

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ILLINOIS STATE MEDICAID
FRAUD CONTROL UNIT:
2012 ONSITE REVIEW**



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**EXECUTIVE SUMMARY: ILLINOIS STATE MEDICAID FRAUD CONTROL
UNIT: 2012 ONSITE REVIEW
OEI-07-12-00510**

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) oversees all Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG reviews all Units. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements.

HOW WE DID THIS STUDY

We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and documentation of the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

WHAT WE FOUND

Our review of the Illinois Unit identified instances of noncompliance with Federal regulations and instances where the Unit could better adhere to performance standards. The Unit's organizational structure with regard to the Unit's attorneys conflicts with certification requirements and attorneys assigned to the Unit are ineligible for Federal reimbursement. Opportunities for improvement in the Unit's adherence to the performance standards include, but are not limited to, reporting all convicted individuals for exclusion purposes, updating the Unit's Memorandum of Understanding with the State Medicaid agency, improving communication and collaboration efforts with external stakeholders, and establishing a minimum number of training hours required for each professional discipline.

WHAT WE RECOMMEND

We recommend that the Illinois Unit submit a corrective action plan within 30 calendar days from the date of the final report to resolve the Unit's noncompliance with the certification requirements and the full-time employment rule for attorneys. The Unit should also work with OIG's MFCU oversight division to ensure full compliance with each of the 12 performance standards. The Illinois Unit concurred with six recommendations and concurred in part with four recommendations.

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OBJECTIVE

To conduct an onsite review of the Illinois State Medicaid Fraud Control Unit (MFCU or Unit).

BACKGROUND

The mission of the State MFCUs, as established by Federal statute, is to investigate fraud and patient abuse and neglect by Medicaid providers and to prosecute it under State law.¹ Under the Medicaid statute, each State must maintain a certified Unit, unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State, and (2) the State has other, adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.² Currently, 49 States and the District of Columbia (States) have created such Units.³ In Federal fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, and Units employed 1,901 individuals.⁴

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an office with such authority.⁵ Units must be located in the State Attorney General's office or another State government office with statewide prosecutorial authority, or operate under a formal arrangement with the State Attorney General's office.⁶

¹ Social Security Act (SSA) § 1903(q)(3).

² SSA §§ 1902(a)(61). Regulations at 42 CFR § 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

³ North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

⁴ FY references in this report are based on the Federal FY (October 1 through September 30).

⁵ SSA § 1903(q)(1).

⁶ Ibid. 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on November 22, 2011. Note that the Office of Inspector General (OIG) published revised performance standards on June 1, 2012. (See 77 Fed. Reg. 32645.) The standards referred to in this report are those from 1994, which were in effect at the time of our review.

In 44 States the Units are located within offices of State Attorneys General; in Illinois and the remaining 5 States, the Units are located in other State agencies.^{7,8} Generally, Units within other State agencies must refer cases to other offices with prosecutorial authority, such as an Attorney General or State's Attorney.⁹ See Appendix A for the authorized structures for organizing a State MFCU.

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.¹⁰ Unit staff review complaints provided by the State Medicaid agency and other sources to determine their potential for criminal prosecution. In FY 2012, the 50 Units collectively reported 1,337 convictions and 823 civil settlements or judgments.¹¹ That year, the Units reported recoveries of approximately \$2.9 billion.¹²

Each Unit must be a single, identifiable entity of the State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—i.e., a Memorandum of Understanding (MOU)—that describes the Unit's relationship with that agency.¹³

Oversight of the MFCU Program

The Secretary of Health and Human Services delegated to OIG the authority to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs of operating certified Units.¹⁴ All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.¹⁵ To receive Federal

⁷ The Units share responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates fraud, waste, and abuse activities for the State agency.

⁸ In Connecticut, the Unit is located within the Chief State's Attorney's office, which has statewide prosecutorial authority. In West Virginia and the District of Columbia, the Unit is located within the Inspector General's office. In Tennessee, the Unit is located in the Bureau of Investigation, and in Iowa, it is located in the Department of Inspections and Appeals. For each of these five Units, the Unit attorneys are located within the same organizational component as the Unit itself, according to the information these States gave OIG.

⁹ SSA § 1903(q).

¹⁰ SSA § 1903(q)(6) and 42 CFR § 1007.13.

¹¹ OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures and Statistics*. Accessed at <http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> on March 7, 2013.

¹² Ibid.

¹³ SSA § 1903(q)(2); 42 CFR §§ 1007.5 and 1007.9(d).

¹⁴ The portion of funds reimbursed to States by the Federal government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation (FFP).

¹⁵ SSA § 1903(a)(6)(B).

reimbursement, each Unit must submit an application to OIG.¹⁶ OIG reviews the application and notifies the Unit of its approval and certification. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.¹⁷

Under the Medicaid statute, States must operate Units that effectively carry out their statutory functions and meet program requirements.¹⁸ OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory functions and meeting program requirements.¹⁹ Examples of criteria include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines (i.e., attorneys, investigators, and auditors), and establishing policy and procedure manuals for the Unit's operations. See Appendix B for a complete list of the performance standards.

Illinois State MFCU

The Medicaid Fraud Control Bureau in Illinois operates as a division of the Illinois State Police (ISP) and acts as the State MFCU. At the time of our review, the Unit's 63 employees were located in two regions: the Northern and Southern commands.^{20, 21} The Unit conforms to the ISP command structure. The Unit director is located in Springfield, and holds the rank of captain. The Northern and Southern command supervisors hold the rank of lieutenant. First-line supervisors hold the rank of master sergeant and report to a lieutenant. Investigators, auditors, and support staff are supervised within this structure.

The Unit employs investigators and auditors, but does not directly employ attorneys. Rather, the Unit has an MOU, dated March 14, 2005, establishing a formal working relationship with the Illinois Office of the Attorney General. Under the terms of the MOU, the attorneys are employees of the Attorney General's office and are supervised by that office, although they are assigned to work with the Unit. Illinois is the only MFCU organized in this manner. (See Appendix F for the Unit's organization chart.)

¹⁶ 42 CFR § 1007.15(a).

¹⁷ 42 CFR § 1007.15(b) and (c).

¹⁸ SSA § 1902(a)(61).

¹⁹ 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://www.oig.hhs.gov> on November 22, 2011. OIG published revised performance standards on June 1, 2012. (see 77 Fed. Reg. 32645.) The standards referred to in this report are the 1994 standards, which were in effect during the review period of FYs 2009–2011.

²⁰ The Northern command staff work from Tinley Park, Sterling, East Moline, and Des Plaines, and the Southern command staff work from the State capital of Springfield and the cities of Collinsville, DuQuoin, Effingham, and Mattoon.

²¹ OIG analysis of the *2012 Illinois Recertification Questionnaire to MFCU Director – Review Period April 1, 2011, Through March 31, 2012*.

