Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Illinois Focused Program Integrity Review

Final Report

January 2019

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Illinois to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in the calendar year 2014.

Background: State Medicaid Program Overview

The Illinois Department of Healthcare and Family Services (HFS) administers the Illinois Medicaid program. The Office of Inspector General (OIG) is maintained within the agency, but functions as a separate, independent entity reporting directly to the governor's office and is responsible for the prevention and detection of fraud, waste, abuse, misconduct, and mismanagement in the programs administered by the Departments of Healthcare and Family Services and Human Services. The Illinois contracts with a mix of health plans. At the time of the review, Illinois had contracts with nine plans to provide managed health care services. Those plans were: Aetna Better Health, Blue Cross Blue Shield of Illinois, County Care, Harmony Health Plan, Humana, IlliniCare, Meridian, Molina, and NextLevel Health.

As of July 1, 2018, the program served approximately 3,159,553 beneficiaries. Illinois has a managed care program which operates statewide and serves approximately 2,272,138 beneficiaries, or 72 percent of Illinois's Medicaid population. At the time of the review, the Illinois Medicaid program had nine managed care organizations (MCOs) enrolled in the state's managed care program. Total Medicaid expenditures for federal fiscal year (FFY) 2017 were approximately $15.1 billion. Total capitated payments to MCOs during FFY 2017 were approximately $6.7 billion or 44 percent of the total Medicaid expenditures.

Illinois elected to expand Medicaid coverage to low-income adults. The Federal Medical Assistance Percentage in Illinois is 51.30 percent.

Methodology of the Review

In advance of the onsite visit, CMS requested that Illinois and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of August 20, 2018, the CMS review team visited Illinois HFS. It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with the state's MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted a sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

Section 1: Managed Care Program Integrity

Overview of the District's Managed Care Program

Approximately 2,272,138 beneficiaries, or 72 percent of the state's Medicaid population, were enrolled in nine MCOs during FFY 2017. The state spent approximately $6.7 billion on managed care contracts in FFY 2017.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review: CountyCare, Harmony Health Plan, and NextLevel Health.

The CountyCare (hereinafter referred to as CC), is a Medicaid only plan, owned and operated under Cook County Health and Hospitals Systems (CCHHS) serving family health plan and seniors and persons with disabilities living in Cook County. The CC was established October 2012 under CMS 1115 waiver to early enroll Affordable Care Act -eligible adults into managed care. The CC was awarded the new HealthChoice Illinois contract with HFS effective January 1, 2018, to serve Cook County, Illinois Medicaid enrollees. The CC's membership increased from 132,000 to 330,000 under the new contract due to other plans leaving the market. The CC's SIU consists of seven full-time employees (FTEs), one executive leadership, one internal auditor, three-and-a-half investigators, and one-and-a-half compliance analysts that are fully-dedicated to program integrity, fraud, waste, and abuse activities. The CC also holds a contract with a third-party administrator (TPA) to conduct program integrity activities for medical and behavioral health. The TPA conducts investigations, reporting of case tracking, investigation summaries, data and algorithm reviews. The CC's provider relations representatives conduct onsite visits of provider locations. Additionally, the MCO SIU conducts unannounced in-depth provider site visits to investigate findings or allegations of claims fraud. To get an accurate description of a provider's activity, the CC will send an investigator to perform the onsite investigation which includes a room-to-room investigation of the location to retrieve pertinent records and document the facilities and equipment. The CC also has the ability to utilize the investigators for surveillance outside provider sites to document patient traffic and daily activity. However, the CC has not conducted announced or unannounced site visits in the past year. In addition, the program integrity unit (PIU) does not conduct pre-/post-enrollment unannounced provider site visits.

Harmony Health Plan (hereinafter referred to as Harmony), a WellCare Company, is a licensed Illinois health maintenance organization providing services to Medicaid beneficiaries under HealthChoice Illinois and to Medicare Advantage members. Currently, they serve approximately 253,578 Medicaid beneficiaries and 16,436 Medicare Advantage members. Harmony provides services throughout the state of Illinois. Harmony has provided benefits in the state of Illinois since 1995. Harmony's SIU is responsible for the detection, prevention, investigation, reporting, correction, and deterrence of fraud, waste, and abuse. Harmony's Compliance Director and one investigator are physically located in Chicago, Illinois. The Corporate Compliance Investigations Department is directed by a Vice President who reports directly to the Chief Compliance Officer. The SIU employs a team of 42 individuals. Of these 42 FTEs, ten are assigned to Harmony. The team is led by the SIU's Senior Director, who provides day-to-day guidance and supervision of two SIU Investigations Managers, a Coding Auditor Manager, and a Data/Reporting Manager. The SIU team includes Investigators who collaborate with Medical Coding Auditors and Clinical Nurses to resolve allegations of fraud, waste, and abuse on the part of medical providers and members. The SIU's Analyst Team is responsible for identifying possible cases of fraud, waste, and abuse by utilizing data analytics tools. The SIU Business Analysts and Information Case Admins provide additional support for case referrals, case management system, SIU anti-fraud hotline, and the SIU's regulatory reporting responsibilities as needed.

