Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Illinois Comprehensive Program Integrity Review

Final Report

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Illinois Medicaid program. The MIG conducted the onsite portion of the review at the Illinois Department of Healthcare and Family Services (HFS), Office of Inspector General (HFS-OIG) office. The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of HFS-OIG within HFS which is primarily responsible for Medicaid program integrity oversight. This report describes three noteworthy practices, three effective practices, six regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Illinois improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Illinois's Medicaid Program

The HFS administers the Illinois Medicaid program. As of January 2011, the program served approximately 2,480,000 beneficiaries, with 196,454 enrollees in one of the three managed care organizations (MCOs). All Medicaid providers must enroll in the Illinois Medicaid program and as of January 1, 2011, there were 142,547 participating providers. Medicaid expenditures in Illinois for the State fiscal year (SFY) ending June 30, 2010 totaled $14,407,139,465.

Office of Inspector General

The HFS-OIG is the organizational component responsible for carrying out the Medicaid program integrity activities for the organization. At the time of our review, the HFS-OIG had approximately 125 full-time equivalent (FTE) employees. This represented a 29 percent drop in authorized FTEs from SFY 2009, with the chief reductions occurring in managers and support staff. From SFY 2008 through SFY 2010, HFS-OIG staff conducted an annual average of 635 preliminary and 413 full investigations. The table below presents the total number of investigations, and overpayment amounts for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2008	873	581	$26,779,023	$22,858,498
2009	661	313	$26,954,203	$26,355,301
2010	574	487	$18,584,787	$10,929,229***
2011****	432	270	$9,353,574	$5,271,069

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
*** HFS-OIG conducted fewer audits due to staff attrition and putting more resources into a new predictive modeling system. In addition, there is generally a two year cycle between audits, which sometimes leads to significant crests and declines.
**** The figures for SFY 2011 represent partial year data.

Methodology of the Review

In advance of the onsite visit, CMS requested that Illinois complete a comprehensive review guide and supply documentation in support of its answers to the review guide. The review guide included such areas as provider enrollment, program integrity, managed care and the MFCU. A five-person team reviewed the answers and documents that the State provided in advance of the onsite visit.

During the week of May 9-13, 2011, the MIG review team visited the HFS-OIG offices and also met with the MFCU director. The review team conducted interviews with numerous officials from HFS, including the Provider Participation Unit (PPU), which oversees provider enrollment. The review team also met with the MFCU.

Illinois has nine home and community-based services (HCBS) waiver programs, eight of them overseen by sister agencies outside HFS. These include the Department of Human Services (DHS) which runs waiver programs through its Division of Rehabilitation Services (DRS) and Division of Developmental Disabilities (DDD), the Department on Aging (DOA), and the University of Illinois – Division of Specialized Care for Children (DSCC). The team interviewed the DHS staff who oversee the DRS and DDD waiver programs and reviewed enrollment documents for the waiver programs run by DOA and DSCC.

To assess MCO compliance with State requirements and Federal regulations on program integrity, the MIG team reviewed the State-MCO contracts and interviewed personnel from three of the MCOs. The team also met with staff from the HFS Bureau of Managed Care (BMC), which oversees the managed care program. In addition, the team conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the HFS-OIG as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care, and the non-emergency medical transportation program, which uses the acronym NET in Illinois.

Illinois operates its Children's Health Insurance Program (CHIP) both as a stand-alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as Illinois' Title XIX program. The same noteworthy and effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the expansion CHIP. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, Illinois provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that the State provided.

Results of The Review

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified three practices that merit consideration as noteworthy or "best" practices. The CMS recommends that other States consider emulating these activities.