The Unit refers a case for prosecution depending on whether the county in which the case is to be prosecuted is located in the Northern, Central, or Southern Districts of Illinois. A case within the venue of the U.S. District Court, Northern District of Illinois, is referred for prosecution to the Attorney General's office. The Attorney General's office may prosecute the case, or permit the MFCU to refer the case to another prosecuting authority. A case referred for prosecution within the Central District of Illinois is referred to the Central Illinois Healthcare Fraud Task Force (and thereby to the Attorney General), to determine the appropriate prosecuting authority. Finally, the Unit director, in consultation with the Chief MFCU Prosecutor, has the discretion to determine the appropriate prosecuting authority for a case within the Southern District of Illinois.

For FY 2011, the Illinois Unit was authorized to receive \$9.2 million in Federal funds, but actually expended just under \$7.3 million in Federal funds, and \$2.4 million in State matching funds.²² Total combined Federal and State Medicaid expenditures in the State of Illinois increased from \$13 billion in FY 2009 to \$13.6 billion in FY 2011.²³

For FYs 2009 through 2011, the Unit received an average of 1,628 referrals per year from all sources. The Illinois Department of Public Health (DPH), the State agency that regulates, licenses, and inspects nursing homes in Illinois, refers the majority of complaints that the Unit receives. DPH operates the Central Complaint Registry, a 24-hour hotline that accepts complaints of potential abuse, neglect, or exploitation occurring in health care facilities, as well as reports from consumers and the public. For FYs 2009 through 2011, the Unit received an average of 1,401 complaints per year from DPH.

The Illinois Department of Healthcare and Family Services (HFS), the State Medicaid agency, reported referring only a couple of cases per month to the Unit. Additional referral sources include OIG, the ISP website, other State agencies, and concerned citizens.

Upon receipt of a referral, a lieutenant determines whether the facts of the complaint merit opening a case. Once a case is opened, the lieutenant assigns the case to the appropriate master sergeant, who assigns the case to an investigator. The terms of the MOU with the Attorney General's office requires the Unit director to ensure that the assigned attorneys have the opportunity to fully participate in all investigations. Once the investigation is concluded, the Unit refers the case to the Attorney General's office or

²² OIG analysis of State form SF-425 for FY 2011.

²³ *Medicaid Fraud Control Units FY 2011 Statistical Chart*. Accessed at <http://oig.hhs.gov> on January 9, 2013.

another prosecutorial authority, such as a State’s Attorney or one of the three U.S. Attorneys for Illinois who will determine the potential for prosecution.

Previous Review

In 2010, OIG conducted an onsite review of the Illinois MFCU and found that the Unit: (1) expended grant resources to investigate non-Medicaid-related financial exploitation allegations; (2) employed investigators who lacked knowledge of the policies and procedures manual; (3) maintained an inadequate case management and tracking system; (4) failed to perform regularly scheduled supervisory case reviews; (5) lacked staff with extensive Medicaid-related investigative experience; and (6) experienced frequent turnover in the Unit director position.

In the 2010 review, OIG recommended that the Unit (1) contact OIG for guidance when clarification is required in determining whether a case falls within the parameters of 42 CFR § 1007.11(b); (2) provide all investigators with a copy of the operations manual; (3) continue to work with the Information Technology staff to obtain and implement an upgraded case management and tracking system; (4) conduct regularly scheduled supervisory reviews of case files every 30 days and regularly scheduled “command reviews”—i.e., reviews by the command (second-line) supervisor and the Unit director—of case files every 90 days;²⁴ and (5) ensure that new investigators continue to receive Medicaid-specific investigative training. OIG also recommended that ISP senior management strive to maintain continuity of the supervisory command structure.

METHODOLOGY

Our review covered the 3-year period of FYs 2009 through 2011. We analyzed data from seven sources: (1) a review of policies and procedures and documentation of the Unit’s operations, staffing, and caseload for FYs 2009 through 2011; (2) a review of financial documentation for FYs 2009 through 2011; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit’s management; (6) an onsite review of case files that were open in FYs 2009 through 2011; and (7) an onsite review of Unit operations, to include the Unit headquarters and offices located in the Northern and Southern commands. If interview and survey respondents provided information that fell outside our 3-year review period, we used it to explain further the results of our analyses.

²⁴ As noted on page 3, first-line supervisors hold the rank of master sergeant and report to either the Northern or Southern command supervisor, who holds the rank of lieutenant. The two command supervisors report to the Unit director, who holds the rank of captain.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not fully meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.²⁵

Data Collection and Analysis

Review of Unit Documentation. We reviewed policies, procedures, and documentation of the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also reviewed the Unit's policies and procedures describing how it detects, investigates, and prosecutes Medicaid cases. We collected data on the number of referrals received by the Unit and the number of investigations opened and closed.

Review of Financial Documentation. We reviewed Unit policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel to evaluate internal controls and design our tests for financial documentation. We reviewed the Unit's claimed \$25.5 million (\$19.1 million Federal share and \$6.5 million State share) in grant expenditures for FYs 2009 through 2011 to: (1) reconcile final Financial Status Reports and the supporting documentation; (2) purposively select and review transactions within direct cost categories to determine whether costs were allowable; and (3) verify that no indirect costs were reported during the period. We reviewed records from the Payment Management System to identify, if any, unusual patterns of "drawn-down" amounts (i.e., amounts withdrawn from the grant funds). Finally, we reviewed revenue accounts to identify program income amounts.

Interviews With Key Stakeholders. We conducted structured interviews with key stakeholders who were familiar with the operations of the Unit. Specifically, we interviewed staff from the Office of the Illinois Attorney General; the U.S. District Attorneys from the Northern, Central, and Southern districts of Illinois; the Administrator of HFS's Division of Medical Programs; HFS's Office of Inspector General (HFS OIG), which serves as the State's Program Integrity Unit; and management and staff from the Illinois Office of the Long-Term Care Ombudsman and Department on Aging. Additionally, we interviewed Special Agents from OIG's Kansas City and Chicago regional offices, who work regularly with the Unit. Each of these interviews focused on the Unit's interaction with external agencies.

²⁵ All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

Survey of Unit Staff. In August 2012, we administered an electronic survey of all nonmanagerial Unit staff. We requested and received responses from each of the 47 nonmanagerial staff members, a 100-percent response rate. Our questions focused on operations of the Unit, opportunities for improvement, and practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Interviews With Unit Management and Staff. We conducted structured interviews with the Unit director, the lieutenants, and the master sergeants. We also met with the Unit's chief auditor. We asked these individuals to provide additional information to better illustrate the Unit's operations, identify opportunities for improvement, identify practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, and clarify information obtained from other data sources.

