



Illinois Health Care Fraud Elimination
TASK FORCE

Interim Report

October 2017

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I. Executive Summary



In April 2016, Governor Bruce Rauner created the Illinois Health Care Fraud Elimination Task Force (Task Force) with the purpose of “develop[ing] and coordinat[ing] a comprehensive effort to prevent and eliminate health care fraud, waste, and abuse in State-administered health care programs using a cross-agency, data-driven approach.”¹ Since April 2016, the Task Force has diligently worked to ensure that taxpayer funds for the State of Illinois (State) government-administered health care programs are being spent properly. The value of reducing fraud, waste, and abuse is immense, and in these economic times would allow the State to utilize funds currently being misspent to provide better programs and services for the citizens of Illinois. Those who defraud the system are taking money from individuals who depend on these services, such as seniors, children, injured employees, and persons with disabilities.

The State devotes a substantial amount of resources and taxpayer dollars to its health care programs, making these programs particularly vulnerable to fraud, waste, and abuse. The

Task Force has specifically targeted fraudulent conduct and wasteful spending in the following Illinois health care programs: Medicaid, Workers’ Compensation, and State Employee Group Insurance.

In federal fiscal year (FY) 2016, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to over 3.2 million Illinois residents, and Illinois spent approximately \$20 billion on Medicaid expenses.² The Medicaid expenditures include both State and federal monies.³ In that same year, the United States (U.S.) federal and state governments spent a total of approximately \$571 billion on Medicaid expenses.⁴ The U.S. Department of Health and Human Services estimates that in FY 2016, nationwide there were about \$35 billion in net improper Medicaid payments.⁵

In addition, Illinois administers a workers’ compensation program for about 100,000 State employees. Work-related injuries and illnesses create great costs for employees, employers, taxpayers, and society as a whole.

In State FY 2017, State employees filed 4,925 workers' compensation claims, and the State paid approximately \$99,841,196 in workers' compensation benefits.⁶

The State Employee Group Insurance Program provides health care coverage for nearly 450,000 people, including State employees, retirees, survivors, and their dependents. In addition, this Program covers retired teachers, retired community college members, and certain local governmental units. The Illinois Department of Central Management Services (Illinois CMS) estimates that for State FY 2018, the liability for employee health insurance benefits will be \$3.42 billion.⁷

The Task Force found that the work of various agencies and units across State government have been successful in avoiding or recouping wasteful or fraudulent spending in certain State-administered health care programs. For example, in Illinois during State FY 2017, the Office of Inspector General for the Department of Healthcare and Family Services (HFS-OIG) will report \$195 million in savings, recoupment, and avoidance for the State Medicaid program (references to Medicaid savings and recoveries include State and federal dollars). In addition, during federal FY 2016, Illinois State Police Medicaid Fraud Control Unit⁸ (ISP-MFCU) referrals led to 46 fraud convictions and \$35.4 million in recoveries through criminal prosecutions, civil actions, and/or administrative referrals.⁹

Despite the great successes of individual State agencies, there is potential to secure additional savings through collaborative work to improve fraud prevention and recovery. In order to yield the best return on investment for taxpayers, the Task Force concentrated its efforts, actions, and recommendations within four areas: (1) collaboration and coordination; (2) data analytics and metrics; (3) accountability and efficiency; and (4) safety and wellness.

Approximately one year ago, in October 2016, the Task Force delivered its initial six-month report to Governor Rauner. At the time of that report the Task Force had identified its four focus areas, but was in the beginning stages of developing methods to implement best practices within those areas. The Task Force has made great strides since its last report in October 2016. This Interim Report outlines the Task Force's work. These accomplishments showcase the diversity of the Task Force's focus and membership. Further, the results highlight the willingness of Task Force members to collaborate and reach across agency lines to drive value. The collective ideas of the Task Force are carried out within individual Task Force members' agencies. A sample of our work includes:

- **In-Home Care Program Initiative.** This Initiative focuses on rooting out fraud, waste, and abuse in in-home care programs to maximize quality of service for the vulnerable citizens these programs serve. The work of this initiative has resulted in:
 - The Illinois Department of Human Services (DHS) establishing internal controls and investigative techniques that identified approximately \$1.4 million in overpayments and led to 52 criminal referrals;
 - DHS and the Illinois Department on Aging (DoA) increasing the number of staff who focus on investigating and monitoring in-home care program fraud;
 - Updated in-home care provider timesheets to require workers to certify that they worked the hours reported. This language will deter fraud and assist in the prosecution of cases when fraud occurs;
 - The implementation of training and education programs that will reach thousands of in-home care workers and recipients each year; and

- Policies and procedures for reporting and recording critical events in DoA programs.
- **Hospital Global Billing Initiative.** This Initiative, which involves hospitals reviewing potential billing errors, has resulted in the identification of \$4.4 million in overpayments. Of those funds, \$3 million has been recovered, and the rest is in the process of being recovered.
- **Nationwide Takedown.** For the first time, Illinois ISP-MFCU participated in a national health care fraud takedown. ISP-MFCU's involvement included assisting in obtaining indictments for 13 individuals. Those individuals allegedly perpetrated a combined fraud amount of approximately \$140,000.
- **The Health and Human Services Transformation.** The Illinois Department of Healthcare and Family Services (HFS) has been collaborating with the Office of the Governor and eleven other State agencies, as well as a broad stakeholder community, to improve health outcomes while slowing the growth of health care costs and putting Illinois on a more sustainable financial trajectory.
- **Enterprise Memorandum of Understanding (eMOU).** In May 2016, thirteen State agencies signed an eMOU, which provided for inter-agency data sharing. Over the past year, the Illinois Department of Innovation and Technology (DoIT) expanded the number of agencies involved, and as of September 2017, the eMOU now includes 21 State agencies. The eMOU allows the State to use its data analytics system to review data involving State health care programs across the board versus viewing them in the silos of individual programs or agencies.
- **Educating State Employees about Wellness and Fraud, Waste, and Abuse.** As a result of the continued success of the flu shot program (22,000 vaccinations administered at nearly 200 clinics in 2016), the Task Force

explored opportunities to include educational information as part of the program. During the 2017 flu shot program Illinois CMS will distribute information about wellness programs offered by the State's health plan carriers and how to report fraud, waste, and abuse to the Office of Executive Inspector General (OEIG).

While the Task Force has made great strides forward, there is still work to be done. In the coming months and year, the Task Force will continue to carry out its strategic plan to yield the best return on investment for taxpayers. As part of the plan, the Task Force will be:

- engaging in greater collaboration and coordination among State agencies, private and public sector partners, and vendors to maximize efficiency and prevent information and cost-effective measures from being siloed;
- exploring opportunities to expand data sharing among agencies, private and public sector partners, and vendors to leverage current resources;
- increasing proactive outreach and education of providers and State employees regarding fraudulent schemes and how to proactively address fraud and waste; and
- benchmarking and using metrics to evaluate the success of our initiatives and ensure the greatest impact on combating fraud, waste, and abuse in State-administered health care programs.

As the Task Force pushes forward with a robust portfolio of projects, it will continue to meet publicly at least quarterly, and will submit periodic reports to the Governor and the public outlining its progress.

II. Background

A. Executive Order 5 (2016)—the Creation of the Task Force



In April 2016, Governor Rauner issued Executive Order 5 (2016), an Executive Order Establishing the Health Care Fraud Elimination Task Force. The Task Force was created, in part, because “a more comprehensive and cross-disciplinary approach is needed to harness the State’s various fraud-prevention resources to further prevent and eliminate fraud, waste, and abuse and ensure that taxpayers are receiving the best return on investment for the State’s fraud prevention efforts.”¹⁰

The Executive Order outlines the following specific duties for the Task Force:¹¹

1. Identify and catalog the forms of health care fraud existing within State-administered health care programs and identify all Executive Branch agencies and resources currently involved or that should be involved in health care fraud prevention and enforcement.
2. Review best practices being utilized in the private sector, the federal government, and other states to prevent and reduce health care fraud, waste, and abuse and assess how those best practices could be applied to anti-fraud, waste, and abuse efforts in Illinois.
3. Explore the use of data analysis, predictive analytics, trend evaluation, and modeling approaches to better analyze and target oversight of State-administered health care programs.

4. Identify priority prevention and enforcement areas in order to ensure that the State’s fraud prevention and enforcement efforts are providing the best return on investment for taxpayers.
5. Collaborate with industry experts to develop a multifaceted strategy to reduce the State’s exposure to health care fraud and recover taxpayer funds that have been wrongly paid out as a result of fraud, waste, or abuse.
6. Analyze patterns of system-wide fraud, waste, and abuse in order to make recommendations to State agencies for improved internal controls to prevent future wrongdoing.
7. Work with other State agencies, boards, commissions, and task forces to obtain information and records necessary to carry out its duties.
8. Periodically report to the Governor and the public on the Task Force’s fraud, waste, and abuse identification, prevention, and elimination efforts and activities.

Also, the Task Force is required to conduct at least one public meeting each quarter.

The Task Force is scheduled to dissolve on June 30, 2019, but may be renewed by a new executive order.

B. Task Force Members

Executive Order 2016-05 appointed the following individuals to the Illinois Health Care Fraud Elimination Task Force:

MAGGIE HICKEY

Executive Inspector General, Office of Executive Inspector General for the Agencies of the Illinois Governor (Chair)

BRADLEY HART

Inspector General, Office of Inspector General for the Department of Healthcare and Family Services

TREY CHILDRESS

Deputy Governor and Chief Operating Officer, Office of the Governor

MICHAEL HOFFMAN

Acting Director, Department of Central Management Services

JILL M. HUTCHISON

Deputy General Counsel and Chief Compliance Officer, Office of the Governor

FELICIA F. NORWOOD

Acting Director, Department of Healthcare and Family Services

CHRISTOPHER KANTAS

Special Counsel and Policy Advisor to the Governor for Healthcare and Human Services, Office of the Governor

JAMES DIMAS

Acting Secretary, Department of Human Services

JEAN BOHNHOFF

Acting Director, Department on Aging

KIRK LONBOM

Acting Secretary, Department of Innovation and Technology

CAPTAIN BRIAN LEY

Director, Illinois State Police Medicaid Fraud Control Unit

JENNIFER HAMMER

Director, Department of Insurance

C. Background: Medicaid and Medicare, Workers' Compensation, and State Employee Group Insurance in Illinois



1. *The Medicaid and Medicare Programs*

Medicaid and Medicare are government programs that were created by federal legislation in 1965 to provide health care coverage to individuals who meet program eligibility requirements. According to the Centers for Medicare and Medicaid Services, “Medicaid is the single largest source of health coverage in the [U.S.].”¹²

Medicaid is administered through a joint federal-state partnership. Medicaid provides health care to individuals who meet certain financial and non-financial program requirements.¹³ Currently in Illinois, the State receives approximately 51 percent reimbursement from the federal government for Medicaid-funded expenses.¹⁴ The Affordable Care Act, enacted in 2010, allowed states to expand Medicaid coverage to additional adults under age 65 and children who meet certain income requirements. Illinois opted to expand its Medicaid coverage, and the State is currently reimbursed by the federal government at a rate of 95 percent for individuals included under this expanded coverage. This reimbursement rate, however, will be reduced over the next two years by the federal government. In

2020, the reimbursement rate will be 90 percent for this expanded population.¹⁵

THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. The Centers for Medicare and Medicaid Services is the federal agency that administers Medicare, and works with states to run Medicaid, Children’s Health Insurance Programs, and the federally facilitated marketplace. This agency is part of the U.S. Department of Health and Human Services. The Centers for Medicare and Medicaid Services gathers data, conducts research, and issues regulations and guidance regarding federal and state health care programs. It also reviews state program integrity efforts to assess whether they comply with federal laws and regulations and whether they are effective.¹⁶

In Illinois, HFS administers the Medicaid program in which services are provided to, on average, approximately 25 percent of Illinois’ population. In State FY 2016, Medicaid, and the medical programs associated with it, provided comprehensive health care coverage to over 3.2 million Illinois residents.¹⁷

The Illinois Medicaid program consists of both a fee-for-service delivery system as well as managed care models. In the fee-for-service delivery system, health care providers are paid for each service (e.g. office visit, test, procedure, etc) they provide to a Medicaid beneficiary. In contrast, Managed Care Organizations (MCOs)

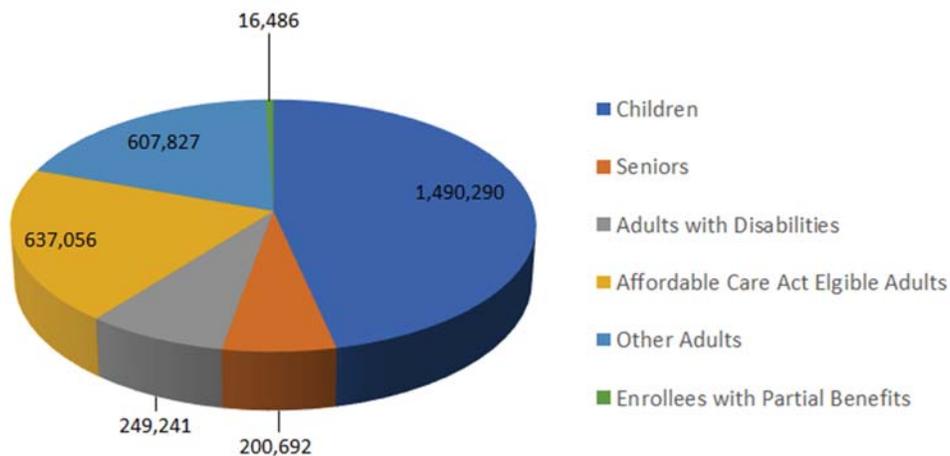
participating in the Medicaid program are reimbursed on a capitation basis (per-person payments rather than per-service payments). HFS contracts with an actuary to establish the MCO payment rates based on several factors including fee-for-service claims experience, health plan claims experience, and enrollment data.