NextLevel Health (hereinafter referred to as NextLevel) is a local managed care health plan for Cook County Medicaid residents. Currently, they serve approximately 57,812 Medicaid beneficiaries. NextLevel has provided benefits in the state of Illinois since January 1, 2016, however, Next Level's SIU was not implemented until June 1, 2018. According to their contract with the state, they must have one dedicated investigator per 100,000 beneficiaries. The SIU has responsibility for identifying and collecting overpayments associated with program integrity auditing/investigative activities. The Claims Department has responsibility for collecting overpayments not associated with FWA. NextLevel contracts with entities who conduct program integrity activities as part of their delegation agreement with NextLevel: Envolve Vision reviews outlier activity from normal practice patterns; Liberty Dental provides a report card that covers call center, claims, grievances, and credentialing; and MeridianRx runs data mining reports to track and trend outliers for potential fraud, waste, and abuse. MeridianRx is not a current delegate entity for NextLevel. As of January 1, 2018, Envolve Pharmacy Solutions took over these responsibilities. NextLevel has not conducted any unannounced site visits since enrolling as an MCO. Currently, their contracts with providers do not allow them to conduct unannounced site visits. They are in the process of amending their contract language to allow unannounced site visits. In addition, NextLevel does not conduct pre-/post-enrollment provider site visits.

Enrollment information for each MCO as of July 2018 is summarized below:

Table 1.

	CC	Harmony	NextLevel
Beneficiary enrollment total	331,548	260,432	57,812
Provider enrollment total	19,329	13,830	7,665
Year originally contracted	2014	1995	2016
Size and composition of SIU	7.5 FTE	10 FTE	1 FTE
Number SIU FTEs fully-dedicated to state	7.5	2	1
National/local plan	Local	National	Local

Table 2.

MCOs	FFY 2015	FFY 2016	FFY 2017
CC	$895 million	$912 million	$791 million
Harmony	$304.8 million	$330 million	$357.3 million
NextLevel	N/A	$81.4 million*	$196.5 million**

** - **For the period 1/1/16 – 9/30/16.***

** - For the period 10/1/16 – 9/30/17.

State Oversight of MCO Program Integrity Activities

The HFS Bureau of Managed Care (BMC) is responsible for programmatic oversight, but delegates program integrity related functions to the OIG for all fraud, waste, and abuse activities. Additionally, the HFS Director of Medical Programs, BMC, and account managers are responsible for contract monitoring. Currently, there is no inter-agency agreement in place outlining roles and responsibilities between BMC and OIG.

The state requires all MCOs to report their open and closed cases to the state on a quarterly basis through the secure HFS SharePoint site.

The Illinois MCO contract states, “Contractor shall submit contractor’s plan for verifying with enrollees whether services billed by providers were received, as required by 42 CFR 455.20.” All three MCOs are following the requirement to verify that services billed by providers were received by beneficiaries.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

The Illinois MCO contract states, "Contractor shall report in writing to the OIG any suspected Fraud, Waste, Abuse, or financial misconduct associated with any service or function provided for under this Contract by any parties directly or indirectly affiliated with this Contract… The contractor must report the results of such an investigation to the OIG. Contractor shall cooperate with all investigations of suspected Fraud, Waste, Abuse, or financial misconduct reported pursuant to this paragraph. Contractor shall require adherence with these requirements in any contracts it enters into with Subcontractors. Nothing in this section… precludes Contractor or Subcontractors from establishing measures to maintain the quality of services and control costs that are consistent with their usual business practices, conducting themselves in accordance with their respective legal or contractual obligations, or taking internal personnel-related actions."

Illinois's contract with the MCOs does not require the MCOs to refer directly to the Medicaid Fraud Control Unit (MFCU); instead, the state requires all preliminary investigations to be referred to OIG, who is then responsible for case referral to the MFCU after a credible allegation of fraud has been determined. As the OIG is the liaison with the MFCU and is statutorily required to track and report all MFCU referrals, the MCOs should not be referring to MFCU directly. The OIG has confirmed with MFCU that they are not receiving referrals directly from the MCOs.