Onsite Review of Case Files. We selected a simple random sample of 100 cases from the 1,286 cases that were open at some point during FYs 2009 through 2011. We reviewed all files corresponding to these sampled cases for documentation of supervisory approval for the opening of cases, documentation of closing of cases (if applicable), documented supervisory reviews of case files, and documented command reviews of case files. From these 100 cases, we selected a further random sample of 50 cases for a more in-depth review of selected issues, such as the timeliness of investigations and case development.²⁶ We projected the results of our reviews of case files to the population of Unit cases. See Appendix C for the distribution of cases from the population and sample.

Onsite Review of Unit Operations. During our September 2012 onsite visit, we reviewed the Unit's workspace and operations. Specifically, we visited the Unit headquarters in the State Capital and selected Northern and Southern command offices. We observed the Unit's offices and meeting spaces, security of data and case files, location of select equipment, and the general functioning of the Unit.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

²⁶ We excluded from our analysis one case improperly coded as being related to Medicaid.

FINDINGS

For FYs 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$141 million and 97 convictions

The Unit reported total combined criminal and civil recoveries of nearly \$141 million for FYs 2009 through 2011. Recoveries increased from \$23 million in FY 2009 to \$70 million in FY 2010 and declined to \$48 million in FY 2011. Settlements for “global” (i.e., multi-State) cases accounted for \$124 million of the total recoveries but only 33 of the Unit’s 1,286 cases over the 3-year period. Refer to Table 1 below for details regarding criminal and civil recoveries.²⁷

During the review period, the Unit closed 967 investigations and referred 218 cases for prosecution. Prosecution outcomes include 133 individuals charged, 97 criminal convictions, 11 dismissals, and 6 acquittals.²⁸ See Appendix D for details on investigations opened and closed by provider category for FYs 2009 through 2011.

Table 1: Illinois MFCU Criminal and Civil Recoveries, FYs 2009–2011

Type of Recovery	FY 2009	FY 2010	FY 2011	Total Recoveries
Criminal Recoveries	\$5,113,957	\$655,124	\$3,341,296	\$9,110,417
Global Recoveries	\$17,727,644*	\$69,464,241	\$44,464,326	\$124,098,774
Non-Global Civil Recoveries	\$341,620	\$7,089,594	\$126,240	\$7,557,454
Total Recoveries	\$22,841,621	\$70,119,365	\$47,805,622	\$140,766,645

Source: OIG review of Unit self-reported data and Quarterly Statistical Reports, FYs 2009–2011.

* The Unit believed that it was not required to report the Federal portion of global recoveries in 2009. The Federal portion of the Unit’s global case recoveries was \$29,098,445 in 2010 and \$21,218,058 in 2011.

Referrals to the Unit decreased during the period of review

The Unit reported 2,362 referrals in FY 2009, 1,475 in FY 2010, and 1,042 in FY 2011. DPH accounted for 90 percent of all referrals to the Unit in FY 2009. The Unit director reported that many DPH referrals were complaints related to food quality and similar issues outside the scope of the

²⁷ “Global” cases are civil false-claims actions involving the U.S. Department of Justice and other State MFCUs. The National Association of Medicaid Fraud Control Units facilitates the settlement of global cases.

²⁸ One individual was convicted in two different cases.

grant. The Unit director also reported that educating DPH about what constitutes criminal abuse and neglect had decreased that agency's proportion of the Unit's referrals from 90 percent in 2010 to 76 percent in 2011.

The Unit also reported a significant decline in referrals from HFS, which are routed to the Unit through HFS OIG. HFS OIG provided 129 referrals in FY 2009, 62 referrals in FY 2010, and 22 referrals in FY 2011. Unit and HFS management, and the HFS Inspector General, who was newly appointed in 2012, attributed the decline in referrals to "issues internal to OIG" that existed prior to his appointment. Reportedly, as a result, many of the referrals from HFS to HFS OIG were not forwarded to the Unit. The HFS Inspector General is a former Unit attorney and has made positive efforts to reestablish communication and referral processes between the two agencies. See Appendix E for details on referrals received by provider category for FYs 2009 through 2011.

The Unit's organizational structure for its attorneys conflicts with the MFCU certification standards, and attorneys assigned to the Unit are ineligible for FFP

Our review found that all of the attorneys assigned to the Unit are employees of the Attorney General's office and are neither supervised by, nor report to, the Unit director. This arrangement conflicts with the certification requirements in section 1903(q)(6) of the Social Security Act and implemented by OIG in 42 CFR § 1007.13. These certification standards require Units to employ sufficient staff to effectively and efficiently carry out its duties, including employing "[o]ne or more attorneys experienced in the investigation or prosecution of civil fraud or criminal cases."²⁹ The current arrangement, in which all the attorneys assigned to the MFCU are employed by the Attorney General's office, does not satisfy this requirement, nor does it appear to satisfy the statutory definition of a MFCU as a single identifiable entity of the State government under 1903(q).

Further, under 42 CFR § 1007.19(e)(4), FFP is not available for the performance of a person other than a full-time employee of the Unit; Units may only claim FFP for the costs of full-time professional employees. OIG State Fraud Policy Transmittal 89-1³⁰ defines a full-time employee as "an employee who (1) works exclusively on MFCU matters and (2) works under the supervision and direction of the Unit." The policy further states that if an employee "performs duties under the direction of another State office, such

²⁹ 42 CFR § 1007.13(a)(1).

³⁰ OIG State Fraud Policy Transmittal 89-1, *Clarification of the Hiring of Full-time and Part-time Employees*, Jan. 13, 1989. Accessed at <http://oig.hhs.gov> on November 7, 2012.

an employee would not be considered a full-time employee under the program regulations.” The MOU between the Unit and the Attorney General’s office supports the finding that Unit attorneys are employees of the Attorney General’s office, and instructs that “The Attorney General will assign eleven MFCU prosecutors who will be supervised by the Attorney General with input from the Unit Director.”

In support of recertification by OIG in 2010, 2011, and 2012, the Unit submitted organization charts that use a solid line to indicate a direct reporting relationship between the Chief Attorney and the Unit director. See Appendix F for the organization chart submitted by the Unit for the 2012 review. During our onsite review, we noted that attorneys report directly to the Attorney General’s office and learned that the Unit director does not provide input on the supervision or performance of the attorneys. Further, the director does not directly manage the attorneys and may be unable to ensure that they work full-time on MFCU cases. Our review, however, found no evidence to suggest that the attorneys work on activities not eligible for FFP.

With the exception of a lack of compliance with certification standards and the full-time employment rule, our review of financial documentation found no deficiencies in the Unit’s fiscal control of its resources

According to Performance Standard 11, the Unit should exercise proper fiscal control over the Unit’s resources. Although the Unit was not in compliance with certification standards or the full-time employment rule (as addressed in the previous finding), the Unit’s expenditures claims for FYs 2009 through 2011 represented allowable, allocable, and reasonable costs in accordance with applicable Federal regulations. In addition, the Unit maintained adequate internal controls relating to accounting, budgeting, personnel, procurement, property, and equipment.

