



Illinois Health Care Fraud Elimination
TASK FORCE

Interim Report

October 2018

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I. Executive Summary



The Illinois Health Care Fraud Elimination Task Force (Task Force) is pleased to submit this interim report. Since the creation of the Task Force in April 2016,¹ we have been diligently working to ensure that taxpayer funds for State of Illinois (State) government-administered health care programs are spent properly.

The Task Force was created 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.”² For the past two and one-half years, 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.

The State devotes a substantial amount of resources and taxpayer dollars to its health care programs.

In State fiscal year (FY) 2018, Illinois medical assistance programs, consisting of Medicaid and numerous other medical programs, provided comprehensive health care coverage to over 3.16 million Illinois residents, and Illinois spent approximately \$19.6 billion on these Illinois medical assistance programs.³ These expenditures include both State and federal monies. In federal FY 2017, the United States (U.S.) federal and state governments spent a total of approximately \$596 billion on Medicaid expenses.⁴ The U.S. Department of Health and Human Services estimates that in FY 2017, Medicaid made about \$36.16 billion in net improper 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 2018, State employees filed 4,487 workers’ compensation claims, and the State paid approximately

\$112,384,613 in workers' compensation benefits.

The State Employee Group Insurance Program provides health care coverage for nearly 450,000 individuals including, State employees, retirees, survivors, and their dependents. In addition, this Program covers retired teachers, retired community college members, and certain local government units. For State FY 2018, the liability for employee health insurance benefits was about \$3.42 billion.

Task Force agencies 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 2018, the Office of Inspector General for the Department of Healthcare and Family Services (HFS-OIG) will report approximately \$190 million in savings, recoupment, and avoidance for the State Medicaid program (references to Medicaid savings and recoveries include both State and federal dollars). In addition, during federal FY 2017, Illinois State Police Medicaid Fraud Control Unit⁶ (ISP-MFCU) referrals led to 39 fraud convictions and \$27.8 million in recoveries through criminal prosecutions, civil actions, and/or administrative referrals.⁷

Despite the great successes of individual State agencies, there is potential to secure additional savings through collaborative work to improve efficiency and fraud prevention. Today, the Task Force proudly reports on its progress since our last report in October 2017. These accomplishments highlight the willingness of Task Force members to collaborate and reach across agency lines to drive value. A sample of the work discussed in this Report includes:

- **Participating in the Largest Nationwide Health Care Fraud Takedown.** Task Force members participated in the 2018 National Health Care Fraud Takedown, the largest health care fraud enforcement action in U.S. Department of Justice history. The multi-agency effort took place in June 2018

and resulted in 601 defendants, including 165 doctors, nurses, and other licensed professionals, being charged with health care fraud allegations that involved over \$2 billion in false billing. ISP-MFCU was one of 30 state Medicaid Fraud Control Units participating in the 2018 Takedown. ISP-MFCU investigated allegations of fraud in the Medicaid Home Services Program, leading to the indictment of 14 individuals responsible for approximately \$430,000 in fraudulent claims.

- **Hospital Global Billing Initiative.** The Hospital Global Billing Initiative involves allowing hospitals to self-audit potential overpayments identified by HFS-OIG and to correct any billing errors. Specifically, 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. This initiative began in April 2016 as a pilot program at two hospitals. 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, for 272 hospitals. The follow-up audit resulted in the identification of approximately \$800,000 in overpayments for State FY 2018. In addition to those overpayments, approximately 29 hospitals have followed up with the self-disclosure process and found potential overpayments of approximately \$1 million for that audit period.
- **Blood Pressure Machines.** As part of the Task Force's focus on wellness, CMS worked with one of the State's health carriers to install blood pressure machines at various State agencies. These machines, called Higi machines, measure blood pressure, pulse, body weight, Body Mass Index (BMI), and body fat percentage. The machine is connected to the internet and allows the individual to send the results to an email account. In the first three months, nearly 5,000 screenings were completed.

One employee who used the Higi machine contacted CMS to credit the machine with saving her life. When she used the machine, it informed her that her blood pressure was in a critically dangerous zone and instructed her to seek immediate medical attention. The employee went to the hospital emergency room, where she was admitted for early stages of a stroke. This employee was very grateful and told CMS that the machine saved her life.

- **Notice of Injury Form.** The Task Force updated the form employees submit to report a workplace injury. The form now includes a certification that the information is accurate and that it is unlawful to intentionally provide false information. This language will serve as a reminder to State employees of the basic requirement of honest reporting and the seriousness of submitting false statements about workers' compensation injuries. Additionally, this language will assist in the investigations and prosecutions of employees by providing proof that the employee knew or should have known about his or her legal obligations.
- **U.S. Attorney's Office Health Care Fraud Task Force.** As part of furthering the collaboration between the U.S. Attorney's Office Health Care Fraud Unit and this Task Force, State Task Force members attended the U.S. Attorney's Office Health Care Fraud Task Force meetings. We actively participated in discussions about deterring wrongdoing and using data to prioritize resources. Our attendance at these meetings was the result of Deputy Chief in the Financial Crimes Section and Supervisor of the Health Care Fraud Unit within the U.S. Attorney's Office for the Northern District of Illinois Heather McShain speaking at a public Task Force meeting in March 2018. The information sharing at these meetings highlights the importance of the State collaborating with federal partners.

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.”⁸

The Executive Order outlines the following specific duties for the Task Force:⁹

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.

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

The Illinois Health Care Fraud Elimination Task Force includes the following members:¹⁰

SUSAN M. HALING (Chair)
Executive Inspector General, Office of Executive
Inspector General for the Agencies of the Illinois
Governor (OEIG)

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

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

BRADLEY HART
Inspector General, Office of Inspector General
for the Department of Healthcare and Family
Services (HFS-OIG)

LIEUTENANT DAVID ROLL
Director, Illinois State Police Medicaid Fraud
Control Unit (ISP-MFCU)

JEAN BOHNOFF
Director, Department on Aging (DoA)

TIM McDEVITT
Director, Department of Central Management
Services (CMS)

PATRICIA BELLOCK
Director, Department of Healthcare and Family
Services (HFS)

JAMES DIMAS
Secretary, Department of Human Services (DHS)

KIRK LONBOM
Secretary, Department of Innovation and
Technology (DoIT)

JENNIFER HAMMER
Director, Department of Insurance (DoI)

JOANN FRATIANNI
Chairman, Illinois Workers' Compensation
Commission (WCC)

C. Task Force Working Groups

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 Workers' Compensation Program; and (3) the State Employee Group Insurance Program. The mission of each working group 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.

The Medicaid Working Group includes individuals from the OEIG, Office of the Governor, HFS-OIG, HFS, DoA, ISP-MFCU, DHS, and DoIT.

The Workers' Compensation Working Group includes individuals from the OEIG, Office of the Governor, CMS, WCC, and DoI.

The State Employee Group Insurance Working Group includes individuals from the OEIG, Office of the Governor, CMS, and DoI.

D. Summary of Previous Task Force Reports



The Task Force has submitted to the Governor, and the Governor has publicly released, two reports. An initial report was sent to the Governor in October 2016 and an interim report was sent to the Governor in October 2017. The Task Force reports are available on the Task Force website – [https://www.illinois.gov/oeig/health care fraud](https://www.illinois.gov/oeig/health%20care%20fraud).¹¹

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). 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 catalogued the State's health care programs and the resources utilized at the following State agencies to combat fraud, waste, and abuse: HFS, HFS-OIG, ISP-MFCU, OEIG, DHS, DoIT, DoA, CMS, DoI, and the Illinois Department of Transportation (IDOT).

Consistent with the current focus, 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 work during the initial six months was concentrated within four areas: (1) collaboration and coordination; (2) data analytics and metrics; (3) accountability and efficiency; and (4) safety and wellness.

Summary of the Task Force's October 2017 Interim Report

In October 2017, the Task Force provided the Office of the Governor with an interim report of its activities. The Task Force's second report was issued after the Task Force had been in effect for about one and a half years, and thus, illustrated the growth of the Task Force's initial work as well as its more recent accomplishments.

A few highlights of the accomplishments discussed in the October 2017 Interim Report include a discussion of the Task Force's In-Home Care Program Initiative, the Health and Human Services Transformation, and pairing the flu shot initiative with employee education of wellness and fraud, waste, and abuse reporting.

First, the Task Force outlined its 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. Some of the Task Force's work on this initiative included adding worker certifications to timesheets, increasing staff who investigate and monitor in-home care program fraud, and implementing training and education programs for in-home care

workers and recipients.

Another development discussed in the Interim Report was the Health and Human Services Transformation, which involves HFS 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.

The Interim Report also discussed the Task Force's work to pair the flu shot initiative with employee education of wellness and fraud, waste, and abuse reporting. As the flu shot program typically administers over 20,000 vaccines, the Task Force collaborated to provide flu shot attendees with information about wellness programs offered by the State's health plan carriers and how to report fraud, waste, and abuse to the OEIG.