Predictive modeling system

The HFS-OIG has developed an in-house predictive modeling system that will utilize cutting edge predictive modeling techniques to detect aberrant provider behaviors at the earliest possible time. While the fraud prediction applications of the tool have yet to be fully tested and applied, the system has created a comprehensive provider profile report that is already in use. It offers a consolidated snapshot of provider patterns and activities drawing on data from diverse sources and different parts of the agency. The profile report gives HFS-OIG staff quick access to complete up-to-date information on providers of interest as they plan investigations, audits or quality of care reviews. Without it, staff would have to wait lengthy periods for different parts of the agency to supplement baseline data with other relevant information.

The provider profile tool has been utilized in the 180 day monitoring of probationary NET providers and the ongoing audits of transportation providers since March 2009. According to State data, the cost avoidance realized for disenrolling or terminating probationary providers in calendar year (CY) 2010 was $276,478. Likewise, the profiling tool helped Illinois establish a recoupment target of $227,330 as the basis for transportation provider audits. Moreover, as part of the State's work on provider

profiling, HFS-OIG redesigned its Non-Corresponding Medical Services report for transportation services. This is a report which identifies NET billings that cannot be matched up with medical services for which transportation assistance was needed. At the time of the review, the State had identified 412 providers who received potential overpayments of $7,000,000.

Wide range of administrative sanctions, including the ability to impose corporate integrity agreements (CIAs)
The HFS-OIG utilizes a wide range of sanctions to foster provider compliance from provider education up to and including termination. Its flexible provider lock-in programs include limiting provider participation for varying periods of time, disallowing the use of alternate payees or granting power of attorney to anyone else, requiring submission of tax returns, limiting a provider's practice to one site, and the use of individual CIAs.

By requiring certain providers to sign CIAs as a condition of their continued participation in Medicaid, the HFS-OIG is able to commit providers to such program integrity obligations as adherence to a code of conduct and full compliance with all the statutes, regulations, directives, provider notices, and guidelines that are applicable to the State Medicaid Assistance Program. The CIA can also be used to require specific forms of training and education and compliance with relevant certification and reporting requirements. At the time of the review, Illinois had 10 providers operating with required CIAs whom it might otherwise have had to terminate from the Medicaid program.

Illinois MCO network providers must be enrolled in the Medicaid program
Illinois maintains a centralized screening process for all MCO network providers by requiring the providers to enroll in the Illinois Medicaid program. This strategy helps to mitigate vulnerabilities found in other States where the State relies on contracted MCOs to collect network provider disclosures, check providers and affiliated parties for exclusions and oversee other aspects of the provider enrollment process. The State is currently implementing a mandatory integrated managed care program for the Aged, Blind and Disabled population and considering other managed care expansions. The centralized enrollment process for providers should prove useful for front end screening purposes as the managed care program grows. However, its value is diminished because the State does not require its MCOs to report adverse actions taken against network providers. This is discussed in the Vulnerabilities section of this report.

Effective Practices
As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Illinois reported the expediting of certain hearing and review procedures, pre-enrollment verification of new NET and durable medical equipment (DME) providers, and special controls on group psychotherapy and NET services.

Expedited hearing and review procedures within HFS-OIG

The HFS-OIG's Bureau of Administrative Litigation (BAL) has implemented two new initiatives aimed at improving the efficiency and overall management of cases within the agency. These procedures are known as the "Preliminary Call" and "Expedited Recoupment." In recent years, half of the BAL's cases have been reassigned to the Preliminary Call, a single extended monthly call in which hearings are streamlined to allow expedited prosecution of cases. Management of the Preliminary Call is assigned to one BAL attorney, leaving other BAL attorneys available to focus on the prosecution of more complicated and high priority termination and recoupment cases. The types of cases heard on the Preliminary Call deal with limited legal issues and actions such as termination, conviction, and loss of Medicare billing privileges. In most instances, Preliminary Call cases are resolved in one hearing. Expedited Recoupment procedures in turn have permitted the State to devote more resources to priority cases involving administrative actions against high risk providers.