In 2011, the Illinois Public Aid Code was amended to mandate that at least fifty percent of all full-benefit Medicaid beneficiaries be in some form of risk-based care coordination, such as managed care, by January 1, 2015.¹⁸ At the beginning of 2015, just over one-half of Medicaid beneficiaries were part of managed care programs. Today, approximately two-thirds of beneficiaries

are in risk-based managed care plans.

Medicare is federal health insurance that serves individuals 65 years old or older, or individuals who have disabilities or certain health conditions.¹⁹ Medicare consists of parts A, B, C, and D, with each part offering different coverage.²⁰ Nationwide, approximately 55 million individuals participate in Medicare, and in 2015, Medicare benefit payments totaled \$632 billion.²¹ Some individuals who are eligible for Medicare are also eligible for Medicaid. In those situations, Medicaid will generally cover expenses that are not covered by Medicare.

Breakdown of Illinois Individuals Receiving Medicaid Benefits in FY 2016



2. The Workers' Compensation Program



The State of Illinois administers a workers' compensation program for the State agencies, boards, commissions, and universities (State Workers' Compensation Program). The State Workers' Compensation Program is administered by Illinois CMS Bureau of Benefits. Like workers' compensation for private sector employers, workers' compensation for the State as an employer involves a no-fault system of benefits that employers pay to employees who experience work-related injuries or diseases. Under the current workers' compensation laws in Illinois, when an employee is injured during the course of his/her employment, the employer is assumed to be liable. The law is designed to provide injured employees with the financial protection of an automatic recovery in return for limiting the liability of employers.²² The Illinois Workers' Compensation Commission (WCC) administers the judicial process that resolves disputed workers' compensation claims between employers and employees in Illinois.

Workers' compensation and occupational disease benefits consist of compensation for medical expenses, time lost from work, and permanent disability resulting from the accidental injury or occupational disease. The Illinois Workers' Compensation Act requires employers to provide all "necessary first aid, medical and surgical services . . . reasonably required to cure or relieve from the effects of the accidental injury."²³

Employers also must pay temporary total disability benefits to the injured employee during that temporary period immediately after the work-related accident when the injured employee is physically unable to work without endangering his or her life or health. The rate of compensation for temporary total disability benefits is 66⅔ percent of the injured employee's average weekly wage subject to minimum and maximum limits.²⁴ Lastly, employers must pay benefits to an injured employee for various permanent disabilities, including injuries resulting in disfigurement, loss of use of a body part or the body as a whole, partial incapacity from pursuing his or her usual and customary line of employment, complete disability from doing any kind of work, or death. The rate of compensation for permanent partial disability benefits is 60 percent of the injured employee's average weekly wage.²⁵

In State FY 2017, State employees filed 4,925 workers' compensation claims, and the State paid about \$99,841,196 in workers' compensation benefits. The payment of workers' compensation benefits to an injured employee represents only a fraction of the total costs for that injury. The indirect costs for an injury may include lost productivity, overtime by other employees, decreased morale, and hiring and training a replacement employee.

3. The State Employee Group Insurance Program

In Illinois, the State Employee Group Insurance Act mandates health care approved benefits for four groups, including the State Employee Group Insurance Program, Teachers' Retirement Insurance Program, College Insurance Program, and Local Government Health Plan (hereinafter, the four programs are collectively referred to as the State Employee Group Insurance Program). The State Employee Group Insurance Program is administered by Illinois CMS. The State Employee Group Insurance Program provides health care coverage for nearly 450,000 people including State employees, retirees, survivors, and their dependents.²⁶ In addition, this Program covers retired teachers, retired community college members, and certain local government units. For State FY 2018, Illinois CMS estimates the liability for employee health insurance benefits to be about \$3.42 billion.

As part of the State Employee Group Insurance Program, the State offers several health plan options, prescription drug, behavioral health, dental, vision, and life insurance benefits, as well as other optional tax programs such as Flexible Spending Accounts and the Commuter Savings Program.

For health insurance, Illinois CMS offers a choice of a nationwide PPO plan, Open Access Plans, or several health maintenance organization plans. In addition, Medicare Advantage Prescription Drug plans are available for Medicare-covered members.



D. Summary of the Task Force's October 2016 Initial Report



In October 2016, the Task Force submitted its initial six-month report to Governor Rauner (October 2016 Report). On October 19, 2016, Governor Rauner released the Report to the public. The October 2016 Report is available on the Task Force website – [https://www.illinois.gov/oeig/health care fraud](https://www.illinois.gov/oeig/health-care-fraud).²⁷

In its October 2016 Report, the Task Force provided an overview of the first six months of operations, including, among other things, its activities, review of best practices, development of focus areas, data collection, benchmarking, meetings with experts and stakeholders, and public meetings. Further, the October 2016 Report cataloged the State's health care programs and the resources utilized at the following State agencies to combat fraud, waste, and abuse: Illinois Department of Healthcare and Family Services (HFS), Office of Inspector General for the Illinois Department of Healthcare and Family Services (HFS-OIG), Illinois State Police Medicaid Fraud Control Unit (ISP-MFCU), Office of Executive

Inspector General (OEIG), Illinois Department of Human Services (DHS), Illinois Department of Innovation and Technology (DoIT), Illinois Department on Aging (DoA), Illinois Department of Central Management Services (Illinois CMS), Illinois Department of Insurance (DoI), and Illinois Department of Transportation (IDOT).

Consistent with the current focus, and the Executive Order's charge, during the initial six months, the Task Force pooled its resources to address how the State can secure savings for the taxpayers while providing quality and efficient health care services for its employees and the beneficiaries of State-administered health care programs. Through the examination of best practices, the Task Force identified focus areas to ensure optimal return on investment for the State. The Task Force's initial and continuing work is concentrated within four areas: (1) collaboration and coordination; (2) data analytics and metrics; (3) accountability and efficiency; and (4) safety and wellness.

E. Working Group Overview



To fully explore the issues in State-administered health care programs, the Task Force formed three working groups, focused on the three broad health care program areas within State government: (1) Medicaid, (2) the State Employee Group Insurance Program, and (3) the Workers' Compensation Program. The cornerstone of each working group's mission is to identify and address areas of fraud, waste, and abuse that may exist within its respective programs. The focus of each working group has been to engage in a thoughtful analysis of the current status of its program; to compare Illinois' system with the best practices in other states, the private sector, and the federal government; and to foster changes to improve Illinois' system. Each working group has reviewed documentation related to its focus, held multiple meetings, and engaged third-parties to obtain recommendations. This section contains a summary of the working groups.

1. The Medicaid Working Group

The Medicaid Working Group is composed of staff from HFS, HFS-OIG, DHS, DoA, DoIT, ISP-MFCU, OEIG, and the Office of the Governor. The Medicaid Working Group is focusing on reviewing the following areas: (1) in-home care programs, including efforts to increase the dialogue among agencies that administer in-home programs, share agency data, and educate in-home care providers and

beneficiaries about fraud; (2) Medicaid managed care, including exploring opportunities to share data with Medicaid MCOs, thereby establishing the maximum collaboration and coordination of resources; and (3) greater use of data analytics to prevent and address Medicaid fraud, waste, and abuse, including expanding opportunities for pre-payment review.

2. The Workers' Compensation Program Working Group

The Workers' Compensation Program Working Group is composed of staff from WCC, the Illinois Department of Transportation (IDOT), Illinois CMS Bureau of Benefits, DoI, OEIG, and the Office of the Governor. The Workers' Compensation Working Group is focusing on the following areas: (1) developing centralized strategies for improving the State Workers' Compensation Program so that it better achieves the intended outcome of a focus on a safe working environment; (2) returning injured employees to productive work as safely and quickly as possible while ensuring that fund resources are managed effectively and prudently; and (3) ensuring the State investigates and appropriately refers workers' compensation fraud allegations.

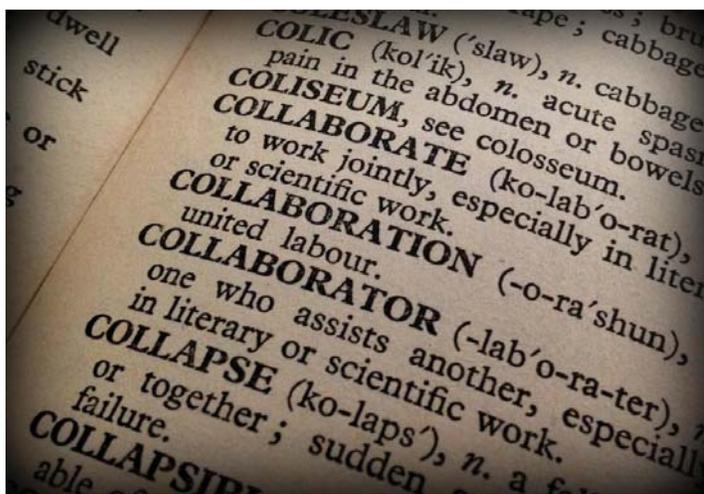
3. The State Employee Group Insurance Program Working Group

The State Employee Group Insurance Program Working Group is composed of staff from DoI, Illinois CMS, OEIG, and the Office of the Governor. The State Employee Group Insurance Program Working Group is focusing on the following areas: (1) the use of auditing and internal controls, including exploring what auditing tools Illinois CMS can use to ensure that only qualified State employees, retirees, and dependents receive taxpayer-funded insurance; (2) wellness, including ensuring group insurance participants are aware of wellness incentives within their plans; and (3) opportunities to promote awareness and education about fraud, waste, and abuse issues among State employees.

III. Overview of Task Force Activities

The Task Force’s study of other state’s best practices, Illinois’ current practices, and federal and private sector best practices has led to the creation of four focus areas. The Task Force determined that issues with fraud, waste, and abuse in State-administered programs can be addressed and alleviated by the State devoting greater attention to the following areas: (1) collaboration and coordination; (2) data analytics and metrics; (3) accountability and efficiency; and (4) safety and wellness. These areas have been used by the Task Force to focus its resources and working groups. The Task Force’s collective accomplishments, including the achievements by the working groups, is outlined in this Section III.

A. Collaboration and Coordination



Increased collaboration and coordination among State agencies, and between State agencies and private sector partners, is necessary to strengthen the State’s ability to address fraud, waste, and abuse in State-administered health care programs. The Task Force has organized leaders from agency staff administering health care programs, agency leadership working to ensure

that services are delivered in a manner that drives value both for the recipients of those services and the taxpayers, and inspectors general focused on oversight and program integrity. Though each of these groups plays different day-to-day roles in the administration of State health care programs, all have the responsibility to safeguard taxpayer resources and prevent misspending. Task Force members and their respective staffs are now regularly discussing fraud prevention ideas, and how coordinating efforts, including programmatic coordination, will help improve their respective agencies’ delivery of health care services.

This section highlights some of the Task Force’s achievements that resulted from collaborating and coordinating among State, federal, and private entities, including: (1) State and federal cooperative efforts; (2) the MCO initiative; and (3) the Health and Human Services Transformation.

1. State and Federal Cooperative Efforts

In federal FY 2016, Illinois spent approximately \$20 billion on Medicaid expenses.²⁸ The Medicaid expenditures include both State and federal monies.²⁹ In that same year, federal and state governments nationwide spent a total of approximately \$571 billion on Medicaid expenses.³⁰ The U.S. Department of Health and Human Services estimates that in FY 2016, there were about \$35 billion in net improper Medicaid payments nationwide.³¹ To effectively combat Medicaid fraud, waste, and abuse, it is imperative that State law enforcement and program staff, as well as private sector players, work collaboratively to address improper conduct while ensuring quality medical care. The Task Force members have been diligent in partnering with public and private-sector stakeholders to achieve results.

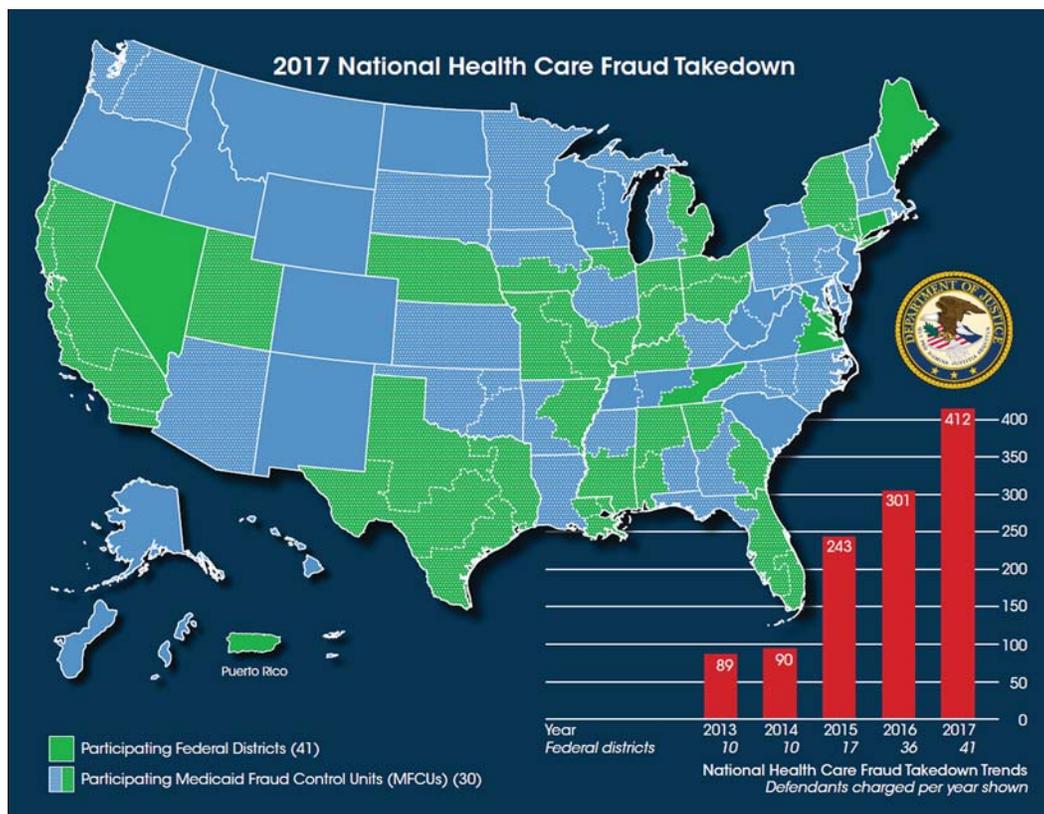
a. Nationwide Health Care Fraud Takedown

ISP-MFCU investigates criminal and civil allegations of Medicaid provider fraud, as well as patient abuse and neglect in Medicaid-funded facilities. On average, ISP-MFCU opens approximately 300 cases a year, and approximately two-thirds involve fraud and one-third involve allegations of abuse and neglect.