The Unit did not report to OIG the identities of 56 convicted providers for the purpose of program exclusion

According to Performance Standard 8(d), when a convicted provider is sentenced, the Unit should send a referral letter to OIG “within 30 days or other reasonable time period” for the purpose of excluding that provider from Federal health care programs. The Illinois Unit failed to report 56 of 97 (58 percent) individuals convicted of fraud, abuse, or neglect. Sentencing for these 56 individuals occurred from 12 months to 47 months prior to our onsite review. Failure to report convicted providers in a timely manner to OIG for program exclusion enables those providers to continue billing

Medicaid and Medicare and/or to receive other Federal grants and contracts. Providers convicted of health care fraud and patient abuse remain a threat to potential victims.

Subsequent to the completion of our onsite review, the Unit director notified the review team that documentation of the convictions previously unreported for exclusion purposes had been submitted to OIG as of December 2012. The Unit director stated that future exclusion reports will be forwarded to OIG.

Failure to report provider convictions to OIG for the purpose of program exclusion resulted in a loss of more than \$20,000 to the Medicaid program

Medicaid claims data shows that a single convicted provider, who had not been reported to OIG for the purpose of program exclusion, received nearly \$20,630 from the Medicaid program during the period of our review. The provider was sentenced on May 5, 2009, but received payments for claims for attendant care services between August 5, 2009, and December 12, 2012 (the most recent data available at the time of our review).

The Unit's MOU with the State Medicaid agency does not reflect current requirements

According to Performance Standard 10, the Unit should periodically review its MOU with the State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice. The current operating MOU—which has an effective date of November 5, 2007—lacks reference to the State False Claims Acts^{31, 32} and does not include payment suspension provisions for providers who are subject to an ongoing investigation related to credible allegations of fraud.³³

Unit case files lacked supervisory approval and documentation of reviews of case files

Performance Standard 6 states that the Unit should have a continuous case flow and cases should be completed in a reasonable time. As a part of this effort, managers should approve the opening and closing of cases and document any supervisory reviews in the case file. Ten percent of opening investigations and 4 percent of closed cases lacked evidence of documented

³¹ 305 Illinois Compiled Statutes (ILCS) 5 Illinois Public Aid Code §§ 8A-3 and 8A-7. Accessed at <http://www.ilga.gov> on December 10, 2012.

³² 740 ILCS 175 Illinois False Claims Act § 4(a) Civil actions for false claims. Accessed at <http://www.ilga.gov> on December 10, 2012.

³³ 42 CFR §§ 455.23 and 1007.9(e)(1).

supervisory approval. Our 2010 onsite review also noted that the Unit lacked appropriate documentation of reviews of case files.

Performance Standard 6 also states that supervisory reviews should be conducted periodically and noted in the case file. The Unit conducts two types of supervisory reviews: “supervisory” review (by a first-line supervisor, i.e., a master sergeant) and “command” review (by a second-line supervisor—i.e., the “command” supervisor, who is a lieutenant—and the Unit director, who is a captain). The Unit’s policy is to conduct a supervisory review of case files every 30 days on all open cases, and to conduct a command review of case files every 90 days on all open cases. Sixty percent of case files lacked documentation of supervisory review and 34 percent lacked documentation of command review.³⁴ We assessed whether supervisory and command reviews of case files occurred during the tenure of the new director (i.e., 2012)—although this timeframe was outside of our review period—and found that all required reviews were conducted for the sampled cases. See Appendix G for sample sizes and 95-percent confidence intervals associated with point estimates.

The Unit investigated three cases in our sample unrelated to Medicaid and one case did not follow prosecution referral protocol

We identified investigations that involved a missing iPod, and a physician alleging that she had not been paid by a group practice that employed her. These do not appear to be Medicaid cases. Another case in our selected sample involved a pair of stolen motorcycles; however, the Unit director stated that the case had been mistakenly archived as a MFCU case in an administrative error and had not been investigated by the Unit. Finally, we noted one investigation in which the Unit referred a case within the Central District to a State’s Attorney for prosecution that, after the referral was declined, was forwarded to the Attorney General’s office. The MOU between the agencies requires that cases in the Central District are to be referred to the Healthcare Fraud Task Force first.

The Unit’s director and management team reported the case management and tracking system is inadequate

According to Performance Standard 3, the Unit should establish an adequate, computerized case management and tracking system. During our surveys of Unit staff and interviews with management, the Unit director reported a lack

³⁴ For the purposes of this report, supervisory approval to open and close a case does not constitute a review of the case file. Periodic supervisory review indicates that a supervisor reviewed a case more than once between the opening and closing of the case.

of confidence in the case management and tracking system. Other Unit managers reported that the system is “inadequate” and “loses information,” requiring staff to reenter the data from archived sources. Results from our staff survey similarly revealed responses that indicated the system is “old” or “outdated,” “loses information,” and is not user friendly.

During our onsite review, we assessed the system and found that the variable field for tracking case reviews was little more than an open text field. Issues with the case management and tracking system remain an unresolved finding from our 2010 onsite review.

Key stakeholders reported a lack of communication and cooperation from the Unit’s Northern command

According to Performance Standard 8, the Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. Our interviews with key stakeholders revealed that the Unit has developed an effective relationship with the Office of the Long-Term Ombudsman. However, room exists for improved communication and cooperation with other external stakeholders.

Stakeholders who primarily interacted with the Northern command offices reported that improved communication and more interagency cooperation would benefit all parties. The U.S. Attorney for the Northern District of Illinois expressed concern that the Northern command disregarded input on cases, which impeded interagency cooperation. We also learned that although the Unit management has a “cordial relationship” with OIG’s Office of Investigations staff, high Unit staff turnover and a lack of regular dialogue between the agencies impeded productivity. The Special Agent in Charge for OIG’s Chicago region and the U.S. Attorney for the Northern District of Illinois expressed an interest in improving their working relationships with the Unit.

In contrast, stakeholders working with the Southern command offices were complimentary of the Unit and reported effective working relationships with staff. The Assistant Special Agent in Charge of OIG’s St. Louis field office works regularly with Unit staff, and reported that his office maintains “great communication and enjoys a close working relationship” with the Southern command. He also noted that the Unit routinely participates in search warrants and assists with cases as needed. Further, the U.S. Attorney’s Office for the Southern District of Illinois described its relationship with the Unit as “excellent and productive.”

Unit training plans did not identify a minimum number of required training hours for each professional discipline

According to Performance Standard 12, the Unit should maintain an annual training plan for all professional disciplines that includes a minimum number of hours of training required for each professional discipline. The Unit had training plans and made funds available to staff for training. However, the training plan did not include a minimum number of training hours for each professional discipline. All staff reported that the Unit provided them with training opportunities and that the training they received aided the mission of the Unit.³⁵

Other observations: Effects of Unit director turnover and drug diversion awareness training

In addition to assessing the Unit's compliance with relevant statutes and regulations and its performance consistent with each of the performance standards, we made two observations involving a potential deficiency and a noteworthy practice that might be of interest to other Units.