As a result of these initiatives, BAL's case management process has become significantly more efficient, doubling the number of resolved cases and monetary recoupment each year. The BAL's focus on NET and group psychotherapy providers, which comprised 70 percent of all cases referred for administrative action, alone yielded over 43 provider terminations and 90 debarments of owners and managers of NET and group psychotherapy companies over the course of the last three years. Additionally, through final administrative decisions and settlements during this time period, BAL recovered over $20 million in overpayments.

NET and DME new provider pre-enrollment verification

Prior to enrolling NET providers in the Medicaid program, HFS performs background checks, fingerprinting, verification of safety training certification and onsite visits. The DME providers are also subject to onsite visits.

In CY 2010, 237 NET and DME providers underwent pre-enrollment verifications. A total of 17 applications were returned to the provider for reasons such as an incomplete enrollment package, inability to contact the applicant, and the applicant not complying with fingerprinting. Four applicants were denied enrollment for reasons such as not establishing ownership of the vehicles.

The State reported that the practice of pre-enrollment verification yielded $2,412,731 for the Illinois Medicaid program during CY 2010.

Controls on group psychotherapy and NET services (NETS)

Group psychotherapy providers within Illinois have been known for their fraudulent billing practices in conjunction with transportation to these services. In an effort to curb abuse, the State promulgated rules in March 2009 which required board certified psychiatrists to provide group psychotherapy services and which limited the frequency of services to no more than two times per week for a given beneficiary.

In the 10 months before MIG's 2011 review, the State began reviewing transportation

requests as part of its NETS Prior Approval Program. The State implemented a Psychiatric Services Treatment Plan form in July 2010 that must be completed before transportation to behavioral health services will be authorized. The appointment information contained in the form is then verified or the requested trip is denied. Since July 2010, only 141 of 1,961 trip requests have been approved.

Although exact figures were not available, as the dramatic drop in approved NET trips suggests, the State rule change and policy on prior approval of NET requests have significantly curbed Medicaid payments for transportation to questionable group psychotherapy services.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to certain disclosure and notification requirements as well as requirements on mandatory exclusions and exclusion searches.

The State does not capture all required ownership, control, and relationship information from FFS providers, agencies in the HCBS waiver programs, the dental program administrator, and MCOs.

Under the version of 42 CFR § 455.104 in effect until March 25, 2011, a provider, or "disclosing entity," must disclose the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling, and under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The regulation was amended effective March 25, 2011. The amendment adds requirements for provision of Social Security Numbers (SSNs) and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. The CMS team reviewed Illinois' provider enrollment packages, disclosure forms, contracts and other provider agreements for compliance with both the prior version of the regulation and the regulation as amended. Any actions the State takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

The MIG 2008 program integrity review found that Illinois was not collecting all the ownership and control disclosure information required in the previous version of 42 CFR § 455.104. While Illinois added the information on the form for FFS providers as a corrective action, the form has not been updated since 2009 and does not include the new information required by the amendment to the regulation.

Most of the HCBS waiver programs in Illinois use different enrollment and disclosure forms

from the FFS program. While the specific compliance issues varied across the waiver programs, all programs failed in some way to obtain all required disclosure and ownership information from applicable parties. The only disclosure information collected from the majority of the waiver providers was the name, SSN, and percentage of ownership for owners/stockholders holding more than 5 percent of the shares. In the State's elderly HCBS waiver program, DOA did not solicit the address or relationship of persons with 5 percent or greater ownership or control interests in the disclosing entity and affiliated subcontractors. It also failed to collect information on other disclosing entities that have persons with ownership and control interests in common.

The State's dental program administrator, which functions as a fiscal agent, also did not provide the required disclosures prior to contracting with the State. The Request for Proposals did not solicit information on persons with control interests or the subcontractor information specified in § 455.104(a)(1), the relationship information in (a)(2), or the other disclosing entity information in (a)(3) of the regulation.

Lastly, in its managed care program, Illinois contractually requires disclosure information to be submitted by the MCOs on an annual basis. Although the contract between the State and MCOs makes only a general reference to meeting the disclosure requirements in 42 CFR Part 455, health plan ownership and control disclosures met the standards of the previous language in 42 CFR § 455.104. However, upon review, the team found that disclosure information provided by the MCOs was not fully compliant with the updated regulation because two of the MCOs provided incomplete information on the names of managing employees, SSNs, and dates of birth.