The MCOs refer suspected network provider fraud or abuse to the OIG. The referral process from the MCOs involves submission of the Quarterly Reporting Tool via the secure HFS SharePoint site as well as submitting individual referrals via the referral portal on the OIG's webpage, however, the MFCU is not copied on the referrals. The OIG conducts a preliminary investigation and cooperates with the MFCU in determining whether there is a credible allegation of fraud. Referrals from MCOs are triaged and vetted by nurses in the Provider Analysis Unit, then discussed in task force meetings and the narrative review committee. The OIG tracks all cases referred by the MCOs to the state through its internal CASE database. The OIG also tracks all OIG fraud referrals to MFCU in its internal CASE database.

Additionally, Illinois's MCO contract states, "Contractor shall have an affirmative duty to report to the OIG in a timely way suspected Fraud, Waste, Abuse, or financial misconduct in the HFS Medical Program by Enrollees, Providers, Contractor's employees, or Department employees." The contract further states that the contractor should have: a designated SIU to oversee fraud, waste, and abuse investigations; employ fraud, waste, and abuse investigators at a minimum ratio of one investigator to every one hundred thousand enrollees; comply with all applicable requirements under the contract and all applicable federal and state requirements, including 42 CFR §438 Part H; form a Regulatory Compliance Committee on the Board of Directors; appoint a single individual to serve as liaison to the HFS and require the liaison to provide notice of any suspected fraud, waste, abuse, or financial misconduct to the OIG within three days after receiving the report; submit a quarterly report to the HFS that includes all instances of fraud, waste, and abuse and certify that the report contains all such instances, or that there was no suspected fraud, waste, abuse, or misconduct during that quarter; and ensure that all its

personnel, network providers, and subcontractors receive notice of, and are educated on, these procedures, and shall require adherence to them.

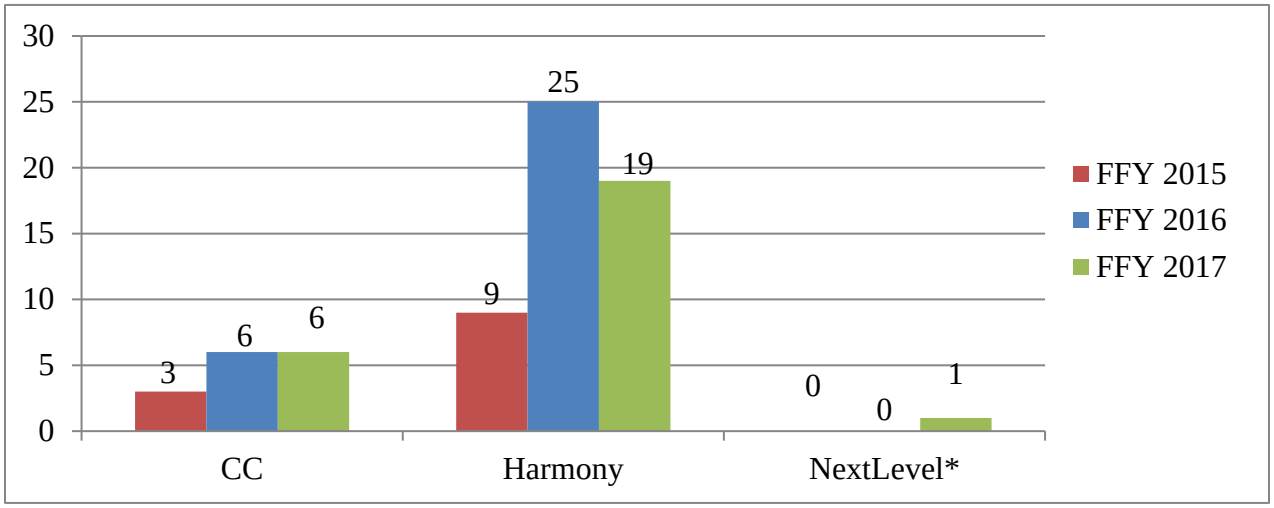
The CC's health plan, TPA's compliance director and PIU staff coordinates all investigations concerning fraud, waste, and abuse. Upon receipt of a referral, it is logged in the fraud, waste, and abuse database which is maintained in SharePoint. If erroneous billing or potential fraud, waste, and abuse is identified, an investigation is initiated promptly by the senior director/PIU, and a financial determination is rendered regarding claims disposition. The TPA's compliance officer provides notice of any suspected fraud, abuse, or financial misconduct to CCHHS corporate compliance within 24 hours after receiving such report. Once it is determined that fraudulent activity may have occurred, CC compliance sends the audit/investigation packet to the HFS-OIG within 24 hours.