Unit director turnover

Between October 2008 and September 2011, the Illinois Unit employed six acting and/or permanent directors. The current director was appointed in December 2011. Twenty percent of the respondents to the Unit staff survey mentioned that the frequency of Unit director turnover is problematic. Although the length of tenure of Unit directors is not specified in the performance standards, a high turnover rate with directors may have a detrimental effect on the effectiveness, efficiency, and morale of a Unit.

Drug diversion awareness training

The Unit has an initiative to provide nursing home staff with drug diversion awareness training to reduce instances of caregivers diverting residents' prescription drugs for personal use or sale. Unit management reported that investigators regularly visit nursing homes to inspect logbooks and train staff to identify dispensing irregularities. Investigators "encourage placement of a three-digit numeral behind the names of staff that dispenses drugs, to identify the person." The practice has reportedly resulted in a drop in diversion cases

³⁵ Although we reviewed training records, we did not evaluate the staff's professional qualifications. Rather, we applied the performance standards to evaluate whether the Unit maintained a formal training plan for each professional discipline and assessed training opportunities specific to Unit operations. We recognize that attorneys, investigators, and auditors receive professional and law enforcement training, and that the lack of an annual training plan does not suggest that professional staff are unqualified.

within nursing homes because “[w]hen you start to educate the administrators, they’re able to pick up problems.”

CONCLUSION AND RECOMMENDATIONS

For FYs 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$141 million, of which \$124 million represented global case recoveries. The Unit referred 218 cases for prosecution, which resulted in 97 convictions, 11 dismissals, and 6 acquittals.

The Unit director reported that educating DPH has improved the quality of its referrals and decreased markedly the number of referrals unrelated to the agency's mission. Additionally, numerous HFS referrals routed through HFS OIG were not forwarded to the Unit.

The organizational charts submitted in support of the Unit's 2010 and 2012 onsite review indicated that attorneys assigned to the Unit were supervised by the Unit director. However, our review found that the Unit director neither supervises the attorneys nor contributes to their performance appraisals. Thus, the Unit does not meet the certification staffing requirements, nor do the attorneys meet the definition of the full-time employee rule. FFP is not available for the compensation of persons other than full-time employees of the Unit.

Because the Unit's attorney structure for its attorneys is not compliant with the certification staffing requirements and the full-time employment rule for attorneys, the Unit must submit a corrective action plan due within 30 calendar days from the date of the final report issuance to resolve noncompliance, and work with OIG's MFCU oversight division to ensure certification requirements are met and that that FFP is available in the future for attorneys.

For FYs 2009 through 2011, the Unit did not report the identities of all convicted providers to OIG for the purpose of program exclusion, which resulted in a loss of approximately \$20,000 to the Medicaid program. The Unit's cases lacked documentation of supervisory reviews and detailed investigatory interview notes. The Unit's current MOU with the State Medicaid agency failed to comply with all Federal requirements. We also noted during our review of case files that the Unit opened cases that were unrelated to Medicaid. In addition, Unit management and staff reported that the computerized case management and tracking system remains inadequate, an issue we also noted during our 2010 Unit review. We also found that the Northern command's communication and cooperation with key stakeholders requires improvement, and that the Unit's staff training plan did not identify the number of training hours to be required for each professional discipline. External stakeholders and Unit staff mentioned the turnover rate within the director's office impeding productivity. Although the length of tenure of Unit directors is not specified in the performance standards, OIG has

concerns that this issue affects the effectiveness and efficiency of Unit operations.

Finally, Unit supervisors reported that providing nursing home staff with drug diversion awareness and logbook inspection trainings has been beneficial to Unit operations, and reduced the number of drug diversion crimes committed.

We recommend that the Illinois Unit:

Submit a Corrective Action Plan to Address Noncompliance With Certification Requirements

Section 1903(q)(6) of the Act, 42 CFR § 1007.13, and OIG State Fraud Policy Transmittal 89-1 require the Unit to employ and supervise full-time professional staff, including at least one Unit attorney. Because the Unit's attorney structure is not compliant with the certification staffing requirements OIG may be unable to recertify the Unit in the absence of a reorganization of the Unit or other acceptable remedy.

Submit a Corrective Action Plan to Address Noncompliance With the Full-Time Employment Rule for Attorneys

Section 1903(q)(6) of the Act, 42 CFR § 1007.13, and OIG State Fraud Policy Transmittal 89-1 require the Unit to employ and supervise full-time professional staff. Because the Unit's attorney structure is not compliant with the full-time employment rule, FFP is not available for attorneys who are employed and supervised by the Attorney General's office.

Note: OIG's expectation is that the Unit submit a single Corrective Action Plan that addresses the issues identified above. This Corrective Action Plan is due within 30 calendar days from the date the final report is issued.

We also recommend that the Illinois Unit:

Refer Individuals for the Purpose of Program Exclusion to OIG Within the Appropriate Timeframe

The Unit should make certain that individuals convicted of fraud, abuse, and neglect are reported within 30 days of their sentencing, in accordance with Performance Standard 8(d) of the revised performance standards.

Update the Unit's MOU With the State Medicaid Agency to Comply With Federal Grant Requirements

The Unit should update the MOU with HFS to include language regarding the Illinois False Claims Acts and provider payment suspension provisions.

Ensure That All Case Files Contain Opening and Closing Investigative Memoranda, Documented Supervisory Approvals, and Documented Periodic Supervisory Reviews

Ensure Referrals for Prosecution Follow Established Protocol

Ensure Investigations Are Related to Medicaid and Repay Grant Funds for Ineligible Cases

The Unit should not investigate cases outside the scope of the Federal grant and should work with OIG to identify the staff hours and expenditures associated with the ineligible cases to repay the Federal grant funds.

Upgrade the Unit's Case Management and Tracking System

The Unit should implement a case management and tracking system that is not vulnerable to the loss of data and is user friendly.

Improve Communication and Cooperation With Key Stakeholders

The Unit should strive to improve outreach efforts and communication among key stakeholders such as HFS, HFS OIG, OIG's Chicago region, and the U.S. Attorney's Office for the Northern District of Illinois.

Establish Training Hour Requirements for Professional Disciplines

The Unit should include a minimum number of training hours for each professional discipline in its training plan.

UNIT COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The Illinois Unit concurred with six recommendations and concurred in part with four recommendations. Regarding our first and second recommendations involving organizational structure, the Unit concurred in part. The Unit agreed that there appears to be an issue with the attorneys' reporting structure but that attorneys assigned to the Unit have been dedicated full-time to Medicaid fraud prosecution. We do not dispute that the attorneys appear to be dedicated full-time to Medicaid fraud and other cases within the Unit's authority. However, the Unit director does not supervise or manage the case work of the attorneys and the Unit thus does not comply with the rule that employees be full-time employees that report to and are supervised by the Unit. The Illinois State Police and Illinois Attorney General's Office are working to revise their Memorandum of Understanding to resolve the compliance issue. A corrective action plan will be provided to OIG in response to the final report.