Recommendations: Modify all provider enrollment applications and contracts to capture all elements of the required ownership, control, and relationship information under 42 CFR § 455.104 that went into effect March 25, 2011. Obtain necessary disclosures from all disclosing entities and their subcontractors, MCOs, and contractors performing fiscal agent functions.

Illinois does not require HCBS waiver program providers to disclose business transaction information, upon request.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or the U.S. Department of Health and Human Services (HHS) information about certain business transactions with wholly owned suppliers or any subcontractors.

The provider agreements used in the DDD and DRS HCBS waiver programs did not contain any language requiring providers to furnish the State or HHS, on request, with information on business transactions with wholly owned suppliers or any subcontractors. In the elderly waiver program administered by DOA, the agreement does not address the need for the provider to furnish business transaction information on request to the State or HHS, nor does the agreement reference the Federal regulation in lieu of such language. In the Specialized Care for Children waiver program, nursing agency providers must complete the State's provider agreement which meets the regulation. However, there was no indication that other provider types utilize this form.

Recommendation: Modify all provider enrollment agreements and State contracts with the HCBS waiver programs to require disclosure, upon request, of the information identified in 42 CFR § 455.105.

Illinois does not collect health care-related criminal conviction disclosures in the HCBS waiver programs.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

Illinois' HCBS waiver programs do not require the providers to disclose health care-related criminal convictions pertaining to owners, agents, and managing employees as stipulated in the regulation.

The Legal Entity Application used in the DOA-run elderly HCBS waiver program asks the applicant to indicate if any of the listed business practices have occurred in the 10-year period preceding the date of the application. It does not require the reporting of healthcare-related criminal convictions "since the inception" of the Medicare, Medicaid, and Title XX programs as the regulation requires.

Recommendations: Modify provider enrollment forms in the waiver programs to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement policies and procedures to report criminal conviction information to HHS-OIG in accordance with 42 CFR § 455.106(b)(1).

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.
Effective March 25, 2011, the Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the HHS-OIG's List of Excluded Individuals/Entities and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

Upon enrollment, the HFS PPU checks providers against the Illinois sanction database, which includes the State's internal sanctions list and information received monthly from the Medicare Exclusion Database (MED). This same list is used to conduct monthly searches of all providers. However, at the time of the review, the State was not searching the EPLS as required by 42 CFR § 455.436(c)(2) at the time of enrollment or subsequently on a monthly basis.

Further, the State does not store the complete information required on owners, agents and

managing employees in the Medicaid Management Information System or an alternate searchable database. As a result, the State is not able to conduct comprehensive monthly exclusion searches on all affiliated parties referenced in the regulation.

Recommendations: Develop a mechanism to capture complete information on providers, persons with ownership or control interest, directors, officers, managing employees, partners, and agents in a searchable database. Develop and implement policies and procedures for conducting monthly searches of all required individuals in the EPLS in addition to the MED and Illinois' sanction database.

The State does not report adverse actions taken on provider applications to HHS-OIG. The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State indicated that it does not notify HHS-OIG when it denies enrollment to a provider for reasons of fraud, integrity, or quality. The HFS-OIG said that it only reports terminations, since by State law it is not able to terminate someone (and subsequently place them on their internal sanctions database) who is not enrolled in the Medicaid program. However, the State statute does not preclude HFS-OIG from also reporting denials on applications.

In reviewing a sample of cases where adverse actions had been taken, the team identified 3 out of 20 cases for which no notification was sent to HHS-OIG. In 2 other cases, the notifications were not made within 20 days, although it was unclear whether the provider had filed an appeal within the 35 days allotted by the State.

Recommendation: Ensure that all applicants who are denied enrollment to the Medicaid program due to concerns with fraud, integrity, or quality are reported to HHS-OIG within 20 days of such action.