This year, for the first time, Illinois ISP-MFCU participated in a national health care fraud takedown. The takedown took place in July 2017, and was coordinated by the U.S. Attorney’s Office and the U.S. Department of Health and Human Services Office of Inspector General. This takedown was the largest health care fraud enforcement action in history. The multi-agency

federal and state work resulted in 412 defendants being charged nationwide, including 115 doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving a total of approximately \$1.3 billion in false billings.³² A graph illustrating the participating MFCUs and federal districts is located below.³³

ISP-MFCU’s involvement included assisting in obtaining indictments for 13 individuals. Those individuals allegedly perpetrated a combined fraud amount of approximately \$140,000. The indictments include one physician from Cook County, nine personal assistants from Cook, Madison, Richland, St. Clair, Saline, and Winnebago counties, and registered nurses from Bureau, Marshall, and Montgomery counties.³⁴



b. Information Sharing Among the Big 5 Medicaid States

A key aspect of the collaboration and coordination focus involves reaching across state lines to partner with other state governments to combat health care fraud, waste, and abuse. A meaningful example of this is the recently reinvigorated information sharing among five states serving very large Medicaid populations—the Big 5 Medicaid states.

In 2017, HFS-OIG began participating in quarterly discussions between Program Integrity Directors and/or Inspectors General in Texas, California, Florida, and New York to discuss large-scale fraud schemes occurring in these states and to brainstorm solutions. These quarterly discussions were initiated by the former Inspector General in Texas. A fundamental component of these discussions is the sharing of best practices. These best practices may translate to solutions or preventative measures that are shared with other states and federal entities. This collaboration is very important and is part of guaranteeing that Illinois incorporates program integrity measures that efficiently target prevalent fraud schemes and wasteful spending.

c. Participation in National Organizations

A crucial part of making sure that Illinois stays current with fraud trends, achieves best practices, and utilizes the most effective investigation techniques is collaborating and coordinating with the Centers for Medicare and Medicaid Services and participating in its national organizations. Illinois is very active in several Centers for Medicare and Medicaid Services organizations. Three examples of this are Illinois' involvement in the Fraud, Waste, and Abuse Technical Advisory Group, the Healthcare Fraud Prevention Partnership, and the Medicaid Integrity Institute. Participation in these organizations has expanded the Task Force's knowledge of tools available to combat health care fraud, waste, and abuse, and shaped its goals and focus.

- Centers for Medicare and Medicaid Services Fraud, Waste, and Abuse Technical Advisory Group (FWA-TAG). The FWA-TAG is tasked with disseminating information about the Centers for Medicare and Medicaid Services policy changes, as well as implementing rules and guidance for program integrity. The FWA-TAG also serves as a sounding board for states to raise issues, concerns, and questions for the states' federal counterparts. Illinois HFS-OIG Inspector General Hart is the National Chair of the FWA-TAG. In this capacity, Inspector General Hart guides discussions pertinent to Medicaid program integrity.
- Healthcare Fraud Prevention Partnership. The Healthcare Fraud Prevention Partnership is a voluntary partnership between state and federal governments, law enforcement, private health insurance plans, and health care anti-fraud associations.³⁵ As a member of the Healthcare Fraud Prevention Partnership, Illinois collaborates with the Centers for Medicare and Medicaid Services, state partners, and commercial insurance companies to address Medicaid fraud, waste, and abuse schemes. The goal of this partnership is to develop scenarios of possible fraud and then test those scenarios. This provides actionable intelligence that state partners can use to combat these schemes.
- Medicaid Integrity Institute. The Medicaid Integrity Institute is a national Medicaid program integrity training program operated by the Centers for Medicare and Medicaid Services. At the Medicaid Integrity Institute, HFS-OIG staff collaborate with the Centers for Medicare and Medicaid Services to train staff on program integrity and Medicaid functions. Participation in this training works to confirm that staff receive up-to-date information on current trends and topics related to Medicaid fraud, waste, and abuse.

2. Managed Care Organization Initiative



Managed care is a rapidly developing area in the landscape of Illinois' State-administered health care programs. The shift toward managed care presents the State with an opportunity to collaborate and coordinate among groups with a shared stake in preventing and addressing health care fraud, waste, and abuse. Thus, the Task Force created a MCO Initiative to focus specifically on issues relating to MCOs.

a. MCO Task Force

HFS-OIG oversees the MCOs and tracks the work of the MCO Special Investigation Units (SIUs). The SIUs are units within the MCOs that conduct activities aimed at fighting fraud, waste, and abuse. For example, these units perform pre-payment reviews, post-payment audits, quality of care analyses, data analytics, and algorithm development to detect and address fraud, waste, and abuse related to MCO plans.

To facilitate better information sharing and the adoption of more consistent practices between the State and the Medicaid MCOs, HFS-OIG created a MCO Task Force. In September 2016, HFS-OIG began conducting MCO Task Force meetings with all Medicaid MCOs. The

membership of the MCO Task Force includes the MCOs that are contracting with HFS to provide Medicaid services, ISP-MFCU, and HFS Bureau of Managed Care. In addition, the DoA, DHS, the Office of the Illinois Attorney General, and the OEIG have attended the MCO Task Force meetings.

Since the October 2016 Report, the MCO Task Force has evolved into a robust forum for collaboration and coordination of efforts. The meetings take place approximately every six weeks. During meetings, members are asked to discuss trends or cases currently under investigation that may have a large recovery, or that may have commonality across different payers or books of business. In addition to assisting MCOs in staying apprised of fraud schemes, the MCO Task Force also aids Illinois in establishing stronger relationships between private and public entities to enhance the quality of Illinois' investigations and internal controls. These meetings have successfully resulted in MCOs collaborating and coordinating regarding:

- **Commercial and Federal Information.** The meetings have involved information sharing regarding commercial insurance entities, national trends shared by the Centers for Medicare and Medicaid Services, and regional sharing sessions by the Healthcare Fraud Prevention Partnership.
- **Emerging Fraud Scheme Information.** A principal component of the MCO Task Force is to discuss emerging areas of fraud, waste, and abuse, and to assist the MCOs in identifying schemes and providers that jump from MCO to MCO to avoid being caught. MCO SIUs openly discuss policies and procedures for investigating certain fraud schemes, preventing schemes before they occur, and highlighting key players that should be involved in developing solutions. This allows the MCOs to build on each other's best practices, thereby enabling greater efficiency of resources.

- **Criminal Referral Information.** The participation of ISP-MFCU allows MCOs to get up-to-date information about successful prosecutions and what information was used to build strong cases against fraudulent providers. MCOs also have a platform to openly discuss obstacles to criminal convictions with HFS-OIG and ISP-MFCU, which helps each entity brainstorm and take actions to achieve the common goal of prosecuting bad actors. In addition, the SIUs discuss opportunities to combine data to build stronger criminal cases to ensure that those who defraud the health care system are held accountable.
- **Efficient Use of Resources.** The MCO Task Force provides a platform for HFS-OIG to discuss broad statewide trends and issues to aid SIUs in efficiently using resources. For example, discussions regarding pre-payment review, case-management, and other preventative measures are discussed as ways to maximize resources, instead of “pay-and-chase” techniques that may not yield the best return on investment.

- and reduce complexity for enrollees and providers;
- 4. Achieve greater managed care coverage across Illinois; and
- 5. Manage costs without compromising quality or access.

On August 11, 2017, HFS posted a Notice of Award for contracts with six MCOs, and on September 22, 2017, HFS issued a supplemental Notice of Award for a contract with one additional MCO.³⁶ Beginning January 1, 2018, these MCOs will provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system.

3. Health and Human Services Transformation

Illinois is one of the largest funders of health and human services in the country, spending more than 40 percent of its total budget on health and human services for Illinois residents and Medicaid enrollees. The State must improve health outcomes for residents while slowing the growth of health care costs and putting Illinois on a more sustainable financial trajectory.

To this end, the State has embarked on a transformation of its health and human services system. As part of the Health and Human Services Transformation, HFS has been collaborating with the Office of the Governor and eleven other State agencies, including representatives from health, human services, education, and criminal justice, as well as a broad stakeholder community. Illinois has applied for a Medicaid 1115 Waiver to help the State achieve the goals of the Health and Human Services Transformation.

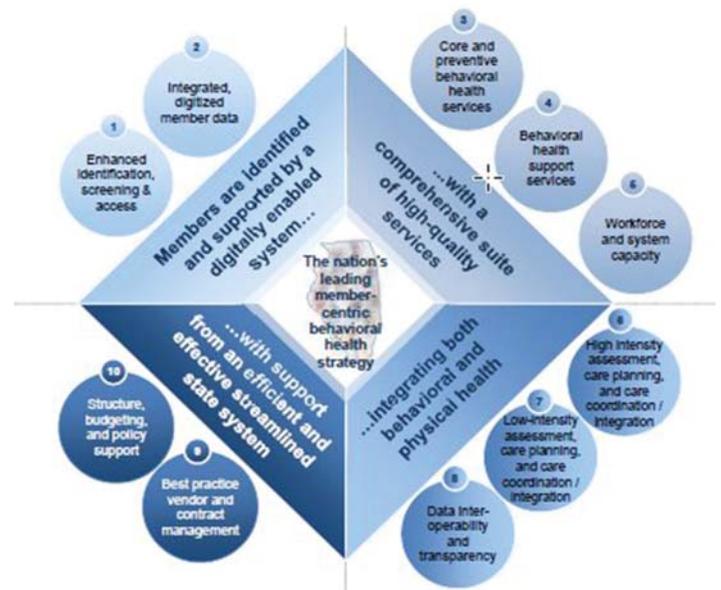
b. MCO Request For Proposals

On February 27, 2017, HFS issued the State of Illinois Medicaid Managed Care Organization Request for Proposals (RFP). This RFP sought services from qualified, experienced, and financially sound MCOs to enter into risk-based contracts for the Medicaid Managed Care Program. After hundreds of meetings with stakeholders, the RFP was deliberately drafted to improve the quality of care for Medicaid enrollees while slowing the growth of health care costs. The RFP sought to accomplish five goals:

1. Align State and MCO objectives to enhance quality and improve outcomes;
2. Increase integration of behavioral and physical health;
3. Streamline current managed care programs

BACKGROUND ON 1115 WAIVERS. An “1115 waiver” is a contract between the federal and state governments that “waives” federal Medicaid requirements and gives the federal government authority to approve experimental, pilot, or demonstration projects. The purpose of these demonstration projects is to evaluate policy approaches such as providing services not typically covered by Medicaid or creating innovative service delivery systems that improve care, increase efficiency, and reduce costs. The federal government requires the demonstrations to be “budget neutral,” meaning that during the course of the waiver Medicaid expenditures cannot exceed what they would be without the waiver. The waiver is not a grant but rather an opportunity to use federal dollars differently to increase the efficiency and quality of care for Medicaid populations.

Illinois, with input from over 2,000 stakeholders, has developed a comprehensive strategy to address these challenges. The strategy puts customers at the center, integrates behavioral and physical health, and transforms a fragmented and unsustainable system with new payment and delivery models, increased managed care, enhanced workforce capacity, and greater accountability across the system. This strategy—the four central approaches and ten initiatives to support them—is illustrated below.



The initial focus of the transformation has been on behavioral health (mental health and substance use) and specifically the integration of behavioral and physical health service delivery. Behavioral health was chosen due to both the urgency of the issue and the potential financial and human impact. Medicaid members with behavioral health needs represent 25 percent of Illinois Medicaid members, but account for 56 percent of all Medicaid spending. Further, building a nation-leading behavioral health strategy will help turn the tide of the opioid epidemic, reduce violent crime and violent encounters with police, and improve maternal and child health.³⁷

Through this waiver, Illinois aims to achieve six main goals:

1. Rebalance the behavioral health ecosystem, reducing over-reliance on institutional care and shifting to community-based care;
2. Promote integrated delivery of behavioral and physical health care for behavioral health members with high needs;
3. Promote integration of behavioral health and primary care for behavioral health members with lower needs;
4. Support development of robust and sustainable behavioral health services that

provide both core and preventative care to ensure that members receive the full complement of high-quality treatment they need;

5. Invest in support services to address the larger needs of behavioral health members, such as housing and employment services; and
6. Create an enabling environment to move behavioral health providers toward outcomes- and value-based payments.

Indeed, the behavioral health transformation will have a significant impact on the State over the next five years as it attempts to:

- Touch all regions of the State, improving care for about 800,000 Medicaid members with behavioral health conditions;
- Build a delivery system focused on integrated physical and behavioral health care impacting all 3.2 million Medicaid members (and lay the foundation for a more integrated system for all Illinoisans); and
- Utilize \$2.7 billion in federal match for Medicaid services.³⁸

B. Data Analytics and Metrics



Data analytics and the use of consistent and data-based metrics are critical to ensuring that an organization is properly monitoring spending in its health care programs and preventing and addressing fraud, waste, and abuse. The Task Force benchmarked Illinois' practices against other states and the private sector, and learned that our use of data analytics and metrics is an area where Illinois has room for improvement, and such improvement could yield monetary savings to the State. As such, the Task Force has acted to break the silos of data and share information to yield the most effective results of the State's data analytics systems. Prime examples of our work to improve data analytics and metrics are the expansion of agencies involved in the Enterprise Memorandum of Understanding (eMOU) and the use of data in audits.