Regarding our third recommendation involving reporting of conviction information, the Unit concurred. The Unit submitted all documentation of convictions for the period of review for the purposes of program exclusion by December 2012. A procedure has now been put in place to ensure the documentation is submitted within 30 days of the sentencing date.

Regarding our fourth recommendation about the MOU, the Unit concurred. The Unit is currently rewriting the MOU with the State Medicaid agency to

address the issues of provider payment suspension and make mention of the Illinois False Claims Act. The Unit anticipates that this will be completed by October 1, 2013.

Regarding our fifth recommendation about case file documentation, the Unit concurred in part. The Unit director asserts that all cases were opened and closed as required but states that not all of these reports made it to the file in the Records Bureau. The Unit director will make efforts to correct these issues and ensure that supervisory and command case reviews are properly documented. The Unit will develop a checklist for case closures to ensure a file is complete before it is forwarded to the Records Bureau.

Regarding our sixth recommendation about following established protocol, the Unit concurred. The Unit is reviewing prosecution protocols to standardize the process of referring cases for prosecution. This will be addressed in the revised MOU with the Attorney General's Office.

Regarding our seventh recommendation about ensuring investigations are related to Medicaid, the Unit concurred. The Unit director asserts that all cases were opened believing there was a Medicaid nexus; once it was clear there was not, all investigations were promptly closed.

Regarding our eighth recommendation about the case management system, the Unit concurred. Subsequent to our review, the Unit has conducted research with various other Units to identify a viable system with demonstrated capabilities. The Unit anticipates it will begin implementing a new system by December 2013.

Regarding our ninth recommendation about communicating and cooperating with key stakeholders, the Unit concurred in part. The Unit identified a "sometimes-stressed relationship" with the U.S. Attorney's Office in the Northern District. The Unit will continue to reach out to Federal partners.

Regarding our tenth recommendation about establishing training hour requirements, the Unit concurred. The Unit is revising its training policy to include a minimum number of training hours for each professional discipline. The Unit anticipates the policy will be completed within the next 30 days.

The full text of the Unit's comments is provided in Appendix H.

APPENDIX A

Social Security Act

[SSA § 1903(q)(1)]

(q) For the purposes of this section, the term “State Medicaid fraud control unit” means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity:

(A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations,

(B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or

(C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

APPENDIX B

Performance Standards for Medicaid Fraud Control Units³⁶

[59 Fed. Reg. 49080, Sept. 26, 1994]

1. **A Unit will be in conformance with all applicable statutes, regulations and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
 - a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
 - b. The Unit must be separate and distinct from the single State Medicaid agency.
 - c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
 - d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
 - e. The Unit must submit quarterly reports on a timely basis.
 - f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
2. **A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
 - a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by the OIG [Office of Inspector General]?
 - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
 - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
 - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
3. **A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:

³⁶ These performance standards were the ones in effect at the time of our review and precede the performance standards published in June 2012.

- a. Does the Unit have policy and procedure manuals?
- b. Is an adequate, computerized case management and tracking system in place?

4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?
- b. Does the Unit work with other agencies to encourage fraud referrals?
- c. Does the Unit generate any of its own fraud cases?
- d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?

5. A Unit's case mix, when possible, should cover all significant provider types. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
- b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
- c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
- d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
- e. Does the Unit consider civil and administrative remedies when appropriate?

6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time. In meeting this standard, the following performance indicators will be considered:

- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
- b. Are supervisors approving the opening and closing of investigations?
- c. Are supervisory reviews conducted periodically and noted in the case file?

7. A Unit should have a process for monitoring the outcome of cases. In meeting this standard, the following performance indicators will be considered:

- a. The number, age, and type of cases in inventory.
- b. The number of referrals to other agencies for prosecution.
- c. The number of arrests and indictments.
- d. The number of convictions.
- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

8. A Unit will cooperate with the OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit communicate effectively with the OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to the OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government. In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
- b. Does the Unit provide program recommendations to single State agency when appropriate?
- c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

- 10. A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:
- a. Is the MOU more than 5 years old?
 - b. Does the MOU meet Federal legal requirements?
 - c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?
 - d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?
- 11. The Unit director should exercise proper fiscal control over the Unit resources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
 - b. Does the Unit maintain an equipment inventory?
 - c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?
- 12. A Unit should maintain an annual training plan for all professional disciplines.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
 - b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
 - c. Are continuing education standards met for professional staff?
 - d. Does the training undertaken by staff aid to the mission of the Unit?

APPENDIX C

Population and Sample Distribution of Case Files Open Any Time During Fiscal Years 2009 Through 2011

Data Element Description	Population of Case Files	Population of Case Files (Percentage)	Sample Case Files	Sample Case Files (Percentage)
Fraud—Civil (Open)	3	0.2	0	0
Fraud—Civil (Closed)	55	4.3	6	6
Fraud—Criminal (Open)	115	8.9	8	8
Fraud—Criminal (Closed)	306	23.8	24	24
Abuse—Civil (Open)	0	0	0	0
Abuse—Civil (Closed)	5	0.4	0	0
Abuse—Criminal (Open)	23	1.8	1	1
Abuse—Criminal (Closed)	666	51.8	53	53
Patient Funds—Civil (Open)	0	0	0	0
Patient Funds—Civil (Closed)	1	0	0	0
Patient Funds—Criminal (Open)	11	0.9	0	0
Patient Funds—Criminal (Closed)	101	7.9	8	8
Total	1,286	100	100	100

Source: Office of Inspector General analysis of Illinois' Medicaid Fraud Control Unit Quarterly Statistical Reports, FYs 2009–2011.

APPENDIX D

Investigations Opened and Closed By Provider Category for Fiscal Years 2009 Through 2011

Table D-1: Fraud Investigations

Provider Category	Fiscal Year (FY) 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Facilities						
Hospitals	1	2	0	2	0	1
Nursing Facilities	1	1	2	3	2	0
Other Long-Term Care Facilities	0	0	0	0	0	0
Substance Abuse Treatment Centers	0	0	0	0	1	0
Other	3	5	9	5	3	9
Subtotal	5	8	11	10	6	10
Practitioners						
Doctors of Medicine or Osteopathy	15	15	9	14	12	21
Dentists	8	5	5	5	2	4
Podiatrists	0	1	1	0	0	1
Optometrists/Opticians	2	0	1	1	3	3
Counselors/Psychologists	0	1	0	0	2	1
Chiropractors	0	1	1	0	1	1
Other	0	0	1	1	0	0
Subtotal	25	23	18	21	20	31
Medical Support						
Pharmacies	1	7	10	5	2	4
Pharmaceutical Manufacturers	0	2	9	10	16	16
Durable Medical Equipment and/or Supplies	1	2	2	0	3	3
Laboratories	1	2	1	1	1	2
Transportation Services	4	7	12	3	9	5
Home Health Care Agencies	0	3	1	2	1	2
Home Health Care Aides	15	23	33	28	63	31
Nurses, Physician Assistants, Nurse Practitioners, Certified Nurse Aides	1	1	0	0	3	0
Radiologists	1	0	0	0	1	2
Medical Support—Other	1	0	0	0	2	1
Subtotal	25	47	68	49	101	66

Table D-1 (Continued): Fraud Investigations

Program Related	Opened	Closed	Opened	Closed	Opened	Closed
Managed Care	0	0	1	0	0	1
Medicaid Program Administration	4	2	3	3	3	3
Billing Company	0	0	0	0	0	0
Other	0	2	3	0	3	0
Subtotal	4	4	7	3	6	4
Total Provider Categories	59	82	104	83	133	111

Source: Office of Inspector General (OIG) analysis of Unit Annual Reports, FYs 2009–2011.