The State's MCO contracts contain no provision for excluding managed care plans. The regulation at 42 CFR § 1002.203 stipulates that the State must provide that it will exclude from participation any health maintenance organization (HMO), or entity furnishing services under a 1915(b)(1) waiver, if such organization or entity could be excluded under 42 CFR § 1001.1001 or § 1001.1051, or has a direct or indirect contractual relationship with an individual or entity that could be excluded under §1001.1001 or § 1001.1051.

The State does not have a statutory provision in the MCO contractual language that stipulates it will exclude from doing business any HMO that could be excluded for the reasons listed in 42 CFR § 1001.1001 or 42 CFR § 1001.1051. These regulations require the exclusion of entities owned or controlled by a sanctioned person and the exclusion of individuals with ownership or control interests in sanctioned entities.

Recommendation: Insert appropriate language in the MCO contracts to meet the requirements of 42 CFR § 1002.203.

Vulnerabilities

The review team identified four areas of vulnerability in Illinois's program integrity practices. These include problems in HFS-OIG's relationship with the MFCU, inadequate review of licenses, the failure to report adverse actions taken on MCO provider networks and inadequate oversight of MCO program activities.

Inadequate CMS fraud referral performance standard practices and cooperation between HFS-OIG and the MFCU.

Effective March 25, 2011, the regulation at 42 CFR § 455.23 requires that the State agency suspend payments to providers against whom there is a credible allegation of fraud unless the agency has good cause not to suspend payments or to suspend payments only in part. Section 455.23(d)(2)(ii) of this regulation also requires that State agencies incorporate the minimum standards adopted by the HHS Secretary when preparing referrals of suspected Medicaid fraud cases to the MFCU. The minimum fraud referral standards were previously issued by CMS in September 2008. At the time of the review, the State agency had not made any fraud referrals to the MFCU since the March 25, 2011 effective date. However, the MIG team determined that HFS-OIG referrals made prior to March 25, 2011 did not meet the September 2008 fraud referral standards. For example, the HFS-OIG leadership stated that the agency adhered to a different referral checklist and content guidelines jointly established with the MFCU at an earlier date. However, as part of its established policy, HFS-OIG sent all complaints, whether fully researched or not, to the MFCU.

Both the HFS-OIG and the Illinois MFCU reported that the relationship between the two organizations is not harmonious, citing examples of variances in practices, policies and terminology, which resulted in significant challenges to each organization's ability to achieve its goals. However both the HFS-OIG and the MFCU also reported that significant steps were being taken to resolve issues and improve the relationship. For example, the MFCU was shortly to be given access to the State agency's data warehouse and the organizations had recently reached an understanding about using common case referral numbers on the quarterly case tracking reports. Plans to restore more flexible direct communications were also under discussion. While these examples demonstrate progress in improving the relationship, much work to restore effective communications is necessary.

***Recommendations*:** Implement the use of CMS-MIG Performance Standard For Referrals Of Suspected Fraud From A Single State Agency To A Medicaid Fraud Control Unit in documenting all MFCU referrals. Resume regular, in-person meetings between the organizations to discuss potential fraud referrals, standardize policies and procedures, and ensure more effective communication and cooperation.

Inadequate review of provider licenses.

The State has inadequate procedures in place to ensure that it has thoroughly screened provider applicants in the Medicaid program, particularly with regard to licensure checks. During interviews, PPU representatives indicated that provider enrollment staff accepted copies of the license submitted by a provider as the sole verification of licensure. The State

did not check the Department of Professional Regulation's (DPR) website to ensure the license was valid unless it happened to expire during the weeks while the State was processing the application.