Harmony's referral process involves submission of a Quarterly Reporting Tool via the secure HFS SharePoint site as well as submitting individual referrals via the referral portal on the OIG's webpage. Harmony conducts periodic assessments to determine how best to focus its fraud, waste, and abuse efforts. These assessments include any identified or reported fraud, waste, and abuse schemes or trends, identified outliers, or other data that dictates a targeted response or preventive action by the plan. These efforts include, but are not limited to: an education and awareness training program to maximize employee, business partner, and downstream entity referrals to develop tips regarding possible fraud, waste, and abuse; investigating referrals from anyone, including employees, business partners, law enforcement agencies, and providers; utilizing a combination of analytical tools, clinical expertise, and investigative knowledge to identify potential fraud, waste, and abuse; and establishing baseline data to enhance efforts to recognize unusual trends or changes in utilization patterns. Once a referral is received, the matter is entered into the secure Compliance 360 database by the SIU Information Case Admin. The referral is then preliminarily assessed by the intake team to confirm that the matter concerns potential fraud, waste, and abuse. The SIU will pursue reactive and proactive investigations to either corroborate the allegations or determine them unfounded. The SIU conducts audits which begin with pulling a statistically valid random sample and requesting medical records. Upon receipt of the medical records, an examination is conducted of the submitted claims and corresponding supporting documentation. The review of the medical records begins with the coding auditor verifying coding is correct. The records may then be reviewed by a nurse and medical director to determine medical necessity. When the review is complete, a summary is provided to the investigator. Once a determination has been made that the target party has engaged in fraud, waste, and abuse, a referral is submitted to the HFS-OIG outlining the findings and proposed remedial actions to be pursued, which depends upon the misconduct at issue. Some investigative findings may result in the need for remedial actions in addition to pursuit of overpayments, referral to other government entities, and/or termination. Remedial measures may include audit notifications and provider education. Harmony also partners with dental and vision vendors to assist with audits. The plan's SIU makes the necessary regulatory referrals to the state for any matters worked jointly.

As mentioned previously, NextLevel did not have an investigator or SIU prior to June 1, 2018. Prior to this time, the agency was more reactive than proactive when addressing fraud, waste, and abuse. Prior to implementation of the SIU, the compliance officer was responsible for addressing complaints and the agency focus was mainly on the use of algorithms and oversight to detect fraud, waste, and abuse. The primary source of complaints was the compliance hotline, compliance officer, provider materials, and employees in the field. A change in leadership was implemented January of 2018, at which time the agency became more proactive at addressing fraud, waste, and abuse. The agency was also not sending out beneficiary verifications. This process was put on hold when the previous compliance officer left the agency, but they are starting back under the direction of the new compliance officer. Their contract with the state requires them to have a process and to report on this process annually. Their annual report for SFY 2018 states, "Due to the transition of vendors in 2017 and 2018, the information needed to complete the Member Verification letters did not go out for Q1, Q2, and Q3 of SFY 2018. The next round of mailings will go out in September 2018 for Q4 2018 and monthly thereafter." NextLevel has been working closely with the HFS-OIG to develop changes to their policies.

Table 3 lists the number of referrals that CC's, Harmony's, and NextLevel's SIU made to Illinois in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by the MCO is low, compared to the size of the plan. The level of investigative activity has changed over time.

Table 3.



NextLevel did not start providing services until 2016 as an MCO.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608.

The state does have a process to review the compliance plans and programs, however, this process is not documented.

As required by 42 CFR 438.608, the state does review the MCO's compliance plans and communicates approval/disapproval to the MCOs.

According to HFS contract requirements with the MCOs, the contractor is required to submit its compliance plan designed to guard against fraud and abuse to the HFS for prior approval initially and then annually and have a regulatory compliance committee that meets, at minimum, on a quarterly basis.

The CC, Harmony, and Next Level provided the review team with a copy of their compliance plan. A review of the compliance plan revealed they were in compliance with 42 CFR 438.608. However, the CC was unsure of how often the compliance plan is submitted to the state.