Finally, the October 2017 Interim Report outlined the continued focus of the three working groups and how the collaboration within those groups has led to more clearly defined goals and focus areas.

E. Task Force Public Meetings



The Task Force's public meeting agendas and minutes are posted on the Task Force website – [https://www.illinois.gov/oeig/health care fraud](https://www.illinois.gov/oeig/health%20care%20fraud).

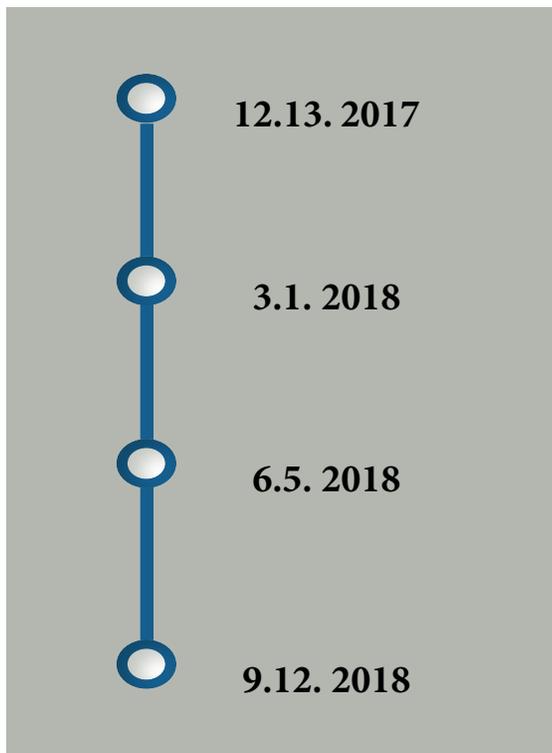
The public meetings offer a unique opportunity for all of the Task Force members and relevant staff to come together to report on the activities within their working groups. At every public meeting, each of the three working groups report on its progress.

The public meetings are also utilized to exchange ideas, best practices, and perspectives from individuals outside of the Task Force. The following individuals spoke at the public Task Force meetings:

As previously mentioned, the Task Force is charged with holding at least one public meeting each quarter. Since our October 2017 Interim Report, the Task Force has held four public meetings. The meetings took place on December 13, 2017, March 1, 2018, June 5, 2018, and September 12, 2018.

Heather McShain,
Deputy Chief in the Financial Crimes Section & Supervisor of the Health Care Fraud Unit - U.S. Attorney's Office for the Northern District of Illinois

Deputy Chief McShain provided an overview of the U.S. Attorney's Office Health Care Fraud Unit, including information about the volume of health care fraud investigations, and factors the U.S. Attorney's Office considers when deciding whether to open an investigation. Deputy Chief McShain also discussed advancements in data analytics and how those tools have enabled the U.S. Attorney's Office to be more efficient in conducting its investigations. She also discussed a new U.S. Attorney's Health Care Fraud Task Force, and invited our members to attend the bi-annual meetings.



Mark Sakalares,
Supervisory Special
Agent & Chris Kluz, Field
Information Analyst -
National Insurance Crime
Bureau

This presentation introduced Task Force members to the National Insurance Crime Bureau, a not-for-profit insurance fraud-fighting organization. The NICB speakers discussed free resources the organization offers to law enforcement, including data analytics capabilities and training opportunities. The NICB speakers presented Illinois' statistics regarding fraud, including questionable claims in the area of workers' compensation. The ISP-MFCU Director, a Task Force member, also shared how NICB works with ISP-MFCU to assist in conducting fraud investigations.

Allen Griffy, Health
Care Worker Registry
Supervisor & Colleen
Trader,
Office Coordinator -
Illinois Department of
Public Health

This presentation focused on the Illinois Health Care Worker Registry, including statutory requirements, the purpose of the Registry, and Registry functions. For example, the Illinois Department of Public Health speakers discussed background checks, disqualifying convictions, and employer responsibilities regarding the Registry.

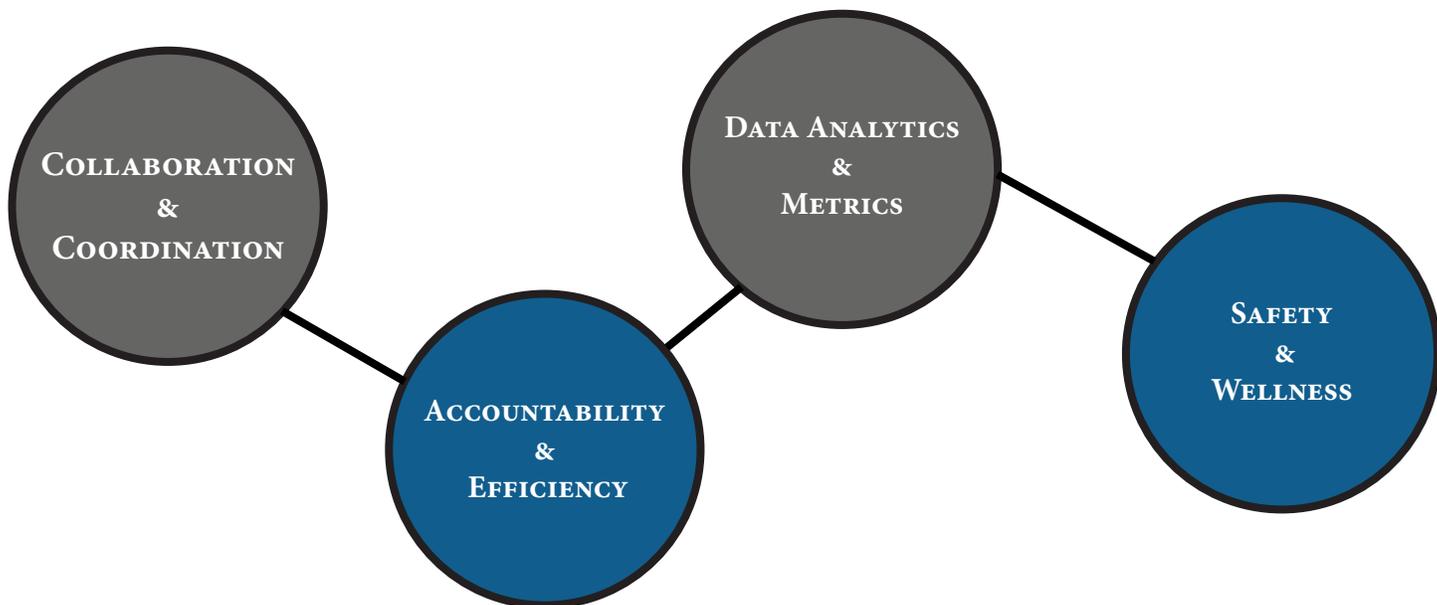
Elizabeth Lopic,
Assistant Bureau Chief -
Illinois State Police Medicaid
Fraud Control Unit

Ms. Lopic shared with the Task Force information about Illinois' participation in the multi-state, federally coordinated Health Care Fraud Takedown that occurred in June 2018. Ms. Lopic outlined the State and federal agencies that participated, fraud trends, and statistics regarding the takedown. For example, during the takedown Illinois ISP-MFCU indicted 14 individuals for submitting claims for services not performed. These individuals were responsible for approximately \$430,000 in fraudulent claims.

Jeff Myers,
Enterprise Data & Analytics
Director - State Farm

Mr. Myers discussed data and its role in problem-solving and brainstorming solutions, including innovative uses for data and analytics in the area of health care fraud, waste, and abuse. Mr. Myers challenged the Task Force members to re-think opportunities to gather and analyze data. Mr. Myers also focused on ethical uses of data and the potential for cross-referencing data-sets.

III. Overview of Task Force Activities

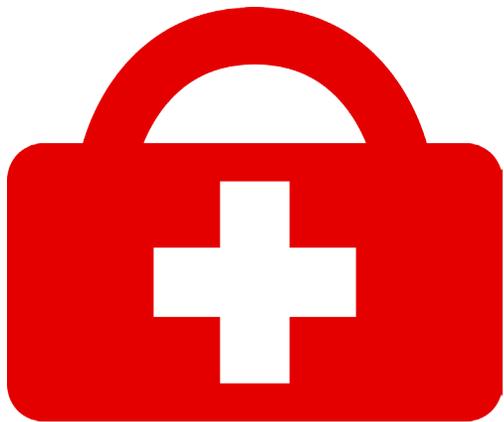


The three Task Force working groups – Medicaid, Workers’ Compensation, and State Employee Group Insurance – have diligently and creatively collaborated this year to achieve results for the State of Illinois. The work includes a multi-state federal fraud takedown, self-audit and self-disclosure initiatives, rule and contract reviews to hold providers accountable, changes to forms to

put employees on notice of their duty to accurately report information, collaboration with private-sector partners, reviews of best practices, and wellness initiatives for State employees, among other activities. This section contains a summary of the activities and accomplishments of the working groups.