1. Multi-agency Data Sharing Agreements

In May 2016, thirteen state agencies signed an eMOU, which provided for inter-agency data sharing. The agencies that signed the agreement include almost all the agencies involved in the Task Force, as well as several additional agencies. Those agencies are: DoA, HFS, DHS, DoIT, Illinois CMS, the Department of Children and Family Services, the Department of Commerce and Economic Opportunity, the Department of Corrections, the Department of Employment Security, the Department of Juvenile Justice, the Department of Public Health, the Illinois State Board of Education, and the Department of Veterans' Affairs.

Over the past year, DoIT has continued its effort to efficiently utilize State agency data and has expanded the eMOU to 21 agencies. The eMOU now also includes the following Illinois agencies, councils, and commissions: DoI, Department of Agriculture, Historic Preservation Agency,³⁹ Department of Labor, Sentencing Policy Advisory Council, Department of Financial and Professional Regulation, Guardianship and Advocacy Commission, and Criminal Justice Information Authority.

DoIT's data sharing allows the State to use its data analytics system to review information involving State health care programs across the board, instead of separately in individual programs or agencies. Operationally, the eMOU: enables greater customer-centric service delivery; provides information tailored to the needs of citizens; assists in effective strategic policymaking; offers executives trustworthy data to make informed decisions; and encourages efficient program management, leading to increased productivity of State employees.

Noteworthy is DoIT's close work with HFS-OIG to utilize data-sharing through eMOUs to enhance HFS-OIG's data analytics capabilities. To pinpoint and address fraud, waste, and abuse in the State's Medicaid system, HFS-OIG engages in extensive data analytics. However, to most effectively use its data analytics system, Dynamic Network Analysis (DNA), HFS-OIG must continually acquire, share, and verify data from numerous sources. To improve HFS-OIG's access to data among the State agencies, DoIT and its Analytics Center of Excellence has partnered with HFS-OIG to begin implementing extensive data sharing agreements through the eMOU process.

The goal is to further expand HFS-OIG's data analytics system through comprehensive eMOU data sharing agreements, thereby allowing the data analytics system to be more effective, by, for example, delving deeper into the available data, creating more extensive profiles, and extending HFS-OIG's ability to use social network information.

WHAT IS THE DYNAMIC NETWORK ANALYSIS (DNA) SYSTEM? The DNA system was funded by a Centers for Medicare and Medicaid Services Medicaid Transformation Grant that offered to build a predictive analytics system. The State uses the DNA system to research, develop, and implement selection criteria to identify: providers with potentially fraudulent behavior; program integrity solutions; pre-payment claims processing edits; policy innovations; operational innovations; fraud referrals; and desk, field, and self-audit reviews. The DNA system also assists the State in the following functions:

- providing early warning and monitoring by analyzing service and payment trends;
- identifying exception processing through outlier analysis;⁴⁰
- incorporating Surveillance and Utilization Review System functions;⁴¹
- creating provider and recipient profile reports;⁴²
- compiling statewide trends to help support administrative decision-making;
- summarizing all State Medicaid, transportation, and post-mortem payments;⁴³ and
- compiling data on sanctioned, disciplined, or terminated providers from the U.S. Department of Health and Human Services and the Illinois Department of Financial and Professional Regulation.

2. Hospital Global Billing Initiative

HFS-OIG uses data analytics to identify outliers in Medicaid provider billing. In order to maximize its resources, HFS and HFS-OIG have also encouraged Medicaid providers to review their data to identify billing errors and overpayments. These efforts emphasize pre-payment review and work to invoke systemic changes at the provider level to capitalize on the power of data. A key example of this is the Hospital Global Billing Initiative.



Through the use of data analytics, HFS-OIG found that hospitals and individual practitioners were billing for the same professional component of certain procedure codes. Specifically, HFS-OIG identified that hospitals may have been improperly billing for lab and x-ray services whereby the hospitals received the global rate (technical and professional component), while the non-salaried pathologist and/or non-salaried radiologist also billed separately for the professional component of the rate for the same patients on the same day as the patient was receiving services in an outpatient setting.

As a result of this data, in April 2016, HFS-OIG developed an initiative to direct hospitals to self-audit potential overpayments identified by HFS-OIG and to correct any billing errors.

The self-audit allows the hospital to review all instances of global billing overpayments HFS-OIG found and to submit repayments for all services determined to be inaccurately billed.

The Hospital Global Billing Initiative resulted in numerous phone conversations with hospital staff and their compliance officers and/or chief executive officers. A positive and transparent process was established and maintained that allowed the hospitals to review their own internal billing processes. Further, as a result of this initiative, many of the hospitals implemented changes to their internal billing processes to prevent these overpayments from occurring in the future

WHAT IS AN OVERPAYMENT? An overpayment describes an instance where the provider over-billed the State for Medicaid covered services, causing the provider to be reimbursed for more money than they were entitled to receive. For example, overpayments may occur because of a billing code error that is inadvertently entered on a routine basis.

The Hospital Global Billing Initiative resulted in \$4.4 million in overpayments identified for recoupment. Of that amount, \$3 million has already been recovered, and \$1.4 million is in the process of being recovered. The period audited was January 1, 2010 through December 31, 2014.

Due to the success of this initiative, in September 2017, HFS-OIG rolled out a follow-up global billing audit project for the audit period of January 1, 2015 through September 1, 2017. Hospitals whose services were already named within the self-disclosure process are excluded from this audit.

C. Accountability and Efficiency



Accountability and efficiency underline all the fraud, waste, and abuse identification and prevention efforts the Task Force undertakes. Providers, vendors, and State employees must always remember that they are accountable to the taxpayers and to the recipients of State services. During the Task Force's review of State-administered health care programs, one type of program in particular—the State's in-home care programs—stood out to the Task Force members as an area where increased accountability and efficiency could not only deliver better results and customer service for recipients, but also could drive value to taxpayers through instituting better internal controls. Thus, the Task Force launched an In-Home Care Initiative to focus specifically on in-home care programs in Illinois.

Another area the Task Force determined as an area that would benefit from adding additional measures to establish greater accountability and efficiency is the investigation of workers' compensation claims. Consequently, DoI has expanded its Workers' Compensation Fraud Unit to add additional investigators, and Illinois CMS has revised the contract with the State's Workers' Compensation Program third party administrator to strengthen accountability and efficiency.

Finally, to improve accountability and efficiency, the Task Force renewed efforts to work with providers to incentivize self-disclosure of overpayments.

1. *In-Home Care Program Initiative*

In-home care programs provide valuable and necessary services to some of Illinois' most vulnerable citizens. Every dollar spent on these programs is designed to provide necessary assistance that recipients depend on to live with dignity within their homes. The Task Force therefore is compelled to protect those funds and address the criminal fraudulent activity and waste that cheats these programs. The In-Home Care Program Initiative focuses on rooting out fraud, waste, and abuse to maximize quality of service.

During the beginning stages of the In-Home Care Program Initiative, the Task Force studied current internal controls in two in-home care programs and identified issues and solutions related to potential fraud, waste, and abuse in these programs. Over the past year, the Task Force members have continued to meet frequently to discuss ways to improve the in-home care programs. A meaningful focus of these discussions has been prevention and opportunities to educate providers. The Task Force's collaboration has also led to DHS and DoA stepping up and expanding its investigations into allegations of fraudulent practices by in-home care providers and recipients, an enhanced Electronic Visit Verification system, and updated policies and forms to improve accountability. As previously mentioned, the work of the Task Force is carried out within the Task Force members' agencies, which oversee the programs. The work of the In-Home Care Program Initiative is outlined in this section.



a. **In-Home Care Programs: Background**

DHS and DoA each administer in-home care programs. The Task Force has focused on DHS's Home Services Program (HSP). The HSP is a home- and community-based Medicaid waiver program designed to prevent the unnecessary institutionalization of individuals who may instead be satisfactorily maintained at home at a lesser cost to the taxpayers. Services provided to HSP customers include individual providers, homemaker services, home health services, electronic home response services, home-delivered meals, adult day care, assistive equipment, environmental modifications, and respite services. In the HSP, the customer and DHS are considered "co-employers," whereby the customers select, hire, and manage their own providers and DHS pays the providers. These providers are referred to as Individual Providers. There are approximately 26,331 open cases within the HSP, with approximately 48,000 Individual Providers paid to provide services to the HSP customers. Every month DHS has a large influx of new Individual Providers, averaging approximately 700-900 new Individual Providers each month. The HSP has a budget of approximately \$500 million, and is funded by the State's General Revenue Fund and by federal funds for customers who qualify for Medicaid.

The Task Force has also focused on DoA's Community Care Program (CCP). The CCP is a Medicaid waiver program that provides in-home and community-based services to assist adults who are at least 60 years old and who might otherwise need nursing facility care to remain in their own homes. Through the CCP, seniors may receive adult day care, emergency home response, and in-home services to allow them to maintain independence within their home. Unlike in DHS's HSP, DoA contracts with CCP providers who hire and monitor in-home care workers. There are approximately 115 CCP providers that oversee the workers that provide direct in-home services to the CCP customers.

In State FY 2016, approximately 80,000 senior citizens received services through the CCP. In State FY 2015, the CCP had a budget of approximately \$844 million. The CCP is funded through General Revenue Funds, and by federal funds for customers who qualify for Medicaid.

b. Recent In-Home Care Fraud Convictions



To add context to the fraud in the in-home care programs, below is a small snapshot of convictions secured in 2017. These convictions highlight the real and personal impact fraud has on the community. The experiences of Task Force members' agencies, such as ISP-MFCU, DHS, DoA, OEIG, and HFS-OIG, in uncovering fraud in in-home care programs is part of what fueled the Task Force to focus on in-home care

programs and make this area a principal initiative of the Task Force. A few examples of the 2017 convictions include:

- On January 27, 2017, Janene Wright-Stephenson from Rockford entered a guilty plea to a class 3 felony. The ISP-MFCU investigation revealed that from January 7, 2009, through January 31, 2013, Wright-Stephenson improperly billed the State for hours she claimed she worked as a personal assistant, but in fact she was working at a hospital. Further, the individual Wright-Stephenson claimed to be assisting was incarcerated at Winnebago County Jail on some of the dates she billed the State for services. The improper billing led to a total of about \$4,469 in fraudulent overpayments.
- On April 13, 2017, Kattie Sanders entered a guilty plea to one count of Vendor Fraud (class 1 felony); on May 17, 2016, Starvaiena Sanders entered a guilty plea to one count of Vendor Fraud (class 3 felony); and on July 7, 2017, Judy Melchor entered a guilty plea to one count of Vendor Fraud (class 1 felony). These convictions stemmed from an ISP-MFCU investigation, which revealed that from May 16, 2010, through June 30, 2012, DHS HSP Personal Assistant Melchor submitted fraudulent timesheets, and that the recipient of services, K. Sanders, was either in a hospital, nursing home, or incarcerated during the time she was allegedly being serviced, and was splitting the money Melchor received. Additionally, K. Sanders had another personal assistant, S. Sanders, who admitted to submitting fraudulent timesheets to DHS from July 16, 2012, through October 15, 2012. In addition to probation, in total, these individuals were ordered to pay over \$42,000 in restitution.
- On June 7, 2017, Lisa Opinga entered a guilty plea to one count of Vendor Fraud (class 3 felony). This conviction stemmed from an ISP-MFCU investigation that revealed that Personal Assistant Opinga submitted

timesheets that indicated she provided home services in Rockford, Illinois from April 2014 through June 2015, when in fact, the recipient was actually out of the country. Opinga was sentenced to 24 months of probation and ordered to pay restitution in the amount of \$4,723.

c. Maximizing Return on Investment by Focusing on Prevention and Education in In-Home Care Programs

Prevention efforts focused on fraud, waste, and abuse offer a greater return on investment than pay-and-chase solutions. Indeed, the Task Force members bring decades of experience in Medicaid program services, investigations, and law enforcement, and have seen first-hand the value of investing in prevention and education. Further, public and private sector partners have stressed the importance of focusing on prevention and education. As such, the Task Force has focused Medicaid Working Group discussions on opportunities to raise awareness of fraud and educate providers and customers. One important example of this is the DHS HSP multi-tiered, collaborative approach to Individual Provider training.

As mentioned above, DHS processes an average of 700-900 new Individual Providers each month. To ensure the Individual Providers are properly trained, DHS HSP has recently put together training programs and educational materials for Individual Providers. As discussed in more detail below, DHS HSP is working with the Service Employee International Union (SEIU) and the Centers for Independent Living to provide training, and is also circulating an educational pamphlet (pictured on page 28) to the HSP customers and using posters to inform Individual Providers of their responsibilities.

- SEIU Individual Provider Training. In collaboration with and funded through DHS, SEIU has begun training new and incumbent Individual Providers. This collaboration led to the revision of the New Individual

Provider Orientation training curriculum. The New Individual Provider Orientation for both new and incumbent Individual Providers now includes a comprehensive course about fraud, abuse, neglect, and financial exploitation. For example, SEIU is responsible for hosting a 3.5-hour voluntary statewide training titled: “Identifying & Reporting Fraud.” SEIU also conducts trainings titled: “How to Identify Signs of Abuse, Neglect, Financial Exploitation” and “What to Do if You See Signs of Fraud.”