Encounter Data

According to HFS's contract, the contractor is required to submit complete and accurate data quarterly to HFS in accordance with the Illinois Medicaid Health Plan Encounter Utilization Monitoring (EUM) requirements. During the program integrity team interview with state staff, the soundness of encounter data did not meet the quality and specificity to allow the continuation of the OIG analytics system. Specifically, OIG provided the following examples they discovered as being problematic: a) services rendered by transportation companies with claim credentials (vehicle license plates) other than the billing provider, which for transportation claims should be the company providing the services; b) billing provider, e.g., clinic or group designation, omitted from physician encounter claims and replaced by the managed care plan credential (Payee ID), thus not allowing determination of where services are being rendered (e.g., clinic or group); c) same dental services (tooth extraction) submitted repeatedly by managed care plan and accepted by HFS; d) claim encounters are listing exorbitant payment amounts to which OIG is concerned that services are being bundled as opposed to being submitted at claim level, but haven't verified this due to missing fields of data; and e) transportation encounter data not being submitted by a managed care plan, going back to January 2016.

The CC has access to all levels of data within the MCO to conduct data mining and to analyze claims data. The CC conducts a number of algorithms to identify overpayments inappropriately paid to a provider including aberrant billing trends, national schemes, and peer to peer comparisons. The CC also runs analytics on providers based on tips from the hotline, OIG, or from other sources providing information on potential fraudulent activities. Standard and ad hoc reports are provided monthly and on an as-needed basis. The CC submits encounter data to the state weekly, as well as additional information on a quarterly basis. Harmony's SIU has access to all of Harmony/WellCare's claims data. The SIU uses data mining technologies to proactively identify potential fraud and abuse. The SIU employs a data team to conduct targeted claims queries, leveraging the Statistical Analysis System data network, to identify members and providers with suspicious activity or unusual patterns of behavior that might indicate fraud and abuse. Harmony uses a fraud and abuse analytics library to produce reports for the identification and investigation of fraud and abuse. These reports include visit trend analysis, provider up-code checker, and abnormal provider utilization. The SIU uses COGNOS business intelligence software to produce a Physician Trend Report by specialty. This report enables the SIU to identify aberrant spikes or trends. When this analysis identifies a provider with suspicious activity, a more detailed set of reports are generated, which allows investigators to view the entire billing and claims history for that provider. Additionally, Harmony uses Verscend STARS Solutions to identify outlier providers, members, pharmacies, etc. for all lines of business. It provides predictive models/algorithms identifying aberrant patterns, outliers, scoring, or statistical views to be prioritized and forwarded to investigators with the outcome of increased recoveries for the SIU. Verscend STARS Solutions predictive analytics algorithms are applied to Harmony/WellCare pharmacy and medical claims data each month. All SIU team members have access to standard reports and they are routinely produced. In addition, Harmony SIU's data team produces ad hoc reports upon request. Harmony submits and certifies encounter data weekly to the state and HFS formally evaluates MCO encounter claims submission on a quarterly basis through a methodology developed by its consulting actuary, Milliman, Inc. called EUM. However, Harmony did express concerns with the submission of encounter data but is working with HFS to resolve this issue.

NextLevel encounter data is submitted on a regular basis to the state after each check run and attested to monthly. Reports supporting NextLevel's actuarial soundness of their capitation rates, medical loss ratio, and solvency are reported and attested to quarterly. Provider network adequacy reports are submitted quarterly and are not required to be attested. The accuracy and completeness of provider directories are submitted and attested to monthly.

Overpayment Recoveries, Audit Activity, and Return on Investment

Illinois's MCO model contract states, "If the Department requires Contractor to recover established overpayments made to a Provider by the Department for performance or nonperformance of activities not governed by this Contract, Contractor shall immediately notify the Department of any amount recovered"

All three MCOs report overpayments to HFS via the MCO tool, however, there is no claw-back provision in the contract. The state cannot collect overpayments from network providers, although OIG has collected MCO claims through self-disclosure protocol. The MCO annual financial statements include an exhibit of an analysis of health care receivables collected and accrued; however, amounts reported as claims overpayment receivables are not broken out so the HFS is unable to determine how much is directly attributed to provider overpayments.

The table below shows the respective amounts reported by CC for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations*	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2015	24	1	$5,334.20	$5,334.20
2016	66	24	$868,056.44	$13,216,15
2017	77	48	$1,221,017.34	$349,563.79

The CC's identified and recovered overpayments are tracked by their TPA and reported to the state on a quarterly basis. Both preliminary and full investigations significantly increased in FFY 2016 and FFY 2017, as a result of continued growth of the SIU; more interactions between CC and the OIG; improved staff experience; and more efficient processes being implemented. The CC's overpayments identified significantly increased in FFY 2016 and FFY 2017 due to more algorithms being used. The CC's overpayments recovered significantly increased in FFY 2017 as a result of a very large dental overpayment.