Further, if PPU staff did check licensure on the DPR's website and find the provider's license to be restricted or that disciplinary action was being taken against the provider, they would normally take no action on the information, nor would they consult with another division, such as HFS-OIG's Bureau of Medicaid Integrity, Peer Review Section, to determine whether it is appropriate to continue enrolling the provider. The PPU will continue to enroll the provider as long as the status on the license is "active." The absence of internal controls and clear procedures on licensure checks leaves the Medicaid program vulnerable to enrolling high-risk providers and/or providers who would otherwise be excluded from participation.

Recommendations: Develop policies and procedures for conducting verification of all professional licenses with the licensing agency. Develop a mechanism to alert the appropriate component within HFS to any limitation or disciplinary action which a license check reveals prior to enrolling any provider.

Not reporting to HHS-OIG adverse actions taken on managed care network provider applications.

The State Medicaid agency does not require its MCOs to inform the agency when the MCOs have denied enrollment or credentialing to a provider due to program integrity concerns. One MCO acknowledged in the interview that it was not reporting program integrity-related denials of enrollment. The failure to transmit this information leaves the State unable to report such denials to HHS-OIG as the regulation at 42 CFR §1002.3(b)(3) would require it to do when taking adverse actions against FFS providers.

Recommendations: Modify the HFS contracts with MCOs to require reporting to the State all adverse actions taken on provider network applications for program integrity reasons. Develop and implement policies and procedures to ensure that the State reports all applicable MCO adverse actions to HHS-OIG.

Insufficient oversight of MCO program integrity activities.

The BMC exercises limited oversight over the program integrity activities of managed care contractors. As a result, it is not fully informed about MCO program integrity efforts or the information that plans may or may not be giving enrollees on how to report suspected fraud and abuse.

The BMC's contract with each of the MCOs requires that a compliance plan be established. However, during interviews with the MCOs, it was mentioned that the State has never requested, nor reviewed, the compliance plan of the MCOs to ensure it is in accordance with contract requirements.

Although BMC has standard operating procedures for dealing with marketing fraud, it does not have policies and procedures explaining how it will oversee MCO activities to prevent and detect provider fraud, waste and abuse. The BMC provides a number of general program integrity requirements in its contract with the MCOs. However, without having written policy and procedures on how its staff will monitor and enforce those requirements, the State is vulnerable to inconsistent operations and ineffective functioning in the event it needs to replace managed care staff.

The BMC's contract with the MCOs requires the plans to notify the State of investigations. During an interview with one MCO which had conducted investigations, the MCO indicated that the State is only notified upon the initiation of an investigation. The plan maintained that it is not contractually required to provide updates on the status of the investigation. As a result, the State is not aware of the status or outcome of MCO provider investigations. Without this information, the State is unable to obtain a comprehensive view of provider investigations across MCO and FFS delivery systems.

The team also observed that one of the MCO's beneficiary handbooks did not contain any information on how to report fraud, waste, or abuse. The absence of such information may leave beneficiaries unaware of whom to contact in case they have knowledge of fraud, waste or abuse to report.

Recommendations: Establish contract provisions requiring periodic MCO reporting on cases of suspected fraud and abuse from the point of case initiation to conclusion of the investigation. Contractually require the regular reporting of other relevant information on MCO fraud prevention and detection activities as well as enrollee handbook information explaining how beneficiaries may report suspected fraud and abuse. Develop and implement State policies and procedures to ensure that such contract provisions are enforced.

Conclusion

The State of Illinois practices several noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- a predictive modeling system,
- a wide range of administrative sanctions, including individual provider CIAs,
- mandatory enrollment of all MCO providers in the Medicaid program,
- procedures for expediting certain provider hearings and reviews,
- site visits and enhanced screening requirements for new NET and DME providers, and
- expanded prior authorization and utilization controls on group psychotherapy and NET providers.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages HFS and HFS-OIG to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Illinois to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Illinois will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Illinois has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Illinois on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Illinois
February 2012

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February 16, 2012

Mr. Robb Miller, Director
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Re: Illinois Comprehensive Program Integrity Review Final Report

Dear Mr. Miller:

The Department is in receipt of the Illinois Comprehensive Program Integrity Review Final Report. Provided below are the State's responses for each area of non-compliance. Also enclosed are the corrective action plans for each issue reported.