- Centers for Independent Living Training. The HSP staff are developing contract agreements with the Centers for Independent Living to provide training to the HSP customers about fraud so that they can recognize Individual Providers who may be trying to take advantage of them and defraud the State. This training will also alert customers to schemes that involve Individual Providers working with the customer to perpetuate fraud. The HSP staff have already created a curriculum containing fraud and abuse information and will teach this curriculum through webinars using the WebEx platform. The WebEx platform is cost-efficient and allows the HSP to reach virtually anyone in the State. This training also includes a Computer Access Real-Time Translator that provides captions for participants who are hearing impaired. This training will be provided to both new and existing customers.
- Educational material. The HSP Policy and Fraud Unit staff drafted a pamphlet titled: “Safeguarding Your Services, Preventing Medicaid Fraud (DHS 4251).” The HSP staff who work at DHS local offices have been trained on fraud schemes and have been asked to review the fraud pamphlet with customers during the customer’s initial assessment and during annual face-to-face assessments. DHS is in the process of training its counselors to routinely review the pamphlet during assessment visits.

Additionally, the HSP Fraud Unit created a poster to display at DHS local offices to further educate customers and Individual Providers.

DoA is also maximizing prevention efforts by proactively conducting compliance reviews of the CCP providers. Indeed, DoA has doubled the number of monitoring staff from six to twelve. Further, DoA's General Counsel's background includes prosecutorial work and one of her focuses is the prevention of fraud, waste, and abuse. Another key change DoA has made

to its compliance program is the reorganization of its review system to streamline processes for bringing provider agencies into compliance where deficiencies were identified (discussed in more detail below).

d. Stepping Up Investigations of In-Home Care Programs: The HSP Fraud Unit

DHS HSP Fraud Unit is a specifically designated unit to combat fraud in its in-home care programs by investigating allegations of Individual Provider and customer fraud. Investigations focus on customer and Individual Provider(s) eligibility issues, as well as fraudulently obtained benefits and services. The Fraud Unit has maximized its impact by collaborating with HFS-OIG and ISP-MFCU regarding fraud investigations. The Fraud Unit also works closely with DHS's Bureau of Collections. The Bureau of Collections is responsible for collecting fraud overpayments.

In State FY 2017, DHS has significantly increased staffing resources within the HSP Fraud Unit, going from a headcount of four staff to nine staff. With the increase in personnel, the HSP Fraud Unit has stepped up investigations and can devote resources to addressing the most prevalent fraud schemes.

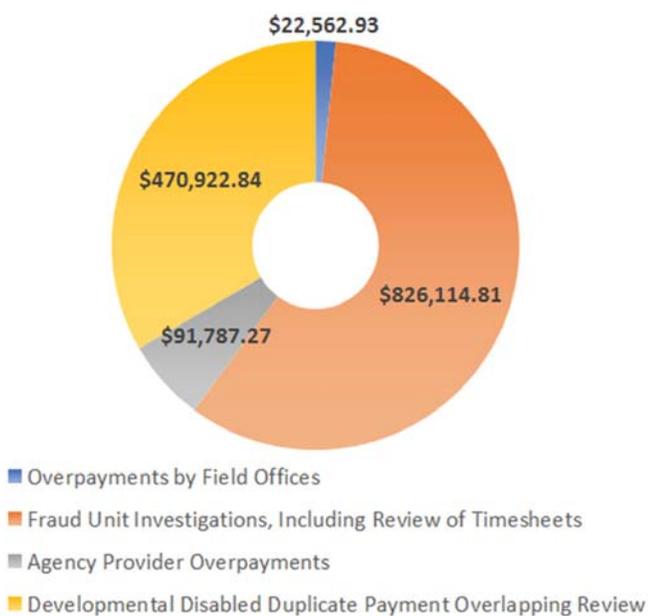
Two noteworthy schemes the Fraud Unit has focused on are: (1) fraudulent use of in-home care services by incarcerated individuals; and (2) fraudulent reporting of hours on timesheets. First, the Fraud Unit has put into place the internal control of reviewing incarceration reports and comparing those reports with Individual Provider payments. This process allows DHS to determine if Individual Providers worked the hours they reported. For example, in State FY 2017 this process allowed DHS to find an overpayment of about \$34,835 that was paid to an Individual Provider while he was incarcerated.⁴⁴ Second, the HSP Fraud Unit has been reviewing timesheets, especially timesheets submitted late, and cross-checking those timesheets against other employment records, to determine whether Individual Providers are double-billing.



In State FY 2017, the HSP Fraud Unit reviewed a total of 1,040 Critical Incident Reports that documented alleged fraudulent activity by the customer and/or Individual Provider. Critical Incident Reports are reports generated by field staff at DHS whenever they learn of an issue in one of their cases such as fraud or customer abuse. As a result of the HSP Fraud Unit’s investigation of Critical Incident Reports, in State FY 2017, the HSP Fraud Unit staff made 52 referrals of fraud for criminal prosecution to ISP-MFCU.

Further, the work of the HSP Fraud Unit has resulted in the identification of \$1,411,388 in overpayments. The chart below outlines the breakdown of overpayments identified. DHS is in the process of collecting those overpayments.

Overpayments in the Home Services Program Identified by the Illinois Department of Human Services



The chart depicts the following:

(1) “Overpayments by Field Offices,” refers to incidents when a field office worker inadvertently paid the Individual Provider more than once for the same hours worked. This can occur because of computer errors. These errors were identified by the HSP Fraud Unit through the use of internal controls.

(2) “Fraud Unit Investigations, Including Review of Timesheets,” refers to the overpayments that were made as a result of fraud or inappropriate activity by Individual Providers.

(3) “Agency Provider Overpayments,” refers to instances when an agency provider inadvertently paid an Individual Provider more than once for the same hours worked.

(4) “Developmental Disabled Duplicate Payment Overlapping Review,” refers to instances when an Individual Provider has received payments from the HSP and from the Developmental Disabled Program. Individual Providers are only entitled to receive payment from one of those programs, and therefore DHS recovers overpayments from an Individual Provider who was paid for the same hours by both programs.

e. Using Policies and Attestations to Ensure Accountability of Providers

i. Requiring Certification of Accuracy on Individual Provider Timesheets

The HSP Fraud Unit has stepped up its efforts by working with ISP-MFCU and HFS-OIG to identify elements of successful referrals and prosecutions. A noteworthy fruit of these discussions is the new Individual Provider timesheets, which require Individual Providers to certify that the timesheet is accurate. After working with HSP Fraud Unit, the following language was added to Individual Provider timesheets:

“I certify the above information is true and that the customer was in his or her home at the time services were rendered (not on unapproved vacation, in the hospital, in a nursing home, etc.). I understand falsification of any information submitted on this form could lead to criminal prosecution.”

This language will serve as a reminder to the Individual Provider of the basic requirement

of honest reporting and the seriousness of submitting falsified timesheets. Additionally, this language will assist in the prosecution of in-home care services cases by providing proof that an Individual Provider knew or should have known about their legal obligations.

f. Streamlining the Reporting of Critical Events to Promote Efficiency at DoA

In the summer of 2017, DoA implemented a policy and automated process that requires CCP and Care Coordination Unit providers to submit critical event reports involving its participants. The Critical Events Policy requires any of DoA's network of providers to electronically submit information to DoA regarding critical events. Critical events, include, for example, incidents that impact the participants' health, welfare, and safety, e.g. falls, hospitalizations, and emergency room visits. Reports of abuse, neglect, and financial exploitation continue to be addressed by DoA's Adult Protective Services. Previously, the system for reporting issues to DoA was cumbersome and inefficient, and relied on the use of paper forms that were submitted to DoA via fax, email, or U.S. Mail. These paper forms were also tracked in separate systems and databases, making it difficult and time-consuming to compare and aggregate information. In contrast, the new Critical Events Policy utilizes one electronic database. These new policies and procedures will streamline the communication and allow DoA to efficiently and quickly diagnose risk, barriers to service, and potential fraud, waste, and abuse in its programs.

The form is titled 'HOME SERVICES PROGRAM TIME SHEET' and is from the State of Illinois Department of Human Services - Division of Rehabilitation Services. It contains the following sections:

- Header:** State of Illinois Department of Human Services - Division of Rehabilitation Services. HOME SERVICES PROGRAM TIME SHEET. District: _____
- Case Information:** Case Number: _____; Customer Name: _____; Address: _____ Apt. #: _____; City/Zip Code: _____; Phone: (_____) _____-_____. (Information has changed since last time sheet was submitted.)
- Worker Information:** Worker SSN: _____; Worker Name: _____; Home Address: _____ Apt. #: _____; City/Zip Code: _____; Phone: (_____) _____-_____. (Information has changed since last time sheet was submitted.)
- Service Hours Table:** A table with columns for 'Dates (check box)', 'Start', 'Stop', 'Start', 'Stop', 'Start', 'Stop', and 'Daily Total'. Rows are categorized by service type and time intervals:
 - Personal Assistant: 1st-16th, 2nd-17th, 3rd-18th, 4th-19th, 5th-20th, 6th-21st, 7th-22nd, 8th-23rd, 9th-24th, 10th-25th, 11th-26th, 12th-27th, 13th-28th, 14th-29th, 15th-30th, 31st.
 - Certified Nurse Assistant: 1st-16th, 2nd-17th, 3rd-18th, 4th-19th, 5th-20th, 6th-21st, 7th-22nd, 8th-23rd, 9th-24th, 10th-25th, 11th-26th, 12th-27th, 13th-28th, 14th-29th, 15th-30th, 31st.
 - Licensed Practical Nurse: 1st-16th, 2nd-17th, 3rd-18th, 4th-19th, 5th-20th, 6th-21st, 7th-22nd, 8th-23rd, 9th-24th, 10th-25th, 11th-26th, 12th-27th, 13th-28th, 14th-29th, 15th-30th, 31st.
 - Registered Nurse: 1st-16th, 2nd-17th, 3rd-18th, 4th-19th, 5th-20th, 6th-21st, 7th-22nd, 8th-23rd, 9th-24th, 10th-25th, 11th-26th, 12th-27th, 13th-28th, 14th-29th, 15th-30th, 31st.
 - Physical or Occupational Therapist: 1st-16th, 2nd-17th, 3rd-18th, 4th-19th, 5th-20th, 6th-21st, 7th-22nd, 8th-23rd, 9th-24th, 10th-25th, 11th-26th, 12th-27th, 13th-28th, 14th-29th, 15th-30th, 31st.
 - Speech Therapist: 1st-16th, 2nd-17th, 3rd-18th, 4th-19th, 5th-20th, 6th-21st, 7th-22nd, 8th-23rd, 9th-24th, 10th-25th, 11th-26th, 12th-27th, 13th-28th, 14th-29th, 15th-30th, 31st.
- Certification Section:**

CUSTOMER/INDIVIDUAL PROVIDER CERTIFICATION FOR SERVICES RENDERED

I certify that the above information is true and in accordance with the Individual Provider Payment Policies (IL488-2252). I certify the above information is true and that the customer was in his or her home at the time services were rendered (not on unapproved vacation, in the hospital, in a nursing home, etc.). I understand falsification of any information submitted on this form could lead to criminal prosecution.

Worker Signature: _____ Date: _____

I certify that the above information is true and that services were received as stated. I understand falsification of any information submitted on this form could lead to criminal prosecution.

Customer Signature: _____ Date: _____
- Footer:** IL488-2252 (R-05-17) - Home Services Program Time Sheet. Printed by the Authority of the State of Illinois. P.O. #18-0098 100,000 Copies. Page 1 of 1

ii. Requiring Attestation of Acknowledgment on Provider Policy

One way DoA establishes accountability of its providers is through a written attestation of understanding. In the fall of 2016, DoA enacted a policy regarding impermissible and unlawful ways to contact the CCP participants. Specifically, the policy prohibited the CCP providers from engaging in cold calling, door to door solicitations, or scare tactics to entice participants to select their agency. This policy facilitates participants' choice of providers. After the policy was enacted, DoA trained the CCP providers regarding the policy and required all of the CCP and network providers⁴⁵ and staff to sign an agreement acknowledging receipt and understanding of the policy.

g. Improving the Electronic Visit Verification System

The HSP and the CCP both utilize an Electronic Visit Verification (EVV) system to collect timekeeping data for in-home care workers. EVV is a timekeeping system that requires the provider to use the customer's telephone to "call in" and record the time that he or she starts and stops working for the customer. The EVV system is designed to prevent payment to unauthorized providers, providers with overlapping visits, and providers who claim to work for an individual when that individual's case is inactive.

In DHS's HSP, the EVV system shows that on average 83 percent of Individual Providers are calling in to report the same number of hours reported on their timesheet. However, that leaves

a fairly large percentage of Individual Providers who are reporting different hours on their timesheets than are reported via the EVV system.

In August 2016, new enhancements were introduced to DHS's EVV system that have generated a savings for the State by deterring misconduct and verifying Individual Providers' hours. For example, due to the EVV system, from July 2015 through September 30, 2017, DHS has had zero incidents of Individual Provider duplicate or overlapping hours because the system will not allow duplicate approvals. This is because when EVV detects duplicate or overlapping hours reported, the system prevents Individual Providers from clocking in for more than one customer at the same time. The EVV data has led to 623 Critical Incident Reports being generated by staff who were alerted to potential fraud.

2. Workers' Compensation Fraud Investigations

In 2005, the General Assembly passed legislation⁴⁶ amending the Illinois Workers' Compensation Act to require the establishment of a fraud and insurance non-compliance unit within what was then the Division of Insurance and is now the DoI. The purpose was to create a unit responsible for investigating incidences of fraud and insurance noncompliance under the Workers' Compensation Act. The DoI created the Workers' Compensation Fraud Unit (WCFU) in 2005.

The WCFU's primary responsibility involves conducting investigations and referring worthy cases to the Attorney General's Office or the applicable State's Attorney for prosecution. Investigators conduct field investigations, review surveillance footage, issue subpoenas, and review insurance, payroll, medical, and other records. The Act specifically provides that it "shall be the duty of the [WCFU] to determine the identity of insurance carriers, employers, employees, or other persons or entities that have violated the fraud and insurance non-compliance provisions" of the Act.⁴⁷

In the past year, the WCFU increased the number of investigators, which has allowed for more investigations to be assigned and completed.