Additionally, the review team discussed cost avoidance measures with the MCOs reviewed. The CC currently does not perform prepayment review.

The table below shows the respective amounts reported by Harmony for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations*	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2015	81	78	$16.90	$16.90
2016	78	25	$8,538.21	$8,538.21
2017	86	19	$16,851.71	$16,246.83

Harmony was unable to provide an explanation for the low amount of identified and recovered overpayments. Harmony's SIU uses a multi-faceted approach to identify and pursue potential fraud, waste, and abuse including, but not limited to: an education and awareness training program to maximize employee, business partner, and downstream entity referrals to develop tips regarding possible fraud, waste, and abuse; investigating referrals from anyone, including employees, business partners, law enforcement agencies and providers; utilizing a combination of analytical tools, clinical expertise, and investigative knowledge to identify potential fraud, waste, and abuse; and establishing baseline data to enhance efforts to recognize unusual trends or changes in utilization patterns.

The table below shows the respective amounts reported by NextLevel for the past three FFYs.

Table 4-C.

FFY	Preliminary Investigations*	Full Investigations*	Total Overpayments Identified	Total Overpayments Recovered
2015	N/A	N/A	N/A	N/A
2016	2	0	$0	$0
2017	3	0	$0	$0

NextLevel did not start providing services until 2016 as an MCO.

NextLevel began conducting full investigations after the SIU was established in June 2018. The agency became more proactive with fraud, waste, and abuse detection with the change in management on January 1, 2018. NextLevel did not identify or report any overpayments during FFY 2016 or FFY 2017.

Payment Suspensions

In Illinois, provider payment suspensions are not addressed in the contract; however, OIG directs the imposition of payment suspensions to the SIUs upon findings of credible allegations of fraud. This is done via email notification to the MCOs. The state confirmed that there is no contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The CC suspends provider payments upon receipt of payment suspension provider alerts via task force meetings, memorandums, and emails from the HFS-OIG. HFS-OIG has provided guidance to the CC on handling payment suspensions based upon the distribution of its provider alerts.

Harmony places providers on a payment hold upon receipt of payment suspension provider alerts via task force meetings, memorandums, and emails from the HFS-OIG. The HFS-OIG has provided guidance to Harmony on handling payment suspensions based upon the distribution of its provider alerts. Harmony's SIU also has the ability to place a provider on 100% prepayment review. Providers placed on prepayment review by Harmony's SIU typically remain on prepayment review during the course of the investigation. Harmony reports to the state agency on the suspected case(s) of the provider or member fraud and abuse.

NextLevel has not put any providers on payment suspension during the last complete FFY. NextLevel did not identify any providers appropriate for payment suspension. NextLevel may suspend payments to a provider or supplier under the following circumstances: fraud or willful misrepresentation; when an overpayment exists but the amount has not been determined; when payments made or to be made may be incorrect; or based on requests from its contractors, state agencies, or from law enforcement. When NextLevel suspends provider payments, it would be reported to the state within 3 days of issuing the payment suspension notification and on the quarterly HFS-OIG report. The HFS-OIG has provided guidance to the NextLevel on handling payment suspensions based upon the distribution of its provider alerts. NextLevel did not have a suspension policy prior to July 18, 2018.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "Contractor shall ensure that all Network Providers, including out-of-state Network Providers, are enrolled in the HFS Medical Program if such enrollment is required by the Department's rules or policy in order to submit claims for reimbursement or otherwise participate in the HFS Medical Program. Once a contractor is aware that a Network Provider serving one-hundred (100) or more active Enrollees will be terminated, Contractor must inform the Department of this termination in writing (email or letter) within three (3) Business Days." The contract further states that written notification must include: the provider name; the reason for termination; the expected termination date; the current number of enrollees served by the terminated provider; and the plan of action for transferring enrollees to another provider. The CC notifies HFS via email or letter within three business days when a managed care network provider serving one-hundred or more active enrollees will be terminated for any reason and for cause. The CC submits a termination report to the state which includes the reason for termination. The CC receives notifications from HFS-OIG regarding providers who have been terminated for cause via email. CC's compliance division notifies its provider relations team and checks the CC health plan network for participation by the provider. If the terminated provider is present, provider relations will terminate the provider from the network and works to ensure that membership does not suffer access to care by working with other providers to cover any members affected by the termination. In addition, the CC will notify the enrollees of terminated providers within 15 calendar days in accordance with the MCO contract requirements.