Regulatory Compliance Issue: *The State does not capture all required ownership, control, and relationship information from FFS providers, agencies in the HCBS waiver programs, the dental program administrator, and MCOs.*

Recommendation: Modify all provider enrollment applications and contracts to capture all elements of the required ownership, control, and relationship information under 42 CFR 455.104 that went into effect March 25, 2011. Obtain necessary disclosures from all disclosing entities and their subcontractors, MCOs, and contractors performing fiscal agent functions.

Response: The Department accepts the recommendation. HFS will revise all provider enrollment applications and contracts so as to capture all required elements outlined in 42 CFR 455.104 (effective March 25, 2011) such as ownership, control and relationship information. Disclosing entities and their subcontractors, MCOs, and contractors performing as fiscal agents will be required to complete these revised applications and contracts at the time of initial enrollment as well as upon re-enrollment.

Regulatory Compliance Issue: *Illinois does not require HCBS waiver program providers to disclose business transaction information, upon request.*

Recommendation: Modify all provider enrollment agreements and State contracts with the HCBS waiver programs to require disclosure, upon request, of the information identified in 42 CFR 455.105.

Response: The Department accepts the recommendation. All provider enrollment agreements and State contracts associated with the HCBS waiver programs will be revised to require disclosure, upon request, of the business transaction information outlined in 42 CFR 455.105.

Regulatory Compliance Issue: *Illinois does not collect health care related criminal conviction disclosures in the HCBS waiver programs.*

Recommendation: Modify provider enrollment forms in the waiver programs to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement policies and procedures to report criminal conviction information to HHS-OIG in accordance with 42 CFR 455.106(b)(1).

Response: The Department accepts the recommendation. Provider enrollment applications in the waiver programs will be revised in order to be in compliance with the full criminal conviction disclosure requirements pertaining to owners, agents, and managing employees. In addition, policies and procedures will be developed to report all criminal conviction information obtained through these disclosures to HHS-OIG in accordance with 42 CFR 455.106(b)(1).

Regulatory Compliance Issue: *The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.*

Recommendation: Develop a mechanism to capture complete information on providers, persons with ownership or control interest, directors, officers, managing employees, partners, and agents in a searchable database. Develop and implement policies and procedures for conducting monthly searches of all required individuals in the EPLS in addition to the MED and Illinois' sanction database.

Response: While the Department accepts the recommendation, a mechanism for capturing complete information on providers, persons with ownership or control interest, directors, officers, managing employees, partners, and agents can only be implemented when the Department is granted access to an EPLS file that contains identifiers that can be used to perform effective systematic searches and matches. The Department will continue to check applicants upon enrollment and re-enrollment and also review providers on a monthly basis against the Illinois Sanctions Database which contains sanctions from the Medicare Exclusion Database. The Department cannot retain information on persons with ownership or control interest, directors, officers, managing employees, partners, and agents until the new Medicaid Management Information System is fully operational.

Regulatory Compliance Issue: *The State does not report adverse actions taken on provider applications to HHS-OIG.*

Recommendation: Ensure that all applicants who are denied enrollment to the Medicaid program due to concerns with fraud, integrity, or quality are reported to HHS-OIG within 20 days of such action.

Response: The Department accepts this recommendation. OIG currently notifies HHS-OIG of all HFS' sanctions (terminations, barrments, and suspensions) and reinstatement of providers enrolled in the Illinois Medicaid program. The Department will develop a process to notify HHS-OIG of all applicants that are denied enrollment in the Illinois Medicaid program.

Regulatory Compliance Issue: *The State's MCO contracts contain no provision for excluding managed care plans.*

Recommendation: Insert appropriate language in the MCO contracts to meet the requirements of 42 CFR 1002.203.

Response: The Department accepts the recommendation. HFS has amended the contract for Furnishing Health Services by a Managed Care Organization effective October 1, 2011 to meet the requirements of 42 CFR 1002.203.