A. Task Force Activities Related to the Medicaid Working Group

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 Illinois receives approximately 51 percent reimbursement from the federal government for Medicaid-funded expenses.¹⁴

HFS administers the Medicaid program in which services are provided to, on average, approximately 25 percent of Illinois’ population. In State FY 2018, Illinois medical assistance programs, consisting of Medicaid and numerous other medical programs, provided comprehensive health care coverage to over 3.16 million Illinois residents, and Illinois

spent approximately \$19.6 billion on these Illinois medical assistance programs.¹⁵ The Illinois medical assistance programs’ expenditures include both State and federal monies.

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, or procedure) 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. 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.¹⁶ Medicare consists of parts A, B, C, and D, with each part offering different coverage.¹⁷ Nationwide, approximately 59 million individuals participate in Medicare, and in 2016, Medicare benefit payments totaled \$675 billion.¹⁸ 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.

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) using data to efficiently use resources and maximize recoveries; (2) Medicaid managed care, including exploring opportunities to share data with Medicaid MCOs, to further collaboration and coordination of resources; and (3)

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.

Medicaid Working Group Activities and Accomplishments

The Medicaid Working Group has been diligently working to expand its initiatives from last year and develop new strategies for combatting fraud, waste, and abuse in Medicaid programs. This section discusses the activities of the Medicaid Working Group, including its State and federal Medicaid cooperative efforts, the Health and Human Services Transformation, the use of audits and data to maximize recovery of improperly spent funds, its Managed Care Organization Initiative, and its In-Home Care Initiative.

1. Partnering with State and Federal Entities in the Largest Nationwide Health Care Fraud Takedown in History



ISP-MFCU¹⁹ participated in the 2018 National Health Care Fraud Takedown, the largest health care

fraud enforcement action in U.S. Department of Justice history.²⁰ The multi-agency effort included the U.S. Attorney's Office, the U.S. Department of Health and Human Services, Office of Inspector General, the Federal Bureau of Investigation, the U.S. Drug Enforcement Administration, and many others to total approximately 1,000 law enforcement agents. The takedown took place in June 2018 and resulted in 601 defendants, including 165 doctors, nurses, and other licensed professionals, charged with health care fraud that involved over \$2 billion in false billing.

ISP-MFCU was one of 30 state Medicaid Fraud Control Units participating in the 2018 takedown. ISP-MFCU investigated allegations of fraud in the Medicaid Home Services Program leading to 14 individuals indicted for submitting claims for services not performed that were responsible for approximately \$430,000 in fraudulent claims. In addition, ISP-MFCU assisted the U.S. Attorney's Office for the Northern District of Illinois in the investigation of a licensed Chicago psychiatrist accused of billing over \$5.5 million to Medicare and Medicaid for services never performed.

2. State and Federal Medicaid Cooperative Efforts

To effectively combat fraud, waste, and abuse in Medicaid, it is imperative that State law enforcement and program staff work collaboratively to address improper conduct while ensuring quality medical care. The Task Force continues to partner with public-sector government units and organizations to achieve the best results for Illinois.

Attending the U.S. Attorney's Office Health Care Fraud Task Force

As part of furthering the collaboration between the U.S. Attorney's Office Health Care Fraud Unit and the Task Force, Deputy Chief McShain invited

the Task Force members to attend bi-annual U.S. Attorney's Office Health Care Fraud Task Force meetings. Task Force members attended the meetings on April 18, 2018 and October 17, 2018. Task Force members from all three working groups attended. The meetings featured dynamic presentations and interactive discussion. For example, there were presentations from the Centers for Medicare and Medicaid Services Office of Inspector General Office of Counsel, U.S. Attorney Stephen Lee, and an FBI agent who focuses on health care fraud investigations. At these meetings, Task Force members actively participated in discussions regarding deterring wrongdoing and using data to prioritize resources. These meetings highlight the importance of the State collaborating with federal partners.

Ensuring Collaboration and Coordination by Participating in National Organizations

As part of the Task Force's mission to bring best practices in combating Medicaid fraud to Illinois, Task Force agency HFS-OIG actively participates in national organizations and shares the insights of its membership with the Working Group. HFS-OIG Inspector General Brad Hart regularly reports to the Medicaid Working Group regarding fraud trends and best practices he learns from participating in national organizations. The Medicaid Working Group then discusses how that information support its mission in Illinois. The following are some examples of the organizations HFS-OIG participates in and specific resources provided through those organizations.

Information Sharing Among the Big 5 Medicaid States



Illinois participates in information sharing among five states serving very large Medicaid populations—the Big 5 Medicaid states. As part of this effort, there are quarterly discussions between Program Integrity Directors and/or Inspectors General in Texas, California, Florida, New York, and Illinois to discuss large-scale fraud schemes occurring in these states and to brainstorm solutions. A fundamental component of these discussions is the sharing of best practices.

- The National Health Care Anti-Fraud Association. The National Health Care Anti-Fraud Association is the leading national organization focused exclusively on the fight against health care fraud. As a private-public partnership, its members comprise nearly 90 private health insurers and those public-sector law enforcement and regulatory agencies having jurisdiction over private payers and public programs. As a member of this Association, HFS-OIG receives new opportunities for trainings and information sharing related to combating health care fraud, waste, and abuse, including free webinars and access to databases and whitepapers.²¹
- 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.

- 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.²² 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.
- Medicaid Integrity Institute. The Medicaid Integrity Institute is a national Medicaid integrity training program operated by the Centers for Medicare and Medicaid Services. At the Medicaid Integrity Institute, HFS-OIG staff collaborates with the Centers for Medicare and Medicaid Services to train staff on program integrity and Medicaid functions. Participation in this training ensures that Illinois receives up-to-date information on current trends and topics related to Medicaid fraud, waste, and abuse. Presently, hot topics being addressed between all states at the Medicaid Integrity Institute are related to beneficiary fraud, MCO program integrity and encounter data, and in-home care providers. In addition, the Medicaid Integrity Institute provides online resources and HFS-OIG uses these materials internally to cross-train and provide a resource library for all HFS-OIG staff.

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 agencies, as well as a broad stakeholder community. As part of the Health and Human Services Transformation, the State applied for a Medicaid 1115 Waiver.



BACKGROUND ON 1115 WAIVER

A “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 demonstrations 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.

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 to put Illinois on a more sustainable financial trajectory.

The initial focus of the transformation has been on behavioral health (mental health and substance use), specifically the integration of behavioral and physical health service delivery. Medicaid members with behavioral health needs represent 25 percent of Illinois Medicaid members, but account for 56 percent of all Medicaid spending.

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.

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 3.16 million Medicaid members (and lay the foundation for a more integrated system for all Illinoisans); and
- draw down federal match for Medicaid services.

In May 2018, HFS received notice of the Federal Government's approval of the waiver, authorizing the State to receive federal financial participation for the continuum of services for treatment of addictions and other health conditions. The programs and related innovations were announced as the *Better Care Illinois Behavioral Health Initiative*.

This transformation represents a comprehensive way of serving Medicaid clients across the various State agencies and will help Illinois become a leader in integrating physical and behavioral health services for some of the State's most vulnerable residents.

Waiver pilots began launching on July 1, 2018. Some pilots are statewide while others are limited in geographic scope and the numbers of participants. The waivers include residential and

inpatient treatment for individuals with substance abuse disorders, crisis intervention services for individuals experiencing a psychiatric crisis, and intensive in-home services to stabilize behaviors that may lead to crisis.

The waiver and other initiatives were shaped with vital input from hundreds of stakeholders across the State and enjoyed bi-partisan support from both State and federal lawmakers.

4. Using Data to Maximize Recoveries

The Medicaid Working Group has looked to data trends and analytics to best utilize its resources. This section outlines the activities of the Medicaid Working Group, including its work with providers to incentivize self-disclosure of overpayments, the Hospital Global Billing Initiative, the Long-Term Care Asset Discovery Initiative, and electronic memorandums of understanding (eMOU) to expand data analytics functions.

Working with Providers to Incentivize Self-Disclosure of Overpayments

To maximize resources, the Task Force has focused on self-audit initiatives. One way to encourage self-audits is to incentivize disclosure of overpayments. As part of this Task Force work, HFS-OIG renewed its effort to encourage providers to proactively review their own billing patterns and spot and disclose overpayments to HFS-OIG when appropriate. To assist providers and streamline the process, HFS established a 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.

During FY 2017, HFS-OIG worked with providers to identify and collect \$2.84 million in overpayments as a result of the self-disclosure process. HFS-OIG is continuing to reach out to providers to identify overpayments.