Harmony receives notices from HFS-OIG that a provider has been terminated. They will then determine whether or not the provider is an in-network provider and whether or not they have paid this provider. Harmony complies with the requirements of its contract with HFS.

NextLevel notifies the state when it terminates a provider's contract for any reason and when it terminates a provider's contract for cause. NextLevel participates in monthly meetings, hosted by HFS-OIG with all MCO/SIUs represented. If a NextLevel provider were terminated for cause, NextLevel would notify the other MCO/SIUs during this meeting. The state sends provider notices to NextLevel's Compliance Department when they have terminated a provider.

Table 6:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated for Cause in Last 3 Completed FFYs	
CC	2015	0	2015	0
	2016	3	2016	3
	2017	7	2017	7
Harmony	2015	1311	2015	14
	2016	1416	2016	128
	2017	389	2017	12
NextLevel	2015	N/A	2015	N/A
	2016	0	2016	0
	2017	2	2017	1

NextLevel did not start providing services until 2016 as an MCO.

Overall, the number of providers terminated for cause by the plans appears to be low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason.

Illinois reported to the CMS review team that they are downloading and checking the monthly Medicare revocation list and providing the downloaded TIBCO list of terminated providers to their MCOs to assist in identifying providers who should be terminated from the plans' networks.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's List of Excluded Individuals and Entities (LEIE); the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and re-enrollment, and check the LEIE and SAM no less frequently than monthly.

The CMS review team confirmed that CC is collecting and storing all required disclosure information, however, they were not in full compliance with checking all required federal database checks. The CC does not check the SSA-DMF.

Harmony contracts with providers for either Medicare, Medicaid, or both. Providers must be enrolled in the state Medicaid program in order to be eligible for network participation. Harmony does not currently perform any credentialing or re-credentialing for Illinois providers. As of January 1, 2018, provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in a plan's provider network, the plan must verify that a provider is enrolled in IMPACT. The CMS review team confirmed that prior to January 1, 2018, Harmony was collecting and storing all required disclosure information. Harmony does continue to perform monthly on-going monitoring on all Illinois providers to identify any Medicare/Medicaid excluded providers. Excluded providers are identified in their system and terminated immediately.

NextLevel relies on the state's IMPACT system to verify that an individual is not on the Federal exclusion lists. NextLevel checks the IMPACT system at the time the contract is executed. NextLevel does not have more stringent enrollment requirements for high or moderate risk provider types.

Recommendations for Improvement

- The state should ensure site visits are being conducted by all MCOs according to contractual requirements. Regular on-site visits would provide increased oversight by the state Medicaid agency, in addition to the reporting methods currently in place.
- The state should develop operational guidelines, policies, and procedures, or interagency agreements which govern the interaction between BMC and OIG.
- The state should ensure MCOs are providing oversight and have policies related to fraud, waste, and abuse.
- The state should consider developing a formalized process to document/review MCO compliance plans. Currently, there is not a documentation process associated with the state's review of compliance plans submitted by MCOs and the state should ensure that all MCOs understand the submission requirements for compliance plans and the frequency of submission.
- The state should ensure the soundness of encounter data meets the quality and specificity level to allow the OIG analytics system to process encounter data. Specifically, the state should provide clear guidance to the MCOs for reporting denied, adjusted, and paid claims, and ensure that MCOs provide the claims to HFS as required by the contract.
- The state should verify that identified and collected overpayments are fully reported by the MCOs and are incorporated into the rate-setting process.
- The state should ensure all MCO contracts contain payment suspension language mirroring the payment suspension regulation at 42 CFR 455.23.
- The state should work with MCOs to develop policies consistent with the payment suspension requirements in the federal regulation at 42 CFR 455.23. The state should provide training to its MCOs on the circumstances in which payment suspensions are appropriate and should further require the reporting of plan-initiated payment suspensions that were based on credible allegations of fraud.
- Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, ensure that MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.
- The state should monitor the MCOs compliance with contractual requirements for conducting monthly checks of the SSA-DMF, upon enrollment and re-enrollment.
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Section 2: Status of 2014 Corrective Action Plan

Illinois's last CMS program integrity review was in June 2014, and the report for this review was issued in September 2015. The report contained 12 findings. During the onsite review in August 2018, the CMS review team conducted a thorough review of the corrective actions taken by Illinois to address all issues reported in the calendar year 2014. The findings of this review are described below.