Table D-2: Patient Abuse, Neglect, and Funds Investigations

Provider Category	FY 2009		FY 2010		FY 2011	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facility	94	87	227	198	217	214
Other Long-Term Care	0	0	1	7	0	3
Nurses/Physician's Assistant/Nurse Practitioner/ Certified Nurse Aides	17	25	43	37	34	39
Home Health Aides	2	1	0	0	1	1
Other	21	10	26	40	36	29
Total	134	123	297	282	288	286

Source: OIG analysis of Unit Annual Reports, FYs 2009–2011.

APPENDIX E

Medicaid Fraud Control Unit Referrals by Provider Category for Fiscal Years 2009 Through 2011

Referral Source	Fiscal Year (FY) 2009			FY 2010			FY 2011		
	Fraud	Abuse and Neglect	Patient Funds	Fraud	Abuse and Neglect	Patient Funds	Fraud	Abuse and Neglect	Patient Funds
Medicaid Agency – PI/SURS* (Department of Healthcare and Family Services, Office of Inspector General)	119	6	0	58	4	0	18	3	1
Medicaid Agency – Other (Department of Public Health)	6	2,129	3	2	1,256	12	3	780	13
State Survey and Certification	0	0	0	0	0	0	0	0	0
Other State Agencies	15	2	2	34	2	1	64	4	0
Licensing Board	0	1	0	1	5	0	1	1	0
Law Enforcement	3	1	6	9	4	6	2	7	1
Office of Inspector General	7	1	0	15	1	0	9	0	1
Prosecutors	6	3	1	1	2	1	3	2	3
Providers	1	13	6	2	17	7	6	26	11
Provider Associations	1	0	0	0	0	0	0	1	0
Private Health Insurer	0	0	0	0	0	0	3	0	0
Long-Term Care Ombudsman	0	0	1	1	0	3	0	0	5
Adult Protective Services	0	0	0	1	0	0	0	0	0
Private Citizens	11	3	3	15	6	2	25	7	7
MFCU** Hotline	3	1	1	1	0	0	20	6	3
Other	6	1	0	4	1	1	4	1	1
Total	178	2,161	23	144	1,298	33	158	838	46
Annual Total	2,362			1,475			1,042		

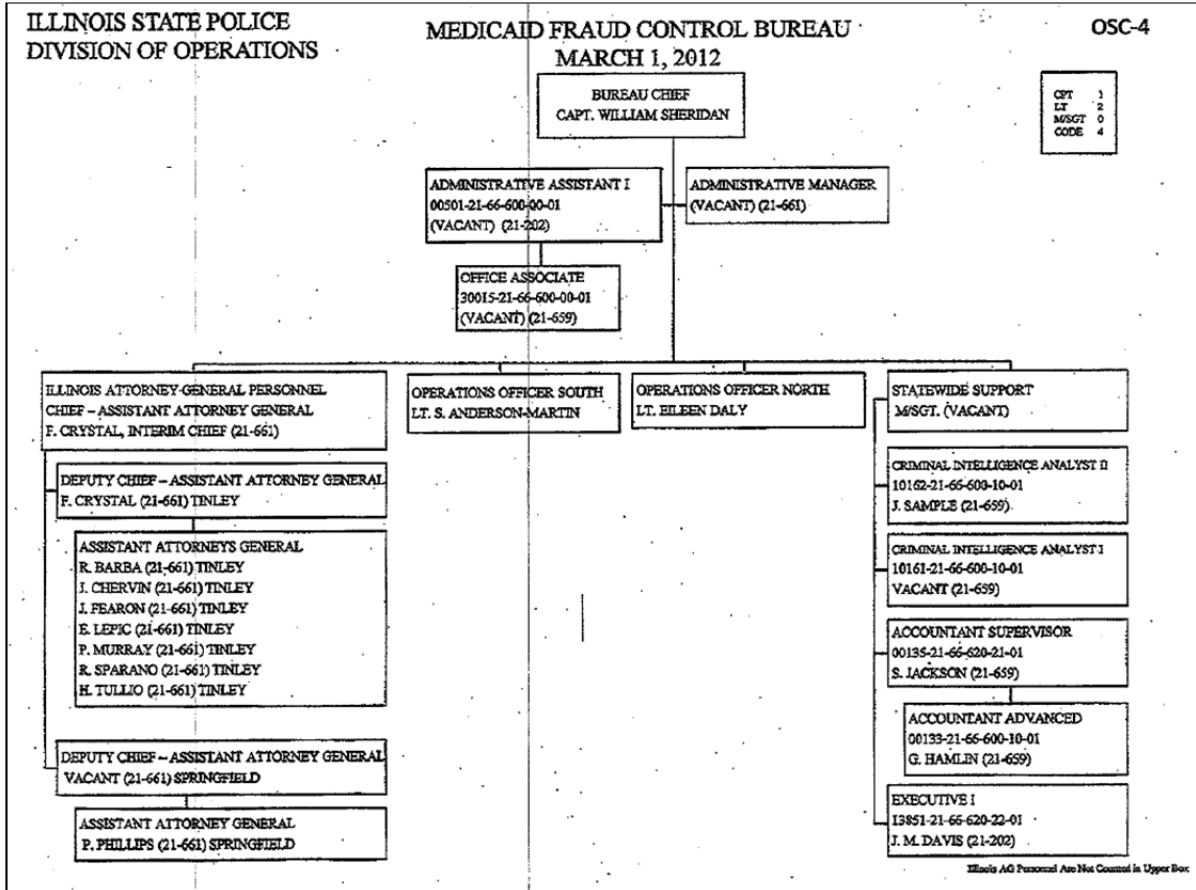
* Program Integrity/Surveillance and Utilization Review Subsystem.

** Medicaid Fraud Control Unit.

Source: Office of Inspector General analysis of Illinois' Medicaid Fraud Control Unit Quarterly Statistical Reports, FYs 2009–2011.