Hospital Global Billing Initiative



One of the Task Force's first initiatives in 2016, was the Hospital Global Billing Initiative. The Hospital Global Billing Initiative gives hospitals a mechanism to self-audit potential overpayments identified by HFS-OIG and to correct any billing errors. Specifically, the self-audit allows the hospital to review all instances of global billing²³ overpayments HFS-OIG found and to submit repayments for all services determined to be inaccurately billed. This Initiative began in April 2016 as a pilot program at two hospitals.²⁴ HFS-OIG expanded the audit to

272 hospitals and audited the period of January 1, 2010 through December 31, 2014. That audit led to the identification and collection of \$4.4 million in overpayments.

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 it was entitled to receive. For example, overpayments may occur because of a billing code error that is inadvertently entered on a routine basis.

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, for 272 hospitals.²⁵ The follow-up audit resulted in the identification of approximately \$800,000 in overpayments for State FY 2018.²⁶ HFS-OIG has recovered \$467,000 so far and is in the process of recovering the remainder. In addition to those overpayments, approximately 29 hospitals have followed up with the self-disclosure process and found a potential overpayment of approximately \$1 million for the audit period of January 1, 2015 through September 1, 2017.

Importantly, beyond recovering overpayments, the Hospital Global Billing Initiative established a positive and transparent process that allows the hospitals to review their own internal billing processes. In fact, as a result of the self-audit, several hospitals implemented changes to their internal billing processes to prevent overpayments from occurring in the future.²⁷

Long-Term Care Asset Discovery Initiative Initiative



HFS is responsible for the Medicaid Long-Term Care (LTC) Program available to approximately 55,000 eligible residents in over 738 nursing facilities. Illinois residents can apply to the LTC Program to have the State pay for their long-term nursing home services. Individuals are only eligible for LTC assistance if they have less than \$2,000 in resources and have not made unallowable transfers in the last five years.

The mission of the LTC Asset Discovery Initiative is to ensure residents requesting coverage for LTC services are eligible and are in compliance with federal and State regulations **before** they receive State assistance. HFS-OIG conducts investigations to ensure that participants in the program are eligible. In carrying out this function, HFS-OIG works with DHS Family Community Resource Centers, which are the entities that refer these investigations to HFS-OIG. During LTC Asset Discovery Initiative investigations, investigators have a 5-year look-back period for all resources and obtain documentation to determine eligibility for the Program. Investigators determine whether illegal conduct occurred, such as not disclosing or improperly transferring assets.

If HFS-OIG discovers that a LTC Program applicant engaged in improper conduct to become eligible for

the LTC Program, it can impose a penalty and will deny that applicant assistance through the Program until he or she obtains proper eligibility. HFS-OIG calculated that in FY 2018, this pre-payment review initiative saved the State approximately \$140 million in savings and cost avoidance. By preventing improper conduct related to eligibility, the LTC Asset Discovery Initiative ensures Program funds go to qualified applicants who have no ability to pay for their own care.

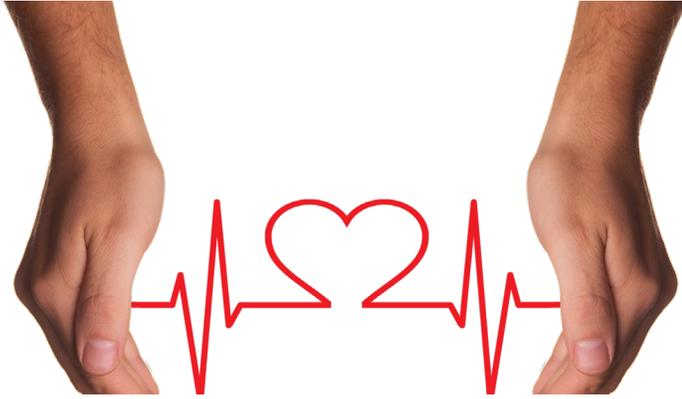
Expanding eMOUs to Improve Data Analytics Functions



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, HFS-OIG must continually acquire, share, and verify data from numerous sources. To improve HFS-OIG's access to data among the numerous State agencies, DoIT and its Analytics Center of Excellence have partnered with HFS-OIG to begin implementing extensive data sharing agreements through the eMOU process. Comprehensive eMOU data sharing agreements will allow HFS-OIG's 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.



The Task Force's Managed Care Organization Initiative



The shift toward managed care in Illinois presents an opportunity to collaborate and coordinate among private and public 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.

MCO Breakout Meetings

To facilitate better information sharing and the adoption of more consistent practices between the State and the Medicaid MCOs, the Task Force initiated breakout meetings between Task Force agencies HFS-OIG, ISP-MFCU, HFS, and 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.

These breakout meetings began in September 2016, and have been facilitated by HFS-OIG. In addition, DoA, DHS, the Office of the Illinois Attorney

General, and the OEIG have attended the MCO Task Force meetings.

The breakout meetings are a robust forum for collaboration and coordination of efforts. The sessions 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 may include providers in multiple plans. In addition to helping MCOs stay apprised of fraud schemes, these meetings aid Illinois in establishing stronger relationships with private entities.

As the volume of information and topics being shared at these quarterly meetings increased, the need for a monthly case-specific subcommittee became apparent. In 2017, the Task Force began holding monthly smaller case-specific meetings. During these meetings, MCOs share specific schemes and providers, and as a result, other MCOs may conduct investigations into similar schemes and behaviors within their own networks. One such discussion was a scheme involving high-priced topical lidocaine creams. As a result of this discussion, MCOs were advised to make changes to their policies regarding reimbursement rates and quantity limitations. According to HFS-OIG data, the change to this policy alone will likely result in over \$1 million in savings to the State.

MCO Cross-Agency Training





The Task Force's In-Home Care Program Initiative

As part of the Task Force's MCO Initiative, HFS-OIG hosted an inaugural collaborative cross-training session on May 29, 2018. This training was developed to further strengthen the relationships and lines of communication between HFS-OIG, the MCOs, and ISP-MFCU. A total of 98 participants attended at several locations via video conference, including locations in Springfield, Joliet, and Chicago. At this inaugural event, representatives from each MCO presented an overview of their MCO and SIU processes. The training also included presentations from HFS-OIG, HFS Bureau of Managed Care, and ISP-MFCU, among others.

To ensure that future trainings are successful, HFS-OIG surveyed the participants in the training. The feedback was overwhelmingly positive, and included comments such as:

“ Great collaboration between OIG/Law Enforcement and MCO. ”

“ The entire presentation/training was very useful. ”

“ This was a good starting point for future meetings with all entities involved. ”

This was the first cross-training session of its kind, and due to its success, HFS-OIG is planning to continue to hold these training events annually.



In-home care programs provide valuable and necessary services to some of Illinois' most vulnerable citizens. Every dollar spent on these programs should work to provide assistance that recipients depend on to live with dignity within their homes. The In-Home Care Program Initiative focuses on rooting out fraud, waste, and abuse in in-home care programs to maximize quality of service.

Background

In-Home Care Programs: Background

DHS and DoA both administer in-home care programs. The Task Force has devoted attention to 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 37,639 open cases within the HSP, with approximately 44,000 Individual Providers paid to provide services to the HSP customers. Every month DHS has a large influx of new Individual Providers, averaging approximately 1,100 new Individual Providers each month. The HSP has a budget of approximately \$500 million, 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 home- and community-based program that supports participants who are enrolled in Medicaid as well as participants that meet the functional eligibility for the CCP who are not financially eligible for Medicaid. The CCP is operated as a program for both Medicaid and non-Medicaid participants.²⁸ The CCP provides in-home and community-based services to assist adults who are at least 60 years old who are at risk of going to a nursing facility for care. Through the CCP, eligible seniors may receive adult day services, emergency home response services, in-home services, and Automatic Medication Dispensing services to allow them to remain in their home. Unlike in DHS’s HSP, DoA contracts with the CCP provider entities that hire and monitor in-home care workers. There are approximately 247 CCP providers that oversee the workers that provide direct in-home services to the CCP participants, and DoA monitors the contracted providers to ensure compliance with federal and State requirements.

In State FY 2018, approximately 84,000 senior citizens received services through the CCP. In State FY 2018, the CCP had an appropriation of approximately \$868.9 million. The CCP is funded through General Revenue Funds and by federal funds for participants who qualify for Medicaid.

The Need for an In-Home Care Initiative in the State of Illinois



RECENT IN-HOME CARE FRAUD CONVICTIONS

Recent convictions highlight the real and personal impact fraud has on the community. Each of these individuals stole money from a program designed to help the most vulnerable of our citizens. The experiences of Task Force agencies (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.