In 2016, the WCFU received 349 allegations of fraud. Although most allegations did not warrant further investigation, in 2016, the WCFU referred eight cases to the Office of the Illinois Attorney General for possible prosecution.⁴⁸

In addition to conducting investigations, the WCFU focuses on building relationships and educating stakeholders. Investigators work with the Federal Bureau of Investigation, the Postal Inspector's Office, the Drug Enforcement Administration, the Internal Revenue Service, U.S. Department of Labor, state medical investigators, local police departments, ISP, and numerous State's Attorney investigators. The WCFU also conducts a variety of educational presentations for public prosecutors and private law firms, as well as the insurance industry, self-insureds, other state agencies, and third-party administrators to assist them in better understanding the Illinois Workers' Compensation Act and the responsibilities of the WCFU.

3. Third-Party Administrator Contract



Shortly after the Workers' Compensation Working Group was formed, it engaged with the State's workers' compensation claims administrator to learn about its process for investigating fraud, waste, and abuse in workers' compensation. The

Working Group also reviewed the agreement for third-party administration of the State Workers' Compensation Program. The contract contains the vendor's responsibilities, including initial claim intake, claims investigation and determination, benefit payment for medical and indemnity, as well as medical case management, bill review, and surveillance activities. The term of the contract is five years with an option to renew for up to five additional years.

In September 2016, to strengthen accountability and efficiency, Illinois CMS finalized an amendment to the third-party administrator contract. The amendment added performance measures to ensure timeliness and accuracy of the vendor's reporting. Specifically, the amendment clarifies the detail required in the monthly and quarterly reports and establishes timelines for reporting. As a result of the amendment, monthly and quarterly reports have been issued on a timely basis. In addition, the accuracy of indemnity benefit payments was clarified with standards established to obtain compliance. These amendments assist Illinois CMS in cutting waste by ensuring decisions are made based on up-to-date and accurate information. Further, these amendments work to guarantee the State is receiving all the services it pays its vendor to complete.

4. Working with Providers to Incentivize Self-Disclosure of Overpayments

Data analytics allows HFS-OIG to find outliers in billing and coding, and to target those providers for investigation. Although, in some cases there are appropriate reasons why a provider had an uptick in billing or coding for a certain procedure, there are also instances when the provider was engaging in improper billing or coding of procedures. To maximize accountability and efficiency, HFS-OIG encourages providers to proactively review their billing patterns and disclose overpayments to HFS-OIG when appropriate.

To assist providers and streamline the

process, HFS established a self-disclosure protocol. Through the work of the Task Force, HFS-OIG has renewed its efforts related to the self-disclosure protocol. The self-disclosure protocol provides guidance and outlines a process for providers to self-disclose Medicaid overpayments to HFS-OIG.

The self-disclosure protocol is intended to establish a fair, reasonable, and consistent process that is mutually beneficial for both HFS and the disclosing provider. For example, the State benefits when providers self-disclose overpayments because it allows HFS-OIG to more efficiently use its resources to investigate intentional wrongdoing. Self-disclosure of overpayments assists the provider because good-faith disclosure will, in most circumstances, result in a better outcome for a provider than if HFS-OIG discovered the matter independently. While the specific resolution of a self-disclosed matter depends upon the individual case, HFS-OIG typically extends benefits to providers who participate in a self-disclosure in good-faith. Examples of those benefits include:

- forgiveness or reduction of interest payments (for up to two years);
- extended repayment terms;
- waiver of some or all applicable penalties and/or sanctions;
- decreased likelihood of imposition of an OIG Corporate Integrity Agreement;
- if made within 60 days of identification, avoidance of False Claims Act penalties; and
- decreased likelihood of the imposition of Civil Monetary Penalties.

From April 2016 to September 2017, HFS-OIG has worked with providers to identify \$1.57 million in overpayments that the State is currently in the process of recouping.

D. Safety and Wellness



often find that process changes made to improve workplace safety and health may result in significant improvements to their organization's productivity and profitability, as well as to employee morale.

To that end, the Task Force has specifically focused on safety and wellness. As part of this focus the Task Force has launched a Workers' Compensation Program Safety Initiative. Through this initiative, Task Force members have collaborated to make changes to Illinois practices that will allow for greater worker safety on the job, as well as safe return-to-work opportunities aligned with the worker's condition. The Task Force also has emphasized preventative wellness measures and is utilizing the success of the flu shot program to further educate State Employee Group Insurance Program participants about wellness and fraud, waste, and abuse in Illinois.

Workplace fatalities, injuries, and illnesses cost employees and employers across the country billions of dollars every year. In State FY 2017, State employees filed 4,925 workers' compensation claims, and the State paid about \$99,841,196 in workers' compensation benefits. Moreover, the payment of workers' compensation benefits to an injured employee represents only a fraction of the total costs for that injury. The indirect costs for an injury may include lost productivity, overtime of other employees, decreased morale, and costs associated with hiring and training a replacement employee. These figures underscore the importance of a safe work environment and a proactive approach to returning injured employees to work in a safe and timely manner.

Employers that promote workplace safety and wellness through preventative initiatives see significant reductions in overall numbers of injuries and illnesses. Moreover, employers

1. The Workers' Compensation Program Safety Initiative



The Task Force launched a Workers' Compensation Program Safety Initiative. Some chief components of the Task Force's efforts include identifying and reviewing positions at State agencies that have a high risk of injury, evaluating and prioritizing State agency return-to-work policies and programs, and holding statewide meetings with agency workers' compensation coordinators.

a. Identifying and Reviewing High-Risk Positions to Ensure Safety

An essential aspect of the Workers' Compensation Program Safety Initiative is to identify and review positions at State agencies that have a high risk of injury. Illinois CMS Risk Management has classified certain positions within the agencies under the Governor that tend to be at the "high-risk" level for work-related injuries. Identification of these types of high-risk positions assists the agencies in effectively targeting safety training, and performing job safety analyses to improve methods of performing duties in the safest manner possible.

As part of this review, Illinois CMS will work with agencies to ensure that position descriptions are updated and accurately reflect the duties of these positions, including specific physical requirements of the job. A detailed job description that outlines the physical demands of the employee's work allows employers to appropriately manage potential safety hazards. Further, in the unfortunate event that an employee is injured, an accurate and detailed position description will allow the treating physician to better determine work restrictions and evaluate an injured employee's ability to return to work.

b. Prioritizing Return-to-Work in Safe, Light-Duty Positions

Another aspect of the Workers' Compensation Safety Initiative is the Task Force's focus on prioritizing the creation of consistent statewide policies for return-to-work programs. Research shows that recovery rates improve when an individual remains connected to the workplace and continues to make a positive contribution to society. A recent study found that Illinois had a longer duration of temporary disability benefits than most other study states.⁴⁹ On average, injured employees in Illinois stayed away from work for 19 weeks (or 4.3 months), compared with 13 weeks (or 2.9 months) in the median of states with permanent partial disability benefit systems.⁵⁰ The setting-in of chronic disability occurs at the highest rate sometime between three to six months after an injury.⁵¹ Return-to-work programs can prevent injuries from developing into disabilities that keep employees from rejoining the workforce.

Given the documented value to both the State and the employee when both parties act quickly and safely bring an employee back to work, Illinois CMS undertook a review of return-to-work policies and practices. As part of the review, Illinois CMS reached out to several agencies, boards, commissions, and universities to determine their return-to-work practices. Through the course of its research, Illinois CMS confirmed that most Illinois agencies have a return-to-work light-duty policy in place. Although the policies are not identical, each policy generally provides for light duty when a treating physician indicates that the employee will be capable of full duty within 120 days (with extensions as appropriate). These are policies that have been negotiated and are included in the State's collective bargaining agreements.

Each agency, board, commission, and university is responsible for implementing its return-to-work policy. However, Illinois CMS has found that return-to-work policies have not been consistently applied or emphasized. As a result

of this discrepancy, the Task Force will continue to discuss how it can collaborate with agencies to establish consistent compliance with return-to-work policies. As a first step, Illinois CMS recently launched a statewide meeting of agency workers' compensation coordinators. More information about that meeting is contained in the next section.

c. Statewide Meeting of Agency Workers' Compensation Coordinators

Every State agency under the Office of the Governor has a workers' compensation coordinator. During Task Force working group meetings members discussed the importance of workplace safety and return-to-work programs. As a result, Illinois CMS prioritized arranging a statewide workers' compensation coordinators meeting to discuss those issues. In October 2017, Illinois CMS conducted statewide workers' compensation coordinator meetings that emphasized:

- workplace safety;
- the purpose and necessity of prioritizing compliance with return-to-work policies and procedures;
- instructions for proper completion of the accident reporting forms;
- the importance of the workers' compensation coordinators role in proper accident investigation;
- payment of temporary total disability benefits versus extended benefit payments;
- identifying 'red flags' of potential fraud or abuse; and
- how to report concerns of program fraud, waste, and abuse.

The meetings included a presentation by Illinois' third-party administrator who discussed the various tools and techniques used in the

private industry to investigate fraud. There was also time set aside to discuss questions that the workers' compensation coordinators had for Illinois CMS.

Following its October 2017 meeting, Illinois CMS plans to hold at least semi-annual meetings with workers' compensation coordinators to confirm they are up-to-date on policies and trends, as well as to facilitate open communication among the coordinators. In addition, Illinois CMS will provide supplemental online training on an as-needed basis. The goal is to assist workers' compensation coordinators and their agencies in developing the full capacity to comprehensively, effectively, and sustainably manage their workers' compensation claims.

As a result of the continued success of this flu shot program, the Task Force explored opportunities to incorporate additional wellness and proactive education information with the flu shot program. As a result of those discussions, this year, during the fall 2017 flu shot program, Illinois CMS will distribute educational information to participants. The information distributed will discuss wellness programs offered by the State's health plan carriers and is aimed at educating members on the various wellness programs available to them. Examples include reduced-cost gym membership and weight-loss programs, and complimentary health and wellness screenings. Illinois CMS has also partnered with the OEIG to circulate informational pamphlets that discuss how to report fraud, waste, and abuse to the OEIG.

2. Pairing Wellness and Fraud, Waste, and Abuse Education with the Flu Shot Program



Wellness and preventative health care measures are central to the Task Force's focus on taking proactive, rather than reactive, measures. One significant step the State takes to provide access to wellness programs and preventative health measures is to coordinate opportunities for eligible current and former State employees to receive the flu shot at a location near their place of work. Illinois CMS Bureau of Benefits coordinates the flu shot program each year, providing free flu vaccinations to eligible State employees and retirees. This program is well attended, and in the fall of 2016, the flu shot program provided approximately 22,000 vaccinations at nearly 200 clinics.

E. Task Force Public Meetings



The Task Force is charged with holding at least one public meeting each quarter. Since our October 2016 Report, the Task Force has held four public meetings. The meetings took place on December 15, 2016, March 24, 2017, June 20, 2017, and September 11, 2017. Meeting agendas and minutes from the Task Force’s public meetings are posted on the Task Force website – [https://www.illinois.gov/oeig/health care fraud](https://www.illinois.gov/oeig/health%20care%20fraud).⁵² This section summarizes the last four Task Force meetings.

At the December 15, 2016 public meeting, Chair EIG Hickey discussed the October 2016 Report and the press conference that followed the release of the report. Director of the ISP-MFCU Captain Brian Ley discussed the progress of the In-Home Care Initiative. Then-Chief Compliance Officer and Deputy General Counsel Georgia Man⁵³ discussed the progress of the State Employee Group Insurance Working Group. During the meeting, Assistant U.S. Attorney Stephen Lee presented regarding issues in health care fraud, specifically how fraud occurs in Illinois’ Medicare and Medicaid programs. Assistant U.S. Attorney Lee outlined suggestions for how the Task Force could prevent fraud. After the presentation, the Task Force engaged in a discussion regarding fraud prevention initiatives raised by Assistant U.S. Attorney Lee. Also at the meeting, Deputy Governor and Chief Operating Officer for the Office of the Governor Trey Childress presented information regarding the State’s work to obtain a Medicaid 1115 Waiver.

Mr. Childress discussed the focus on behavioral health and the use of a cross-discipline approach that includes housing and employment services, among others. Mr. Childress explained that 12 agencies have collaborated as part of applying for the 1115 Waiver.

At the March 24, 2017 public meeting, Chair EIG Hickey discussed the In-Home Care Initiative and the Medicaid Working Group, and its assessment of both short and long term goals. Chair EIG Hickey also emphasized the benefit of Task Force members’ agencies working together and sharing information. Self-Insurers Advisory Board Member David Taylor presented at the meeting regarding return-to-work programs. Mr. Taylor discussed the importance of ensuring that employees who are injured on the job receive quality medical care and treatment so they may eventually return to work. Mr. Taylor also recommended that employers create a centralized approach to manage injured employees, set high goals (e.g., no injured employees, and good performance throughout recovery periods), communicate with injured employees, engineer safety where possible, and reward safe behavior. Also at the meeting, representatives from HFS, DoIT, Illinois CMS, and DoA each discussed initiatives their agencies are taking to “develop and coordinate a comprehensive effort to prevent and eliminate health care fraud, waste, and abuse in State-administered health care programs using a cross-agency, data-driven approach.”⁵⁴

At the June 20, 2017 public meeting, Chair EIG Hickey provided an update on the activities of the Medicaid Working Group, General Counsel and Secretary for the WCC Ronald Rascia gave an update regarding the Workers' Compensation Working Group, and Associate General Counsel for the Office of the Governor Heather Weiner gave an update regarding the State Employee Group Program Insurance Working Group. During the meeting, Adjunct Professor of Law at DePaul University College of Law and Associate at Roetzel & Andress Christina Kuta presented to the Task Force. Ms. Kuta discussed the types of health care fraud she sees in her line of work, the types of individuals who commit fraud, and how to address those individuals. Ms. Kuta stressed the importance of educating providers about how to identify and prevent fraud. Also at the meeting, then Policy Advisor for Healthcare and Human Services and Special Counsel for the Office of the Governor Greg Bassi⁵⁵ spoke about initiatives DoI is taking to address fraud in the State Workers' Compensation Program. Specifically, Mr. Bassi discussed legislation that was introduced in the 100th General Assembly. HFS-OIG Inspector General Brad Hart also spoke at the meeting regarding new initiatives HFS-OIG is taking to address fraud, waste, and abuse in Medicaid programs. For example, Inspector General Hart discussed HFS-OIG's collaboration with other large states to discuss national trends in Medicaid fraud.