Vulnerability: *Inadequate CMS fraud referral performance standard practices and cooperation between HFS-OIG and the MFCU.*

Recommendation: Implement the use of CMS-MIG Performance Standard for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit in documenting all MFCU referrals. Resume regular, in-person meetings between the organizations to discuss potential fraud referrals, standardize policies and procedures, and ensure more effective communication and cooperation.

Response: The Department accepts this recommendation. OIG's relationship with MFCU has been strained over the past several years; however, the November 1, 2011 appointment of a new Inspector General who previously worked in the Medicaid Fraud Control Unit has drastically modified this situation. New policies regarding referrals are being developed with an eye towards much closer cooperation throughout the investigative process and in conjunction with all Performance Standards.

Vulnerability: *Inadequate review of provider licenses.*

Recommendation: Develop policies and procedures for conducting verification of all professional licenses with the licensing agency. Develop a mechanism to alert the appropriate component within HFS to any limitation or disciplinary action which a license check reveals prior to enrolling any provider.

Response: The Department accepts the recommendation. The Provider Participation Unit has developed policies and procedures to ensure that all professional licenses are verified upon an applicant's request for enrollment into the Medicaid Program as well as during the upcoming re-enrollment process for existing providers. It is worthy to note that the Provider Participation Unit does currently review on a regular monthly basis the Expired License Report with action being taken as warranted. This unit plans on continuing with this type of review. Policy and procedures have also been developed to ensure the Unit Manager of the Provider Participation Unit notifies HFS-OIG in writing of any limitation or disciplinary action which a license check revealed prior to enrolling a new applicant or re-enrolling any existing provider.

Vulnerability: *Not reporting to HHS-OIG adverse actions taken on managed care network provider applications.*

Recommendation: Modify the HFS contracts with MCOs to require reporting to the State all adverse actions taken on provider network applications for program integrity reasons. Develop and implement policies and procedures to ensure that the State reports all applicable MCO adverse actions to HHS-OIG.

Response: The Department accepts the recommendation. HFS has amended the contract for Furnishing Health Services by a Managed Care Organization effective October 1, 2011 to require contractors to report to the Department within 30 days if the contractor does not credential or enroll a provider due to the contractor's concerns about fraud, integrity or quality. The amendment also requires 30 day notification to the Department if the contractor de-credentials or terminates a provider for these same concerns.

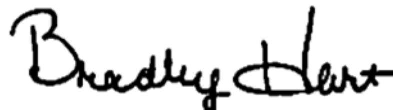
Vulnerability: *Insufficient oversight of MCO program integrity activities.*

Recommendation: Establish contract provisions requiring periodic MCO reporting on cases of suspected fraud and abuse from the point of case initiation to conclusion of the investigation. Contractually require the regular reporting of other relevant information on MCO fraud prevention and detection activities as well as enrollee handbook information explaining how beneficiaries may report suspected fraud and abuse. Develop and implement State policies and procedures to ensure that such contract provisions are enforced.

Response: The Department accepts the recommendation. HFS has amended the contract for Furnishing Health Services by a Managed Care Organization effective October 1, 2011 to require the MCO to provide its Fraud and Abuse Log on a quarterly basis, showing suspected fraud and abuse from the point of case initiation to conclusion of the investigations. The contractor shall submit a quarterly report certifying that the report includes all instances of suspected fraud and abuse or that there wasn't any suspected fraud and abuse during that quarter. Additionaly, the contractor is required to submit its compliance plan designed to guard against fraud and abuse to the Department for prior approval intially and annually. The Department is currently in the process of developing policies and procedures to ensure that such fraud and abuse contract provisions are enforced.

We appreciate the work completed by your team. If you have any questions or comments about our response to the audit, please contact Jamie Nardulli, External Audit Liaison, at (217) 558-2527 or through email at jamie.nardulli@illinois.gov.

Sincerely,



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