ISP-MFCU investigations of fraud in the in-home care programs led to 37 criminal convictions from October 31, 2017 to September 26, 2018, with sentences as high as seven years in the Illinois Department of Corrections. Additionally, over \$509,000 was ordered in restitution. The most prevalent fraud scheme leading to these convictions were instances where the

Individual Provider submitted claims for providing services to a customer when that customer was in the hospital, a nursing facility, or deceased. Another common scheme involves a conspiracy between the customer and the Individual Provider to commit fraud and split the proceeds, having agreed that no services would actually be provided. Two examples of these convictions are outlined below.

On January 8, 2018, Magdolin Samawi entered a guilty plea on one count of Vendor Fraud (class 1 felony). ISP-MFCU investigated Samawi for alleged fraud involving DoA's Community Care Program. Samawi was hired to provide services to her mother and submitted timesheets as having provided care for approximately 19 months after her mother's April 2013 death. Samawi received \$25,344 from the State based on the fraudulent timesheets. She was sentenced to 48 months of probation and ordered to pay \$25,344 in restitution.

On May 16, 2018, Stephanie Patterson was sentenced to five years of probation and ordered to pay \$81,131 in restitution to the Home Services Program. Patterson defrauded the Medicaid Home Services Program by falsely claiming and taking payments for personal assistant services not performed. Patterson falsely billed the program between January 2011 to June 2016, when she claimed that a relative rendered personal assistant services to a customer when, in fact, the relative was incarcerated at the time services were claimed to be performed. As a result, Patterson improperly billed hundreds of hours of services and obtained \$81,131 in payments for services not performed. This was a joint investigation conducted by ISP-MFCU and the U.S. Department of Health and Human Services Office of Inspector General.

The Accomplishments of the Task Force's In-Home Care Initiative

Shared Database of Contractually Terminated Providers

One area of concern raised as part of the collaboration of this Task Force is the need to share information among agencies about providers who are terminated or barred contractually from DHS or DoA. Prior to the development of this Task Force, there was no mechanism for sharing information about contractually barred providers between agencies. To address this issue, HFS-OIG is spearheading the development of an in-house database of contractually barred providers. Agencies like DHS and DoA will provide HFS-OIG with data about contractually barred providers on a regular basis, and HFS-OIG will include that information in the database. In turn, DHS and DoA staff will have access to the database to ensure that they know if any of their providers have been barred from another agency.

In-Home Care Programs: Prevention and Education

Efforts to prevent fraud, waste, and abuse offer a greater return on investment than post-payment solutions. Thus, the Task Force has focused Medicaid Working Group discussions on opportunities to educate and train providers and customers about fraud, waste, and abuse. One important example of this is the DHS HSP's collaborative approach to Individual Provider training.

As mentioned above, DHS processes an average of 1,100 new Individual Providers each month. To ensure the Individual Providers are properly trained, in 2017, DHS HSP put together training programs and educational materials for Individual Providers. Specifically, in collaboration with and funded through DHS in FY 2019, the Service Employee International Union (SEIU) is training new and incumbent Individual Providers. This collaboration led to the revision of the New Individual Provider Orientation training curriculum. The New Individual Provider Training now includes a comprehensive course about fraud, abuse, neglect, and financial exploitation. This two-hour in-person training is offered multiple times throughout the year and reaches Individual Providers across the State. Beginning in July 2018, the HSP now requires all Individual Providers who attend the training to sign an acknowledgment form, certifying that they participated in and understand the training, including the fact that it is the Individual Provider’s responsibility to prevent and report fraud, abuse, neglect, and financial exploitation.

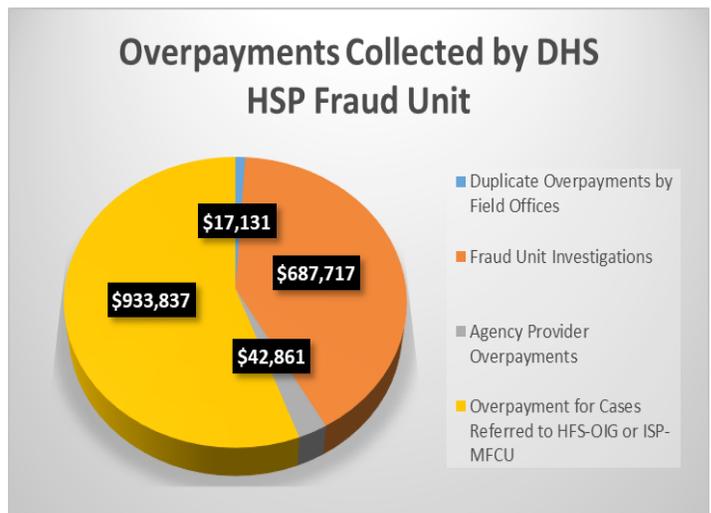
The HSP Fraud Unit

The Task Force’s In-Home Care Program Initiative has included a focus on the DHS HSP Fraud Unit. This Unit works closely with the Task Force to brainstorm ideas for improvement and collaborates with Task Force members regarding best practices. This section outlines updates to the DHS HSP Fraud Unit since the last Task Force report, including a summary of its recoveries, and changes made to its reports.

The 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 eligibility issues, as well as fraudulently obtained benefits and services. The Fraud Unit has maximized its impact by collaborating with Task Force agencies HFS-OIG

and ISP-MFCU regarding fraud investigations. The Fraud Unit also works closely with DHS Bureau of Collections, which is responsible for collecting fraud overpayments.

In FY 2018, the HSP Fraud Unit reviewed a total of 464 cases that HFS-OIG referred back to the Unit after determining the HSP Fraud Unit should handle the cases internally. The HSP Fraud Unit was able to review and resolve all the referred cases with many resulting in the collection of overpayments and Individual Provider terminations. In FY 2018, the work of the HSP Fraud Unit resulted in the recovery of \$1,681,546 in overpayments. In the previous fiscal year, the HSP Fraud Unit recovered \$1,411,388 in overpayments. Thus, in FY 2018 the Unit recovered about \$270,000 more in overpayments as compared to FY 2017. This chart outlines the breakdown of overpayments collected in FY 2018.



The chart depicts the following:

- (1) “Duplicate 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.

Protecting Against Fraud by Revising DoA Policies and Rules

(2) “Fraud Unit Investigations” refers to the overpayments that were made as a result of fraud or inappropriate activity by Individual Providers.²⁹

(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) “Overpayment to Providers for Cases Referred to HFS-OIG or ISP-MFCU” refers to instances when an Individual Provider has received payments from the HSP, but there is fraud involved which requires investigatory collaboration with the HFS-OIG or ISP-MFCU.

In August 2017, the HSP Fraud Unit revised its internal process to improve workflow and increase efficiency in how case referrals are made between HSP, HFS-OIG, and ISP-MFCU. The new process called for dedicated email addresses to be established by each agency and utilizes the State’s File Transfer Utility to electronically transfer case files in a secure and efficient manner. The HSP Fraud Unit’s revised process for handling referrals has significantly decreased ISP-MFCU’s review and response time. In most cases, acceptance or declination of referrals are completed within 7-10 business days. The electronic transfer of case files has also contributed to enhanced tracking of case status and updates.

Additionally, in State FY 2018, the HSP Fraud Unit reviewed a total of 988 Critical Incident Reports that documented alleged improper activity by the customer and/or Individual Provider. This is an increase from 623 critical incident reports that were generated last year. 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 2018, the HSP Fraud Unit staff made 27 referrals of fraud for criminal prosecution to ISP-MFCU.

As stated earlier, the In-Home Care Program Initiative involves a focus on the DoA CCP. Medicaid Working Group meetings include updates from DoA regarding the Program and discussions regarding how to enhance the Program and collaborate with other Medicaid agencies, like DHS and HFS-OIG. To combat fraud, waste, and abuse in DoA’s CCP program, DoA has focused on revising policies, processes, and rules. This section outlines the proactive steps DoA has taken to improve the CCP Program, including: 1) developing stricter guidelines for criminal background checks; 2) amending the Illinois Administrative Code to implement a registry designed to protect the CCP customers; 3) increasing staff to review certain allegations; and 4) providing mandatory webinar training for Home Care Aides.

First, in an effort to prevent fraud and other crimes, DoA developed stricter guidelines for criminal background checks for providers’ employees. The revised criminal background policy expands the positions that must undergo a criminal background check. In addition, DoA’s new policy requires the contracted provider to check the specific registries that list excluded or problem providers. Further, the new policy requires the contracted providers to annually update their employees’ demographics and work history in the State’s Public Health Worker Registry. The purpose of this requirement is to provide other contracted providers with an alert of possible employees that may have recent criminal activity on their records.

