the State of Illinois is complying with all of the required Medicaid program integrity laws and regulations as outlined in the review guide. The State has an inspiring working relationship with its MFCU, and is performing many functions in an innovative way that pushes the State's Medicaid program integrity processes to a high level. The State also has demonstrated a noteworthy capacity to initiate proactive activities that have further elevated its program integrity operations. The State is proposing many other initiatives to enhance its fight against fraud and abuse, which the review team feels can be enriched with the incorporation of the proposed enhancements.

ABBREVIATIONS

Act	Social Security Act
BBA	Balance Budget Act of 1997
BFR	Bureau of Fraud Research
BMC	Bureau of Managed Care
CFR	Code of Federal Regulations
CS-SURS	Client Server SURS
DHHS/OIG	Department of Health and Human Services, Office of Inspector General
DMP	Division of Medical Programs
EIS	Executive Information System
FFP	Federal Financial Participation
FST	Fraud Science Team
HCFA	Health Care Financing Administration
IDPA	Illinois Department of Public Aid
IDPA/OIG	Illinois Dept. of Public Aid, Office of Inspector General
ISP	Illinois State Police
Initiative	National Medicaid Fraud and Abuse Initiative
LEIE	List of Excluded Individuals and Entities
LTC-ADI	Long Term Care Asset Discovery Initiative
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MFPEW	Medicaid Fraud Prevention Executive Workgroup

MMIS	Medicaid Management Information System
NRC	Narrative Review Committee
PAR	*Payment Accuracy Review of the Illinois Medical Assistance Program*
QAO	Quality Assurance Organization
SAS	Statistical Analysis System
SSN	Social Security Number
SURS	Surveillance and Utilization Review Subsystem
TANF	Temporary Assistance for Needy Families