At the September 11, 2017 public meeting, Chair EIG Hickey provided an update on the activities of the Medicaid Working Group, Chairman of the WCC Joann Fratianni gave an update regarding the Workers' Compensation Working Group, and Associate General Counsel for the Office of the Governor Matthew Swift gave an update regarding the State Employee Group Insurance Working Group. During the meeting, Director of the Clinical Ethics Consult Service at the University of Illinois Medical Center in Chicago Dr. Lisa Anderson-Shaw, D.Ph., MA, MSN, presented to the Task Force. Dr. Anderson-Shaw discussed ethics and fraud prevention at the University of Illinois Medical Center. For

example, Dr. Anderson-Shaw discussed policies the Medical Center put into place to prevent misconduct related to health care fraud. She discussed issues of waste regarding patients without guardians, as well. Also at the meeting, Director of the ISP-MFCU Captain Brian Ley and ISP-MFCU Assistant Bureau Chief and Chief Counsel Elizabeth Lepic spoke to the Task Force about Illinois' involvement in the national health care fraud takedown that took place during the week of July 10-14, 2017.

IV. Conclusion

The Task Force is proud of its work and excited to continue to advance and expand its current initiatives. In the one and a half years since the Task Force was formed, it has cataloged best practices and developed targeted initiatives to improve Illinois practices, formed working groups to efficiently and effectively save taxpayer funds, worked to address the most problematic areas of fraud, waste, and abuse so that funds are appropriately used on those entitled to services, and put into place a framework among Illinois agencies that ensures collaboration with key players.

While the Task Force has made great strides forward, there is still work to be done. In the coming months and year, the Task Force will continue to carry out its strategic plan to yield the best return on investment for taxpayers. As part of the plan, the Task Force will be:

- engaging in greater collaboration and coordination among State agencies, private and public sector partners, and vendors to maximize efficiency and prevent information and cost-effective measures from being siloed;
- exploring opportunities to expand data sharing among agencies, private and public sector partners, and vendors to leverage current resources;
- increasing proactive outreach and education of providers and State employees regarding fraudulent schemes and how to proactively address fraud and waste; and
- benchmarking and using metrics to evaluate the success of our initiatives and ensure the greatest impact on combating fraud, waste, and abuse in State-administered health care programs.

As the Task Force pushes forward with a robust portfolio of projects, it will continue to meet publicly at least quarterly, and will submit periodic reports to the Governor and the public outlining its progress.

V. Appendix

A. Executive Order 5 (2016)



EXECUTIVE ORDER

EXECUTIVE ORDER ESTABLISHING THE HEALTH CARE FRAUD ELIMINATION TASK FORCE

WHEREAS, State government-administered health care programs should operate in a transparent and efficient manner with the goal of delivering quality services while providing value to taxpayers; and

WHEREAS, fraud, waste, and abuse in State-administered health care programs increase the State's health care costs, resulting in a bad deal for taxpayers and less resources for critical services; and

WHEREAS, in fiscal year 2015, the State of Illinois spent over \$19 billion on the State Employee Group Insurance Program and the State-administered Medicaid program; and

WHEREAS, the federal Department of Health and Human Services estimates that on a national level, over \$29 billion of taxpayer funds are spent each year on improper Medicaid payments; and

WHEREAS, the private sector, the federal government, and other states across the country are beginning to employ innovative and comprehensive strategies to reduce fraud, waste, and abuse in health care programs; and

WHEREAS, current efforts led by various units across State government have been successful in recouping or avoiding unnecessary spending in certain State agencies and certain State health care programs; and

WHEREAS, notwithstanding these successes, a more comprehensive and cross-disciplinary approach is needed to harness the State's various fraud-prevention resources to further prevent and eliminate fraud, waste, and abuse and ensure that taxpayers are receiving the best return on investment for the State's fraud prevention efforts;

THEREFORE, I, Bruce Rauner, Governor of Illinois, by virtue of the executive authority vested in me by Section 8 of Article V of the Constitution of the State of Illinois, do hereby order as follows:

I. CREATION

There is hereby established the Health Care Fraud Elimination Task Force (the "Task Force").

II. PURPOSE

The purpose of the Task Force is to develop and coordinate a comprehensive effort to prevent and eliminate health care fraud, waste, and abuse in State-administered health care programs using a cross-agency, data-driven approach. Building on anti-fraud work being done across State agencies, the Task Force will develop strategies to ensure that the State has the proper internal controls and analysis and enforcement tools to prevent and eliminate fraud, waste, and abuse in

taxpayer-funded health care programs, including but not limited to the State Employees Group Insurance Program, the Workers' Compensation Program for State of Illinois agencies, boards, commissions, and universities, and the Illinois Medicaid system.

III. DUTIES

The Task Force shall:

1. Identify and catalog the forms of health care fraud existing within State-administered health care programs and identify all Executive Branch agencies and resources currently involved or that should be involved in health care fraud prevention and enforcement.
2. Review best practices being utilized in the private sector, the federal government, and other states to prevent and reduce health care fraud, waste, and abuse and assess how those best practices could be applied to anti-fraud, waste, and abuse efforts in Illinois.
3. Explore the use of data analysis, predictive analytics, trend evaluation, and modeling approaches to better analyze and target oversight of State-administered health care programs.
4. Identify priority prevention and enforcement areas in order to ensure that the State's fraud prevention and enforcement efforts are providing the best return on investment for taxpayers.
5. Collaborate with industry experts to develop a multifaceted strategy to reduce the State's exposure to health care fraud and recover taxpayer funds that have been wrongly paid out as a result of fraud, waste, or abuse.
6. Analyze patterns of system-wide fraud, waste, and abuse in order to make recommendations to State agencies for improved internal controls to prevent future wrongdoing.
7. Work with other State agencies, boards, commissions, and task forces to obtain information and records necessary to carry out its duties.
8. Periodically report to the Governor and the public on the Task Force's fraud, waste, and abuse identification, prevention, and elimination efforts and activities.

IV. COMPOSITION AND FUNCTION

1. The Task Force shall consist of:
 - a. The Executive Inspector General for the Agencies of the Illinois Governor, who will serve as Chairman of the Task Force;
 - b. The Deputy Governor;
 - c. The Chief Compliance Officer;
 - d. The Special Counsel and Policy Advisor to the Governor for Healthcare and Human Services;
 - e. The Inspector General for the Department of Healthcare and Family Services;
 - f. The Director of the State Police Medicaid Fraud Control Unit;
 - g. The Director of the Department on Aging;
 - h. The Director of the Department of Central Management Services;
 - i. The Director of the Department of Healthcare and Family Services;
 - j. The Secretary of the Department of the Human Services;
 - k. The Secretary of the Department of Information Technology; and
 - l. The Director of the Department of Insurance.
2. A majority of the members of the Task Force shall constitute a quorum, and all recommendations of the Task Force shall require approval of a majority of the total members of the Task Force. The Task Force shall conduct at least one public meeting each quarter.

3. The Governor's Office shall provide administrative support to the Task Force as needed, including with respect to compliance with State ethics laws and the Freedom of Information Act.
4. The Task Force shall submit an initial report to the Governor within six months of this Executive Order, outlining its initial fraud, waste, and abuse identification efforts. Thereafter, the Task Force shall submit periodic reports to the Governor and the public outlining its progress in preventing and eliminating health care fraud, waste, and abuse.
5. The Task Force may adopt whatever policies and procedures are necessary to carry out its duties and functions.

V. TRANSPARENCY

In addition to whatever policies or procedures it may adopt, the Task Force shall be subject to the provisions of the Freedom of Information Act (5 ILCS 140). This section shall not be construed as to preclude other statutes from applying to the Task Force and its activities.

VI. SAVINGS CLAUSE

This Executive Order does not contravene, and shall not be construed to contravene, any federal law, State statute, or collective bargaining agreement.

VII. PRIOR EXECUTIVE ORDERS

This Executive Order supersedes any contrary provision of any other prior Executive Order.

VIII. TERM

The Task Force shall be dissolved on June 30, 2019, subject to renewal by a succeeding Executive Order.

IX. SEVERABILITY CLAUSE

If any part of this Executive Order is found invalid by a court of competent jurisdiction, the remaining provisions shall remain in full force and effect. The provisions of this Executive Order are severable.

X. EFFECTIVE DATE

This Executive Order shall take effect immediately upon filing with the Secretary of State.



Bruce Rauner, Governor

Issued by Governor: April 5, 2016
Filed with Secretary of State: April 5, 2016

B. Task Force Member Biographies

MAGGIE HICKEY, Executive Inspector General, Office of Executive Inspector General for the Agencies of the Illinois Governor

Maggie Hickey is the Executive Inspector General for the Office of Executive Inspector General for the Agencies of the Illinois Governor. She was nominated by Governor Bruce Rauner in 2015. Prior to being the EIG, she served the U.S. Attorney's Office for the Northern District of Illinois for over 10 years. From 2010 to 2015, she was the Executive Assistant U.S. Attorney, overseeing a staff of approximately 300 employees, including 170 Assistant U.S. Attorneys. Prior to her supervisory role, EIG Hickey served as an Assistant U.S. Attorney in the Criminal Division, Financial Crimes and Special Prosecution Section where she investigated and prosecuted a wide array of white collar crimes, including health care fraud. EIG Hickey tried multiple cases to verdict and she also briefed and argued many appeals before the U.S. Court of Appeals.

TREY CHILDRESS, Deputy Governor and Chief Operating Officer, Office of the Governor

Trey Childress currently serves as Deputy Governor & Chief Operating Officer (COO) of Illinois under Governor Bruce Rauner, responsible for executive branch transformation efforts. Prior to his current role, Mr. Childress served as the COO for the State of Georgia under two governors. He was responsible for leadership and supervision of Georgia's 50 state departments, agencies, and boards and commissions while leading government transformation initiatives. Prior to that, he served as the Director of the Governor's Office of Planning & Budget. Mr. Childress previously served as Senior Adviser and Director of Policy for the Office of the Governor with the successful passage of more

than 30 signature policy initiatives in education, health care, transportation, taxation and natural resources. He began his career in public service working with the former Georgia Information Technology Policy Council, the Georgia Technology Authority and the Office of Planning & Budget. Mr. Childress earned a master's degree in public policy and bachelors' degrees in industrial and systems engineering and international affairs from the Georgia Institute of Technology in Atlanta.

JILL M. HUTCHISON, Deputy General Counsel and Chief Compliance Officer, Office of the Governor

Jill Hutchison serves as Deputy General Counsel to Governor Rauner and Chief Compliance Officer for the State of Illinois. In this role, she oversees the compliance program, working to make State government more effective, efficient, and ethical. Ms. Hutchison also oversees legal functions in the Governor's Office that include litigation and hiring issues. Prior to joining the Rauner administration, Ms. Hutchison was a partner at Jenner & Block LLP. In her twelve years of private practice, her litigation practice focused on class actions and multi-jurisdictional matters, complex commercial litigation, and consumer protection and product liability issues. She conducted internal investigations and worked with clients to mitigate risk through ethics and compliance and operational improvements. Ms. Hutchison earned her law degree from The University of Texas School of Law. She is a graduate of the University of Illinois at Urbana-Champaign, where she earned a Master of Science in Library and Information Science and a Bachelor of Arts in History.

CHRISTOPHER KANTAS, Special Counsel and Policy Advisor to the Governor for Healthcare and Human Services, Office of the Governor

Christopher Kantas serves as the Special Counsel and Policy Advisor to the Governor for Healthcare

and Human Services. Mr. Kantas began serving in this position in July 2017. Previously Mr. Kantas worked for the Office of the Governor in the Office of the General Counsel as an Associate General Counsel. As an Associate General Counsel, he managed litigation progress and strategy for the executive branch, and served as principal legal relations liaison for the Governor to all Illinois health and human service agencies. Prior to working in the Governor's Office, Mr. Kantas worked as a civil litigator for seven years. Mr. Kantas graduated from the University of Illinois College of Law, Urbana-Champaign, receiving a Juris Doctor. Mr. Kantas attended the University of Illinois, Urbana-Champaign, Institute of Government and Public Affairs as a Public Policy Fellow. Mr. Kantas holds a Bachelor of Arts in History from the University of Illinois, Urbana-Champaign. Mr. Kantas also attended the University of Oxford, Christ Church College.

BRADLEY HART, Inspector General, Office of Inspector General for the Department of Healthcare and Family Services

Bradley Hart was appointed as the Inspector General of HFS-OIG in 2011. Prior to that appointment, Inspector General Hart served as Deputy Bureau Chief for the Office of the Illinois Attorney General's Medicaid Fraud Control Bureau, where he prosecuted health care fraud while assigned to ISP-MFCU. While employed by the Office of the Illinois Attorney General, Inspector General Hart was cross-designated as a Special Assistant U.S. Attorney in the Central and Southern Districts of Illinois, where he prosecuted civil and criminal health care fraud related matters in federal court. Prior to prosecuting health care fraud, Inspector General Hart was in private practice where he worked on family law matters, trusts and estates, municipal representation, civil litigation, criminal defense, and appeals.

CAPTAIN BRIAN LEY, Director, Illinois State Police Medicaid Fraud Control Unit

Captain Brian A. Ley was appointed as the Director of ISP-MFCU in July 2015. Prior to that appointment, Captain Ley served as the ISP First Deputy Director where he served as second-in-command of a full-service police department with approximately 2,900 employees engaged in emergency response, patrol, investigations, forensic services, police training, and law enforcement administration. Captain Ley has spent his entire career dedicated to law enforcement, all 26 years with the ISP. Captain Ley has enjoyed a professional affiliation with the National Association of Medicaid Fraud Control Units. He has a bachelor's degree in law enforcement administration from Western Illinois University.