Second, another mechanism DoA is using to protect Illinois residents from financial exploitation, fraud, abuse, and neglect involves updating the Illinois Administrative Code. Specifically, on July 1, 2018, Part 270 of Title 89 of the Illinois Administrative Code was amended to implement the Adult Protective Services (APS) Registry.³⁰ This Registry applies to caregivers who care for an adult, aged 18

through 59, with a disability or a person age 60 or older who resides in a domestic living situation. The APS Registry lists APS Program caregivers who have a verified and substantiated finding of abuse, neglect, or financial exploitation. DoA will place a caregiver's identity on the APS Registry after any appeals, challenges, and reviews have been completed and a finding for placement on the APS Registry has been sustained or upheld. The information on the APS Registry is confidential and access rights are limited. Placement of a caregiver's identity on the APS Registry³¹ serves to prohibit the hiring, retaining, compensating, or using of an individual to provide direct care if his/her position or employer is regulated by specified State agencies or is paid with public funds.

Third, DoA has increased the number of staff who review the APS allegations and substantiated decisions when allegations include the CCP employees.

Finally, DoA is providing mandatory webinar training for Home Care Aides pertaining to financial exploitation.

Requiring Contract Compliance with Vendors



review of vendors that coordinate care for elderly individuals receiving home care, also referred to as Care Coordination Units (CCU). For example, under DoA's enhanced monitoring structure, it implemented a practice of conducting a six-month compliance review on all new contracts for CCUs and the CCP providers to ensure the compliance standards are being fulfilled from the start of their contract.

As a result of DoA's monitoring efforts, DoA staff identified six CCUs that were performing poorly and not meeting the terms of their contracts. After providing technical assistance and opportunities to come into compliance, DoA terminated and/or chose not to renew those six CCU contracts. These participants are all being served by new CCUs, resulting in improved performance of the contracts and service to participants. Additionally, DoA has added three data analysts that assist with monitoring the CCP provider billings to better track compliance with Medicaid waiver performance metrics.

DoA's focus on monitoring vendors and holding them accountable to the terms of the contract works to reduce waste, and ensures participants are receiving the services the State pays its vendors to provide.

To further encourage accountability and efficiency, DoA has expanded its monitoring and compliance

B. Task Force Activities Related to the Workers' Compensation Program Working Group

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 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 or 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.³² 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."³³ 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.³⁴ 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.

Workplace fatalities, injuries, and illnesses cost employees and employers across the country billions of dollars every year. In State FY 2018, State employees filed 4,487 workers' compensation claims, and the State paid about \$112,384,613 in workers' compensation benefits. In recent years, the total workers' compensation benefit payments for all Illinois employers has averaged nearly \$2.7 billion. 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, 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 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.

The Workers' Compensation Working Group



The Workers' Compensation Working Group is composed of staff from WCC, the Illinois Department of Transportation (IDOT), 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.

Workers' Compensation Working Group Activities and Accomplishments

The Workers' Compensation Working Group has been developing creative strategies for proactively addressing fraud, waste, and abuse in the State Workers' Compensation Program. This section discusses the activities of the Workers' Compensation Working Group, including its work to add a certification to a form used to report workplace injuries, breakout meetings to increase collaboration and coordination of workers' compensation fraud referrals, its study of best practices, and a statewide meeting of agency workers' compensation coordinators.

1. Amending the Notice of Injury Form to Require Employee Certification

The Workers' Compensation Working Group uses its meetings to brainstorm ways to better address fraud, waste, and abuse in the State Workers' Compensation Program. At one meeting, members discussed the form that State employees complete to notify the third-party administrator that they have sustained a work-related injury. This "Workers' Compensation Employee's Notice of Injury" form includes questions about the employee's injury, how the injury occurred, and medical treatment. The Working Group discussed that it would be helpful if employees were required to certify on this form that the information was accurate. The Working Group drafted specific language for the certification and worked with the State's third-party administrator to

add the language to the form. The Notice of Injury form now includes the following certification:

monthly breakout meeting to focus on referrals of workers' compensation fraud cases and to create an open line of communication regarding fraud investigations between DoI, CMS, the Office of the Illinois Attorney General, and the State's third-party administrator. During these meetings, the participants discuss recent cases, what information would be helpful in future cases, and status updates for outstanding matters, among other things. These discussions have resulted in a more efficient process for determining which cases should be referred to the Office of the Illinois Attorney General. In addition, as a result of these meetings, the State's third-party administrator has staffed an additional claims adjuster in Chicago to work directly with DoI.



WORKERS' COMPENSATION FRAUD UNIT

In 2005, DoI created the Workers' Compensation Fraud Unit (WCFU). The WCFU's primary responsibility involves conducting investigations and referring worthy cases to the Office of the Attorney General 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 Workers' Compensation Act specifically provides that it "shall be the duty of the [Workers' Compensation Fraud Unit] to determine the identity of insurance carriers, employers, employees, or other persons or entities who have violated the fraud and insurance non-compliance provisions" of the Act.³⁵ In 2017, the WCFU received 369 complaints of workers' compensation fraud.

This language will serve as a reminder to State employees of the basic requirement of honest reporting and the seriousness of submitting false statements about workers' compensation injuries. Additionally, this language will assist in the investigations and prosecutions of employees by providing proof that the employee knew or should have known about his or her legal obligations.

2. Breakout Meetings to Increase Collaboration and Coordination of Workers' Compensation Fraud Referrals

Since the last Task Force report, the Workers' Compensation Working Group developed a bi-

3. Study of Best Practices in Workers' Compensation



Presentations Regarding Best Practices

Executive Order 2016-05 specifically charges the Task Force with “[r]eview[ing] 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.” To that end, the Workers’ Compensation Working Group has been engaging members of the private sector to learn about their best practices. Over the past year, this Working Group has brought in several speakers. For example, the Workers’ Compensation Working Group has heard from the:

- Regional Manager, Frasco Investigations
- Manager of Workers’ Compensation, Cook County Risk Management
- Corporate EHS Director, NTN Americas
- Program Manager for the State of Illinois, Tristar
- Corporate Claims Manager, Hub Group Trucking
- Vice President of Risk Management, Paramount Staffing

- Director, Workers’ Compensation for Charter Communications

The speakers emphasized the following points:

- The importance of a transitional return-to-work program for controlling workers’ compensation and disability costs. This is important because an extended absence from work after an injury can cause significant physical and mental harm. Further, employees who remain off work until a full-duty release suffer longer recovery times, require more medical interventions, and encounter a far greater risk of re-injury upon their return to work than those employees who continue to work throughout their recuperation. These employees also become disengaged from their employers, lose contact with coworkers, and experience a lost sense of accomplishment and productivity.
- The value of creating a culture of health, safety, and productivity. Specifically, employers should take a proactive approach to safety and identify hazards before they turn into workers’ compensation claims.
- Employers must investigate accidents thoroughly, develop corrective action plans, and set timely remediation goals for all identified hazards.
- There must be employer accountability at all levels to ensure the health and safety of its employees. Employers must set the example for their employees, reward efforts rather than outcomes, provide the best available medical treatment, and seek continuous improvement of the claims management process.
- If fraud is suspected, the investigation must be thorough and consider the “good day defense.” The “good day defense” is a defense that suggests that the day surveillance occurred was the employee’s good day, and the following

day that individual was unable to engage in physical activity.

- The critical role of using social media to gather information and corroborate evidence in an investigation.
- The need for prosecuting workers' compensation fraud to hold bad actors accountable and to deter other employees from defrauding the system.
- The importance of educating State employees on the laws and rules regarding workers' compensation so they can make informed choices.
- The critical role of communicating with all parties during an investigation, including attorneys, department heads, medical professionals, adjusters, and investigators.

In response to these presentations, the Workers' Compensation Working Group discussed options for increasing accountability among the individual State agencies for safety, investigations, costs, and employee absenteeism. For example, to avoid negative outcomes associated with an extended absence, the Working Group discussed the components of work accommodations and a need to better identify return-to-work opportunities within individual State agencies. The Workers' Compensation Working Group will continue to explore the best methods for raising awareness of workers' compensation costs within each State agency and increasing agency ownership of safety and workers' compensation outcomes.

Survey of Other States



The Workers' Compensation Working Group sought information on the best practices for light-duty and modified work in other states. A comparison of Illinois' system with the best practices in other states provides a useful benchmark for evaluating operational performance. As a member of the International Association of Industrial Accident Boards and Commissions ("IAIABC"), the WCC has access to "J2J – Jurisdictions to Jurisdictions," an online community for jurisdictions to ask and answer questions of jurisdictional peers, identify best practices, stimulate conversation and promote the exchange of ideas and lessons learned, and raise the awareness of available solutions to shared practices.³⁶ The WCC used "J2J" to conduct an informal survey of other IAIABC members' return-to-work programs. Some insights from the survey include:

- Montana has a very comprehensive return-to-work program that includes monthly webinars and quarterly training opportunities for the workers' compensation coordinators at each agency. It established a standardized framework for developing and implementing a return-to-work program within agencies and provides sample work plans, guides for interacting with treating physicians, and informational brochures on the workers'

compensation process. Finally, Montana requires treating physicians to complete a Medical Status Form following every office visit with an injured employee.³⁷ The Medical Status Form facilitates communication between the injured employee, employer, and health care provider, and helps enable early return-to-work and transitional employment.