APPENDIX F

Illinois Medicaid Fraud Control Unit Organization Chart



APPENDIX G

Point Estimates and 95-Percent Confidence Intervals Based on Our Reviews of Case Files

We calculated confidence intervals for key data points for our reviews of case files. The sample sizes, point estimates, and 95-percent confidence intervals are given for the each of the following:

Table F-1: Confidence Intervals for Case File Review Data

Data Element Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Case files missing supervisory approval for the opening of investigations	99	10.1%	5.6%–17.6%
Case files missing documented supervisory approval for the closing of investigations	87	3.5%	1.1%–10.0%
Case files missing documented periodic supervisory reviews (30-day supervisory review of case file)	82	59.8%	49.1%–69.6%
Case files missing documented periodic supervisory reviews (90-day command review of case file)	99	34.3%	25.9%–44.0%

Source: Office of Inspector General Analysis of Illinois Medicaid Fraud Control Unit case files, 2012.

APPENDIX H

Unit Comments



ILLINOIS STATE POLICE
Office of the Director

Pat Quinn
Governor

May 28, 2013

Hiram Grau
Director

Mr. Stuart Wright
Deputy Inspector General
For Evaluation and Inspections
Department of Health and Human Services
Office of Inspector General
330 Independence Avenue, SW
Washington, D.C. 20201

Dear Mr. Wright:

Thank you for your correspondence and recent draft audit report entitled Illinois State Medicaid Fraud Control Unit: 2012 Onsite Review, OEI-07-12-00510. We appreciate your efforts and the opportunity to improve Illinois' Medicaid Fraud Control Unit (MFCU).

My office has reviewed each of your recommendations. As requested, below is our response:

Noncompliance with Federal Regulations

The Unit's organizational structure for its attorneys conflicts with the MFCU certification standards, and attorneys assigned to the Units are ineligible for FFP.

- **Submit a Corrective Action Plan to Address Noncompliance with Certification Requirements (42 CFR 1007.13).**
- **Submit a Corrective Action Plan to Address Noncompliance with Full-Time Employment Rule for Attorneys.**

We concur in part. While we agree there currently appears to be an issue with the attorneys' reporting structure, the attorneys assigned to the Unit have been dedicated, full-time, to Medicaid Fraud prosecution. The Illinois State Police (ISP) is working with the Illinois Attorney General's Office (AGO) to revise its Memorandum of Understanding (MOU) with the AGO to ensure compliance with the requirement that the Assistant Attorneys General are on full-time detail or assignment to the MFCU from the AGO, work exclusively on MFCU matters, and work under the direction and supervision of the Unit. The Unit will also maintain a formal procedure for referring cases of criminal fraud in the State Medicaid program to the appropriate State prosecuting authority. A Corrective Action Plan, based on the above, will be provided in response to the Department of Health and Human Services - Office of the Inspector General's (DHHS-OIG) final report.

Opportunities for Improvement

The Unit did not report to OIG the identities of 56 convicted providers for the purposes of program exclusion.

- **Refer Individuals for the Purpose of Program Exclusion to OIG within the Appropriate Timeframe.**

We concur. In October 2006, a staff member at the DHHS – OIG State Medicaid Oversight and Policy informed our Unit we no longer needed to submit copies of the Consolidated Reporting Worksheets (CRWs) with the quarterly report,

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as long as we entered the CRW information into the HIPDB (now called the Data Bank). Our Unit followed those instructions, and we were never contacted regarding our omission. Once we learned of the error, we immediately made corrections. By December 2012, we had submitted all the documentation of convictions for the identified period of time. A procedure has now been put in place to ensure the documentation is submitted within 30 days of the sentencing date.

The Unit's MOU with the State Medicaid agency does not reflect current requirements.

- **Update the Unit's MOU with the State Medicaid Agency to Comply with Federal Grant Requirement.**

We concur. The current MOU between the MFCU and the single state agency (SSA) is currently being rewritten to address the issues of provider payment suspension as prescribed in 42 CFR 455.23. This revision will also make reference to the Illinois False Claims Act. We anticipate it will be completed by October 1, 2013.

Unit case files lacked supervisory approval and documentation of reviews of case files.

- **Ensure that all case Files Contain Opening and Closing Investigative Memoranda, Documented Supervisory Approvals, and Documented Periodic Supervisory Reviews.**

We concur in part. All investigative cases must be opened via an ISP 4-1 Report (Case Initiation). That report requires the supervisor's approval and signature, and all case closures require an ISP 4-8 Report (Case Action), again requiring a supervisor's approval and signature. Although completed as required, we agree not all these reports made it to the file in our Records Bureau. We also agree not all supervisory and command case reviews conducted were properly documented. As noted in the audit report, efforts to correct these issues have been made by the new director and will continue until the issue is rectified. The Unit will develop a checklist for case closures to ensure a file is complete before it is forwarded to our Records Bureau.

The Unit investigated three cases in our sample unrelated to Medicaid and one case did not follow prosecution referral protocol.

- **Ensure Referrals for Prosecution Follow Established Protocol.**
- **Ensure Investigations are Related to Medicaid and Repay Grant Funds for Ineligible Cases.**

We concur. All the cases were originally opened believing there was a Medicaid nexus. Once it was clear there was not, all investigations were promptly closed. The prosecution protocols are being reviewed to standardize the process statewide. Uniform procedures addressing the prosecution of Medicaid fraud cases will be addressed in the revised MOU with the AGO.

The Unit's director and management team reported the case management and tracking system is inadequate.

- **Upgrade the Unit's Case Management and Tracking System.**

We concur. In 2010, the Unit contracted with [REDACTED] to implement a new case management system. [REDACTED] had worked with other MFCUs. By 2012, it became clear [REDACTED] was not going to be able to implement his case management system in Illinois. We conducted research with various other MFCUs to identify a viable system that has demonstrated capabilities that meet grant requirements not only for investigative files but also for the federal reporting requirements. Our Unit is currently working through the procurement process to acquire a new system and it is anticipated we will identify a vendor and begin implementing a new system by December 2013.

Key stakeholders reported a lack of communication and cooperation from the Unit's Northern command.

- **Improve Communication and Cooperation with Key Stakeholders.**

We concur in part. The Unit has identified a sometimes-stressed relationship with the U. S. Attorney's Office for the Northern District of Illinois. The Unit understands the need for a better working relationship and has and will continue to

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reach out to our federal partners.

Unit training plans did not identify a minimum number of required training hours for each professional discipline.

- **Establish Training Hour Requirements for Professional Disciplines.**

We concur. Our Unit is already revising its training policy to include a minimum number of training hours for each professional discipline. We anticipate that the policy will be completed within the next 30 days.

Thank you for taking the time to audit the Illinois MFCU and bringing these concerns to my attention. Please feel free to contact Captain William Sheridan, MFCU Director, at 217/785-3321, with any further questions regarding this review.

Sincerely,

/S/

Hiram Grau
Director

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