JEAN BOHNHOFF, Acting Director, Department on Aging

Jean Bohnhoff is the Acting Director of the DoA, appointed by Governor Rauner in January 2016. She had previously served with Effingham City/County Committee on Aging as the Executive Director, where she oversaw the day-to-day operations of the not-for-profit agency and its five offices that cover nine counties in central Illinois. Previously, she served as an associate manager of sales administration for Yellow Book USA and as a dealer services coordinator for Nova Solutions. Ms. Bohnhoff is an active community member, dedicating her free time to many boards, commissions, and clubs including the Effingham County Chamber, the Effingham County Youth Commission, the Effingham County United Way, and the Dieterich Women's Club, as well as twelve years of service to the Dieterich Unit #30 School District. Ms. Bohnhoff received a bachelor's degree from Simon Fraser University in business administration.

MICHAEL HOFFMAN, Acting Director,
Department of Central Management Services

Michael M. Hoffman was appointed Acting Director of Illinois CMS in January 2016. Mr. Hoffman most recently worked as the Chief Operating Officer of the Illinois Department of Commerce and Economic Opportunity, where he ran the day-to-day operations of the Agency and led the Department's strategic planning effort. Prior to his work for the State of Illinois, Mr. Hoffman worked for RockTenn (now WestRock), a Fortune 500 company that manufactures consumer and corrugated packaging. Mr. Hoffman is a retired Major in the Marine Corps, where he served the U.S. for 15 years. Mr. Hoffman served in a variety of command and operations leadership positions, including serving as the Operations Officer for a 1200-person organization during combat operations in Afghanistan. Mr. Hoffman earned his bachelor's degree from Tulane University and holds a master's degree from the Naval Postgraduate School.

FELICIA F. NORWOOD, Acting Director,
Department of Healthcare and Family Services

In January 2015, Governor Bruce Rauner appointed Felicia F. Norwood to serve as the Director of HFS. Ms. Norwood has more than twenty years of experience in public policy, business operations, and health care delivery systems. Before her appointment, Ms. Norwood was a senior executive in the health insurance industry. In the private sector, Ms. Norwood was the President of the Mid-America region for Aetna. Ms. Norwood previously served as a Senior Policy Advisor on Health and Human Services for Governor Jim Edgar, where she led health care reform initiatives and chaired the Human Services Cabinet. She also served as a Policy Adviser on Human Services to Governor Jim Thompson, where she developed and implemented policies on children and family services, public aid, and mental health. Ms. Norwood earned her law degree from Yale Law School, a master's degree in Political Science from

the University of Wisconsin, and a bachelor's degree in Political Science from Valdosta State University in Georgia.

JAMES DIMAS, Acting Secretary, Department of
Human Services

James Dimas was appointed the Secretary of DHS by Governor Bruce Rauner. Mr. Dimas is an experienced leader in transforming human services departments at the state and local level, including Illinois. He was a primary architect in the consolidation of the current agency. Mr. Dimas has worked in a number of roles at DHS, including the Acting Director of Community Operations. Mr. Dimas began working for the State of Illinois in 1995 on the Governor's Task Force on Human Services Reform under Governor Edgar. He led the development and marketing for the consolidation effort into DHS's current organizational structure. DHS was consolidated into the State's largest agency in 1997 from seven previously separate health and social services agencies. Mr. Dimas is a graduate of Knox College, where he earned a bachelor's degree in political science. He holds a master's degree from the University of Texas in public affairs. Mr. Dimas also attended Harvard University's Executive Program for government performance.

KIRK LONBOM, Acting Secretary, Department of
Innovation and Technology

Kirk Lonbom is the Acting Secretary of DoIT and serves as the Chief Information Officer for the State of Illinois. In this role, Mr. Lonbom is leading a statewide digital transformation in support of Governor Rauner's vision for a more efficient, accessible, competitive and compassionate Illinois. Mr. Lonbom is guiding efforts to empower the State of Illinois through high-value, customer-centric technology by delivering best-in-class innovation and services to client agencies, fostering collaboration and empowering employees to provide better services

to residents, businesses, and visitors. As the designated steward of State data, Mr. Lonbom is leading DoIT's efforts to accelerate data-driven value creation while continuously improving the cybersecurity of the State and protecting the privacy of Illinois' citizens. Mr. Lonbom served as the State's first Chief Information Security Officer and led the development and execution of a statewide transformative cybersecurity strategy. Mr. Lonbom began his career as a police officer, serving in uniform, investigative and undercover roles, and ultimately specializing in criminal intelligence focusing on organized criminal groups and terrorism. In his growth as a technology leader, he has previously served as Assistant Deputy Director and Deputy Chief Information Officer for the Illinois State Police and Chief Information Officer for the Illinois Emergency Management Agency.

Ms. Hammer has a bachelor's degree in Justice Studies from Arizona State University and a J.D. from Southern Illinois University School of Law.

JENNIFER HAMMER, Director, Department of Insurance

Jennifer Hammer, Director of the DoI, was appointed by Governor Bruce Rauner in January 2017, and she was confirmed as Director on February 15, 2017. Ms. Hammer brings more than a decade of experience in healthcare law and policy to the DoI. Prior to her appointment, she served as the Deputy Chief of Staff for Policy in the Office of the Governor where she worked closely with State agencies to develop and implement the Governor's public policy agenda. Previously, she served as Special Counsel to the Governor and Policy Advisor for Healthcare and Human Services. In this role, she coordinated all healthcare-related agencies, including the DoI. Ms. Hammer oversaw the transition of Get Covered Illinois, Illinois' Health Insurance Marketplace, from an independent commission to the DoI. Prior to joining State government, Ms. Hammer was Associate Vice President/Legal Counsel for Government Affairs for the Illinois Chamber of Commerce and a lawyer in private practice with a focus on insurance defense, healthcare, business and advising clients on legislation including the Affordable Care Act.

C. Endnotes

1 State of Illinois Exec. Order No. 2016-05 (2016), <https://www2.illinois.gov/Documents/ExecOrders/2016/ExecutiveOrder16-05.pdf> (hereinafter EO No. 2016-05).

2 *MFCU Statistical Data for Fiscal Year 2016*, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf (last visited Sept. 22, 2017) (hereinafter FY 2016 MFCU Data). Federal fiscal year 2016 ran from October 2015 through September 2016.

3 *Id.*

4 *Id.*

5 SYLVIA M BURWELL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, FISCAL YEAR 2016 AGENCY FINANCIAL REPORT 217 (2016), <https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf> (last visited Sept. 22, 2017) (hereinafter HHS FINANCIAL REPORT). An improper payment is: “when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, the recipient uses the funds in an improper manner, or documentation is not available to verify the appropriateness of the payment.” *Id.* at 35.

6 State fiscal year 2017 ran from July 1, 2016 to June 30, 2017.

7 State fiscal year 2018 runs from July 1, 2017 to June 30, 2018.

8 ISP-MFCU investigates criminal and civil allegations of Medicaid provider fraud, as well as patient abuse and neglect in Medicaid funded facilities. ISP-MFCU is currently comprised of 26 sworn officers, seven non-sworn investigators, four attorneys, three analysts, and two accountants. In addition, ten attorneys from the Office of the Illinois Attorney General are dedicated to prosecute cases investigated by the MFCU. The ISP-MFCU works with multiple Illinois agencies, including the Illinois Department of Healthcare and Family Services, the Illinois Department of Human Services and the Illinois Department of Public Health to obtain referrals and information.

9 *FY 2016 MFCU Data*, *supra* note 2.

10 EO No. 2016-05, *supra* note 1.

11 *Id.*

12 *Eligibility*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicare.gov/medicaid/eligibility/index.html> (last visited Sept. 22, 2017) (hereinafter Eligibility).

13 *Id.*

14 Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children’s Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2017 through September 30, 2018, 81 Fed. Reg. 80078 (Nov. 15, 2016).

15 Rudowitz, Robin, “*Understanding How States Access the ACA Enhanced Medicaid Rates*” (Issue Brief), <http://www.kff.org/medicaid/issue-brief/understanding-how-states-access-the-aca-enhanced-medicare-match-rates/> (last visited Sept. 7, 2017).

16 *See About CMS*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.cms.gov/About-CMS/About-CMS.html> (last visited Sept. 25, 2017).

17 HFS’s programs currently cover approximately 3.2 million enrollees, including 1,490,290 children, 200,692 seniors, 249,241 persons with disabilities, 637,056 federal Affordable Care Act eligible adults, 607,827 non-disabled, non-senior adults, and 16,486 enrollees with partial benefit packages.

18 Illinois Public Act 99-106 defined “care coordination” as “delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care.” Risk-based payment for care coordination usually consists of a capitated payment in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of the services.

19 *What’s Medicare?*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> (last visited Sept. 22, 2017).

20 *Id.*

21 *An Overview of Medicare*, KAISER FAMILY FOUNDATION (Apr. 1, 2016), <http://kff.org/medicare/issue-brief/an-overview-of-medicare/> (last visited Sept. 22, 2017).

22 ILL. WORKERS’ COMP. COMM’N, FISCAL YEAR 2016 ANNUAL REPORT 4 (2017).

23 820 ILCS 305/8(a) (2017).

24 820 ILCS 305/8(b)1.

25 *Id.* §§ 305/8(b)2–2.1.

26 In the fall of 2016, the MyBenefits web-based enrollment portal launched. This portal allows Illinois CMS to more efficiently manage and communicate with plan participants.

27 Please note there are spaces in this website address after the words “health” and “care”.

28 *FY 2016 MFCU Data, supra* note 2.

29 *Id.*

30 *Id.*

31 HHS FINANCIAL REPORT, *supra* note 5, at 217.

32 U.S. Department of Justice website, Office of Public Affairs, Press Release, “National Health Care Fraud Takedown Results in Charges Against Over 412 Individuals Responsible for \$1.3 Billion in Fraud Losses” (July 13, 2017), <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible> (last visited Oct. 20, 2017).

33 U.S. Department of Justice website, Documents and Resources from the July 13, 2017 National Health Care Fraud Takedown Press Conference, <https://www.justice.gov/opa/documents-and-resources-july-13-2017-national-health-care-fraud-takedown-press-conference> (last visited Oct. 18, 2017).

34 The three nurses were charged with unlawful possession of a controlled substance as part of separate drug diversion cases.

35 *About the Partnership*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://hfpp.cms.gov/about/index.html> (last visited Oct. 20, 2017).

36 Additional information regarding the Notice to Award the MCO contracts is available at https://www.illinois.gov/hfs/SiteCollectionDocuments/Notice_of_Award_MCO_RFP.pdf.

37 On September 6, 2017, Governor Rauner issued Executive Order 5 (2017), Establishing the Governor’s Opioid Prevention and Intervention Task Force. Among other things, the purpose of the Task Force is to “develop, approve, and implement a comprehensive Opioid Action Plan to: (1) prevent the further spread of the opioid crisis; (2) treat and promote the recovery of individuals with opioid use disorder; and (3) respond effectively to avert opioid overdose deaths.” State of Illinois Exec. Order No. 2017-05 (2017), <https://www2.illinois.gov/Documents/ExecOrders/2017/ExecutiveOrder2017-5.pdf>.

38 Of the \$2.7 billion, \$1.2 billion as part of the 1115 waiver,

and \$1.5 billion as part of the proposed State Plan Amendments.

39 On July 1, 2017, the Historic Preservation Agency was abolished, and its main functions were transferred to a new division of the Illinois Department of Natural Resources, pursuant to Executive Order 2017-01. See State of Illinois Exec. Order No. 2017-01 (2017), <https://www2.illinois.gov/Documents/ExecOrders/2017/ExecutiveOrder2017-1.pdf>.

40 The outlier analysis includes summaries with indicators of whether providers exceed the normal payment within their peer group (by the same provider type, geographic location, procedure codes, or other pre-defined clusters that share the same characteristics). This analysis allows HFS-OIG investigators to detect providers who behave or perform outside the norm.

41 For example, the DNA Surveillance and Utilization Review System is used to conduct a monthly analysis of providers based on their “risk score” and other predictive measurements.

42 The Provider Profile Reports and Recipient Profile Reports have combined information from various data sources and applied statistical approaches to offer a comprehensive view to examine a targeted provider or a targeted recipient in various categories of services of the Medicaid program. These programs analyze the patterns of fraud or abuse of the Medicaid system, and assess any data quality or billing error issues for future system enhancement or policy changes.

43 The DNA system provides a Statewide Executive Summary that gives an overview on total yearly payments in each county, or by provider type, or at a procedure and/or diagnostic code level.

44 HSP Fraud Unit defines overpayment as the amount an Individual Provider and/or Agency Provider was paid for providing unverified services to a customer.

45 DoA’s network of providers include Care Coordination Units and service providers.

46 Public Act 94-277, Section 25.5 of the Illinois Workers’ Compensation Act (Act) (820 ILCS 305/25.5).

47 820 ILCS 205, §25.5 (2016).

48 Of those eight cases, six of the investigations were initiated in 2015, one was initiated in 2014, and one was initiated in 2016.

49 EVELINA RADEVA, WORKERS COMP. RESEARCH INS., COMPSCOPETM BENCHMARKS FOR ILLINOIS 14 (17TH ED. 2017).

50 *Id.* at 4.

51 INT'L ASS'N OF INDUS. ACCIDENT BDS. & COMM'NS,
RETURN TO WORK: A FOUNDATIONAL APPROACH TO RETURN TO
FUNCTION 9 (2016).

52 Please note there are spaces in this website address after
the words "health" and "care".

53 Georgia Man has since left her position as Chief
Compliance Officer and Deputy General Counsel for the Office of
the Governor.

54 EO No. 2016-05, *supra* note 1.

55 Greg Bassi has since left his position as Policy Advisor for
Healthcare and Human Services and Special Counsel for the Office
of the Governor.