- New York has mandatory alternative duty assignments for its administrative, operational, and professional services employees.³⁸ These employees qualify for alternative duty assignments when their degree of disability reaches 50% or less and they receive a prognosis to return to their regular duties within 60 days of the start of the alternative duty assignment. It is mandatory for qualified employees to accept alternative duty assignments and return to work at full pay. These assignments run for 60 days and can be extended at the agency's discretion.
- Washington passed a law under its civil service provision to promote injured employees retaining their employment following an injury. The law requires the establishment of a return-to-work program that: (1) directs each agency to adopt a return-to-work policy; (2) provides for a permanent employee's eligibility in a light-duty or modified position for up to two years from the date his or her temporary disability commenced; (3) requires each agency to name a representative responsible for coordinating the agency's return-to-work program; and (4) requires training of supervisors on the implementation of the return-to-work policy.³⁹

Overall, the survey responses helped guide the Working Group's continued discussions on establishing consistent compliance with the existing return-to-work policies already in place at most State agencies.

4. Statewide Meeting of Agency Workers' Compensation Coordinators

Every State agency under the Office of the Governor has a workers' compensation coordinator. To facilitate open communication and ongoing training of the workers' compensation coordinators, CMS has arranged for workers' compensation coordinator meetings at various locations throughout the State during the week of October 29 through November 2, 2018. This is the second year CMS has organized workers' compensation coordinator meetings. In October 2017, it reinstated these meetings as a result of Task Force discussions.

The goal of these meetings is to assist workers' compensation coordinators and their agencies in developing the full capacity to comprehensively, effectively, and sustainably manage their workers' compensation claims. These meetings also ensure workers' compensation coordinators are up-to-date on policies and trends.

The 2018 meetings will include a presentation by Illinois' third-party administrator, who will discuss the various tools and techniques used in the private industry to investigate fraud. There will also be a time set aside to discuss questions that the workers' compensation coordinators have for CMS. CMS will provide supplemental online training on an as-needed basis.

C. Task Force Activities Related to the State Employee Group Insurance Working Group

The State Employee Group Insurance Program



In Illinois, the State Employees 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 CMS. The State Employee Group Insurance Program provides health care coverage for nearly 450,000 lives including State employees, retirees, survivors, and their dependents. In addition, this Program covers retired teachers, retired community college members, and certain local government units. For State FY 2018, the liability for employee health insurance benefits was about \$3.42 billion.

As part of the State Employees 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, 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.

The State Employee Group Insurance Program Working Group

The State Employee Group Insurance Program Working Group is composed of staff from CMS, DoI, OEIG, and the Office of the Governor. The State Employee Group Insurance Working Group is focusing on the following areas: (1) using the State online web-based enrollment portal, MyBenefits, to ensure that only qualified State employees, retirees, and dependents receive taxpayer-funded insurance; (2) promoting wellness, including ensuring group insurance participants are aware of wellness incentives within their plans; and (3) increasing awareness and education about fraud in employee benefits.

State Employee Group Insurance Working Group Activities and Accomplishments

This section outlines some of the activities of the State Employee Group Insurance Working Group,

including the hard work done to analyze all health care vendor contracts and to install wellness machines that measure blood pressure, pulse, body weight, Body Mass Index, and body fat percentage.

1. Wellness Initiative - Blood Pressure Machines



As part of the State Employee Group Insurance Working Group’s focus on wellness, CMS worked with one of the State’s health carriers, Aetna, to install blood pressure machines at various State agencies. These machines, called Higi machines, measure blood pressure, pulse, body weight, Body Mass Index (BMI), and body fat percentage. The machine is connected to the internet and allows the individual to send the results to an email account. A message is given to the individual encouraging them to share the results with his or her doctor. By knowing these critical numbers and working with his or her health care provider, the hope is to improve an individual’s overall health to prevent future health issues. The long-term goal is to make people aware of their “numbers” and help them better manage their own health.

In April, May, and June of 2018, CMS installed nine machines. The Working Group’s goal for FY 2019 is to install an additional 55 machines throughout

various State agencies, universities, and retirement facilities. In the first three months, nearly 5,000 screenings were complete, with 40% being registered (recurring) screenings. This figure indicates a high level of interest in the machines and their purpose. CMS has been receiving positive feedback from individuals utilizing the machines.

For example, one employee who used the Higi machine credits it with saving her life. When she used the machine, it informed her that her blood pressure was in a dangerous zone and instructed her to seek immediate medical attention. The employee went to the hospital emergency room, where she was admitted for early stages of a stroke. This employee was very grateful and told CMS that the machine saved her life.

2. Review of Vendor Fraud, Waste, and Abuse Efforts



As part of its participation in the State Employee Group Insurance Working Group, CMS reviewed and analyzed contracts of the health care vendors that participate in the State Employee Group Insurance Program. In reviewing each individual plan, CMS learned that each vendor’s contract requires the vendor to, among other things:

- Have a program in place to prevent and detect fraud, waste, and abuse, which includes written policies, procedures, and dedicated staff.

- Require its employees to complete annual fraud, waste, and abuse training.
- Conduct audits of its network healthcare providers to identify fraud, waste, and abuse, and place providers on notice or terminate contracts with providers as warranted.
- Utilize external third-party information to assist in the identification and review of fraud, waste, and abuse.
- Utilize claims processing systems that include system edits and checks to identify fraud, waste, and abuse.
- Have processes in place to conduct a post-payment review of claims looking for potential fraud, waste, and abuse.
- Annually provide CMS with its plan of fraud, waste, and abuse prevention and detection programs, including any findings.

Through its review, the State Employee Group Insurance Working Group learned that all of the vendors implement processes and use resources to address fraud, waste, and abuse. However, the Working Group also learned that the contract language for these vendors differed, and there was not uniform language in the contracts regarding fraud, waste, and abuse prevention and detection. Thus, CMS will be taking steps to establish uniform language for fraud, waste, and abuse for all health care contracts administered by CMS Bureau of Benefits. Additionally, the Working Group will continually reevaluate the fraud, waste, and abuse procedures within the health care contracts to ensure they meet industry standards.

IV. Conclusion



In the two and a half years since the Task Force was formed, it has built partnerships within State agencies as well as with private and public entities, increased prevention efforts, including education and training opportunities for vendors and recipients of services, and put into place initiatives to improve Illinois' practices, among other things.

Since its last report in October 2017, the Task Force has focused on initiatives combatting fraud and waste in the Medicaid, Workers' Compensation, and State Employee Group Insurance Programs. This Report outlines many of the working groups' accomplishments. These successes highlight the power of collaborating toward a common goal.

The Task Force continues to challenge its members to think critically about current programs and processes to identify ways to make those programs more efficient. As the Task Force pushes forward, 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. Health Care Fraud Elimination Task Force Member Biographies

SUSAN M. HALING, Executive Inspector General, Office of Executive Inspector General for the Agencies of the Illinois Governor

Susan M. Haling was appointed by Governor Bruce Rauner in March 2018. EIG Haling has extensive experience conducting and overseeing investigations. She joined the OEIG in December 2011, and prior to her current appointment, served as First Assistant Inspector General for three years. Before coming to State government, EIG Haling served as a prosecutor for the U.S. Attorney's Office for the Northern District of Illinois for over nine years. As an Assistant U.S. Attorney she tried over 20 criminal trials. She also previously worked for the U.S. Justice Department, Criminal Division in Washington, D.C. EIG Haling began her legal career as a law clerk for the Honorable James F. Holderman, district judge for the Northern District of Illinois. She received her Bachelor of Arts from the University of Notre Dame. She obtained her law degree from DePaul University College of Law where she graduated Order of the Coif, served as editor for the Law Review, and was a member of the Moot Court Trial Team.

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

Trey Childress currently serves as Deputy Governor and 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 M. 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.

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.

LIEUTENANT DAVID ROLL, Director, Illinois State Police Medicaid Fraud Control Unit

Lieutenant David Roll is currently the Director of the ISP-MFCU. Lieutenant Roll has been with the Illinois State Police (ISP) for 24.5 years. Lieutenant Roll has served in several capacities within the ISP, including positions in patrol, swat, investigations and Medicaid fraud. Although Lieutenant Roll has served in multiple units within the ISP, the majority of his career has been devoted to investigations. Lieutenant Roll has significant investigative and supervisory experience in violent crimes and narcotics investigations. Lieutenant Roll is a former Co-Director of the West Central Illinois Drug Task Force, a multi-jurisdictional task force focused on narcotic enforcement in the West Central region of Illinois. Lieutenant Roll joined the ISP-MFCU in June of 2016, serving as the Southern Operations Command Officer overseeing all MFCU investigations involving the ISP-MFCU Southern Command. Lieutenant Roll

began his role as the Director of the ISP-MFCU effective September 1, 2018. Lieutenant Roll holds a Bachelor of Science Degree in Administration of Justice from the University of Missouri-St. Louis. Lieutenant Roll is a member of the Illinois State Police Command Officers Association, The Illinois Drug Enforcement Officers Association, The Illinois Homicide Investigators Association, and The National Association of Medicaid Fraud Control Units.

JEAN BOHNHOFF, Director, Department on Aging

Jean Bohnhoff is the 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.

TIM MCDEVITT, Director, Department of Central Management Services

Tim McDevitt is the Director of CMS. He has previously held positions with the State as Deputy Director of Government Transformation and as Director of the Illinois Lottery. Before his State

service, Mr. McDevitt was a consultant with the Boston Consulting Group, where he advised Fortune 500 clients in the health care and industrial goods sectors. He is a graduate of the University of Chicago Law School, where was elected to the Order of the Coif. Mr. McDevitt is a native of Charleston, Illinois.

PATRICIA BELLOCK, Director, Department of Healthcare and Family Services

HFS Director Patti Bellock has dedicated her public service career to ensuring access to quality health care for Illinois' most vulnerable population and making the State's health care delivery systems more efficient and effective. She has been nationally recognized for the central role she has played in establishing major healthcare reforms and improvements. She has also led efforts to strengthen the child support system in Illinois. As a State Representative in the Illinois General Assembly for 20 years, Director Bellock developed her reputation for bipartisan, collaborative work. She served as a member of two Medicaid-related groups to move legislation forward, approving the Hospital Assessment and the Omnibus Medicaid bill. Director Bellock was the first woman Deputy Minority Leader in the history of Illinois. She served as a spokesperson on both the House Human Services Committee and the Human Services – Appropriations Committee. She also served on committees with three different national organizations working on health care legislation and public policy issues throughout the United States. Director Bellock has received state and national awards for her role in numerous community projects and has served on several local boards and task forces for groups addressing the issues of Taxes, Substance Abuse, Alzheimer's, Autism, Human Services, Mental Health, Multiple Sclerosis, Violence Prevention, Human Trafficking, and the Arts.

JAMES DIMAS, 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, Secretary, Department of Innovation and Technology

Kirk Lonbom is the 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.

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. 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.

JOANN FRATIANNI, Chairman, Illinois Workers' Compensation Commission

Joann M. Fratianni was appointed Chairman of the WCC by Governor Bruce Rauner on February 23, 2015. The Chairman is the Chief Administrative and Chief Executive Officer of the agency which administers the Workers' Compensation Act. The Chairman is responsible for a \$30 million annual budget and staff consisting of just under 200 employees. Chairman Fratianni serves as ex officio Chairman of the Workers' Compensation Advisory Board. Prior to being appointed Chairman, she served as an Arbitrator at the WCC since 1987. Her career as an Arbitrator consisted of having both Chicago and Downstate dockets throughout the State of Illinois. In the interim, she served as a public member Commissioner of the WCC from 1990-1993. Prior to her appointment as an Arbitrator, Chairman Fratianni served as an attorney handling numerous aspects of workers' compensation litigation Statewide for the law firms of Laughlin, Cunningham, Hare & Fanone and Osterkamp, Jackson & Hollywood. Chairman Fratianni also serves as the President of the Central States Association of the IAIABC, Secretary of the Lake County Bar Foundation, co-chairman of the Lake County Bar Association Workers' Compensation Committee and is past-President of the Lake County Justinian Society. Chairman Fratianni is a Graduate of the University of Illinois Champaign-Urbana and Northern Illinois University College of Law.

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 *Id.*

³ State fiscal year 2018 ran from July 1, 2017 through June 30, 2018.

⁴ *MFCU Statistical Data for Fiscal Year 2017*, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2017-statistical-chart.pdf (last visited Sept. 25, 2018) (hereinafter FY 2017 MFCU Data). Federal fiscal year 2017 ran from October 2016 through September 2017. In contrast, State fiscal year 2018 ran from July 1, 2017 through June 30, 2018.

⁵ ERIC D. HARGAN, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, FISCAL YEAR 2017 AGENCY FINANCIAL REPORT 201 (2017), <https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf> (last visited Sept. 25, 2018) (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 25.

⁶ 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, nine non-sworn investigators, three attorneys, four analysts, and two accountants. In addition, eleven attorneys from the Office of the Illinois Attorney General are dedicated to prosecuting 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.

⁷ *FY 2017 MFCU Data*, *supra* note 4.

⁸ EO No. 2016-05, *supra* note 1.

⁹ *Id.*

¹⁰ This report does not distinguish between Task Force members who have or have not yet been confirmed by the Illinois Senate.

¹¹ Please note there are spaces in this website address after the words “health” and “care”.

¹² *Eligibility*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://www.medicaid.gov/medicaid/eligibility/index.html> (last visited August 24, 2018) (hereinafter Eligibility).

¹³ Eligibility, *supra* note 12.

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 HFS’s programs currently cover approximately 3.16 million enrollees, including 1,462,872 children, 207,590 seniors, 246,813 persons with disabilities, 631,693 federal Affordable Care Act eligible adults, 592,850 non-disabled, non-senior adults, and 17,187 enrollees with partial benefit packages.

¹⁶ *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 Aug. 24, 2018).

¹⁷ *Id.*

¹⁸ *An Overview of Medicare*, KAISER FAMILY FOUNDATION (Nov. 22, 2017), <http://kff.org/>

medicare/issue-brief/an-overview-of-medicare (last visited Oct. 4, 2018).

¹⁹ ISP-MFCU investigates health care providers referred for allegations of fraud in the Illinois Medicaid program. In addition, ISP-MFCU reviews complaints alleging abuse or neglect committed against nursing home residents. Of the approximately 300 cases opened each year, roughly two-thirds involve Medicaid provider fraud and one-third involve abuse or neglect allegations in nursing home facilities.

²⁰ The image of the federal agent was taken from the U.S. Department of Health and Human Services Office of Inspector General website, Media Materials: 2018 National Health Care Fraud Takedown, <https://oig.hhs.gov/newsroom/media-materials/2018/takedown/> (last visited October 23, 2018).

²¹ Additional information about the National Health Care Anti-Fraud Association can be found at <https://www.nhcaa.org/about-us/who-we-are.aspx>.

²² About the *Partnership*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <https://hfpp.cms.gov/about/index.html> (last visited Oct. 11, 2018).

²³ Global billing refers to the global billing rate used by hospitals to combine the technical and professional component of a medical service. HFS-OIG has identified that hospitals sometimes charge the global billing rate and then also charge separately for the professional and technical components. This is improper because a hospital should only charge once for the type of service it provides.

²⁴ The pilot phase of this initiative resulted in a 100 percent recoupment of all accurately identified overpayments from the two hospitals.

²⁵ Hospitals whose services had already been named within the self-disclosure process were excluded from this audit.

²⁶ This number includes \$223,000 reported to HFS-OIG by hospitals who self-disclosed global billing overpayments for FY 2018.

²⁷ The Global Billing Initiative process has resulted

in an estimated cost-avoidance amount of approximately \$500,000 for FY 2018.

²⁸ DoA claims federal reimbursement under the Section 1915(c) Medicaid waiver program for those participants that are enrolled in Medicaid.

²⁹ The figures for “Fraud Unit Investigations” includes overpayments collected as a result of the HSP Fraud Unit reviewing Individual Provider timesheets. The HSP Fraud Unit reviews timesheets, especially timesheets submitted late, and cross-checks those timesheets against other employment records, to determine whether Individual Providers are double-billing for their hours.

³⁰ The APS Registry is managed by the Illinois Department of Public Health.

³¹ The State agencies, entities, and direct care providers must obtain credentials from the Illinois Department of Public Health to access the APS Registry. These credentials will allow online checks on an annual basis for purposes of retention and prior to hiring, compensating, or using a caregiver.

³² See ILL. WORKERS’ COMP. COMM’N, FISCAL YEAR 2017 ANNUAL REPORT 2 (2018).

³³ 820 ILCS 305/8(a) (2017).

³⁴ 820 ILCS 305/8(b)1.

³⁵ 820 ILCS 305/25.5(c) (2016).

³⁶ INTERNATIONAL ASSOCIATION OF INDUSTRIAL ACCIDENT BOARDS AND COMMISSIONS, <https://www.iaiab.org>.

³⁷ MONT. CODE ANN. § 39-71-1036 (2018).

³⁸ AGREEMENT BETWEEN THE CIVIL SERVICE EMPLOYEES ASSOCIATION, INC. AND THE STATE OF NEW YORK - ADMINISTRATIVE SERVICES UNIT § 11.8 (2016-2021).

³⁹ WASH. REV. CODE § 41.06.490 (2018).