Findings -

1. ***Failure to capture required provider ownership and control disclosures (42 CFR 455.104). Although the state has taken some steps to correct the issue, they are relying on the implementation of a new Medicaid Management Information System (MMIS) to fully come into compliance with the requirements of the regulations. (FY2011)***

Status at time of the review: Corrected

Illinois reported to the CMS review team that as of July 20, 2015, they are capturing the provider ownership and control disclosures in their new MMIS system, IMPACT.

2. ***Failure to require Home and Community Based Service waiver program providers to disclose business transaction information (42 CFR 455.105 (b)). Although the state has taken some steps to correct the issue, they are relying on the implementation of a new Medicaid Management Information System (MMIS) to fully come into compliance with the requirements of the regulations. (FY2011)***

Status at time of the review: Corrected

Illinois reported to the CMS review team that they are requiring Home and Community Based Service waiver program providers to disclose business transaction information which is captured in IMPACT.

3. ***Failure to collect healthcare related criminal conviction disclosures in the Home and Community Based Service waiver programs (42 CFR 455.106). Although the state has taken some steps to correct the issue, they are relying on an implementation of a new Medicaid Management Information System (MMIS) to fully come into compliance with the requirements of the regulations. (FY2011)***

Status at time of the review: Corrected

Illinois reported to the CMS review team that they are collecting healthcare related criminal conviction disclosures in the HCBS waiver programs.

4. ***Failure to conduct complete searches for individuals and entities excluded from participating in Medicaid (42 CFR 455.436). The state indicated and the 2014 Review Team verified that exclusion checks (List of Excluded Individuals and Entities (LEIE) or System for Award Management (SAM)) are not being done during the monthly exclusion checks as required by 42 CFR 455.436. This issue continues to be a vulnerability to the Medicaid program, and, the state must correct this problem without relying on a new MMIS. (FY2011)***

Status at time of the review: Corrected

Illinois reported to the CMS review team that exclusion checks (LEIE or SAM) are being done during the monthly exclusion checks as required by 42 CFR 455.436.

5. ***42 CFR 455.410: Enrollment and screening of providers. Develop policies and procedures to implement the requirement that all ordering and referring physicians, or other professionals providing services under the state plan or a waiver of the plan, be enrolled as participating providers.***

Status at time of the review: Corrected

Illinois reported to the CMS review team that all providers are being enrolled with the same screening procedures.

6. ***42 CFR 455.414: Revalidation of enrollment. Develop a formal plan, policies, and procedures to ensure that all Illinois Medicaid providers enrolled on or before March 25, 2011, will be revalidated by the required completion date of March 24, 2016. The plan should include a contingency if the transition to the new MMIS is not completed as expected in 2015.***

Status at time of the review: Corrected

Illinois reported to the CMS review team that all Illinois Medicaid providers enrolled on or before March 25, 2011, were revalidated by the extension date of September 2016.

7. ***42 CFR 455.420: Reactivation of provider enrollment. The state requires providers who have been deactivated or terminated to resubmit the enrollment documents required for initial enrollment and undergo rescreening. However, the state does not have a process to collect the associated application fees. The state indicated that a process to collect application fees for reactivated Medicaid-only institutional providers will be implemented with the new MMIS.***

Status at time of the review: Uncorrected

Illinois reported to the CMS review team that they are not collecting the appropriate application fees from any applicable providers during the reactivation process. However, the state is currently working on a process which should be completed by December 2018.

8. ***42 CFR 455.432: Site visits. Develop and implement a process to conduct pre- and post-enrollment site visits of all providers categorized as moderate and high risk, or, where appropriate, the state can verify that a site visit was performed within the prior 12 months by Medicare using the Provider Enrollment, Chain, and Ownership System.***

Status at time of the review: Corrected

Illinois reported to the CMS review team that they are conducting pre- and post-enrollment site visits of all providers categorized as moderate and high risk.

9. ***42 CFR 455.436: Federal database checks. The state must obtain access to the Social Security Administration Death Master File and develop a process to check the names of providers, persons with an ownership or control interest in the provider, agents, and managing employees of the provider against all required federal databases at the time of enrollment and re-enrollment.***

Status at time of the review: Corrected

Illinois reported to the CMS review team that the state has obtained access to the SSA-DMF and all disclosed parties are checked against the SAM and the LEIE or Medicare exclusion database on a monthly basis.

10. ***42 CFR 455.440: National Provider Identifier (NPI). Develop procedures to capture the NPI during the enrollment process for all ordering and referring providers. Develop and implement edits to reject claims lacking an NPI number or containing an incorrect NPI number.***

Status at time of the review: Corrected

Illinois reported to the CMS review team that they have implemented edits to reject claims lacking an NPI number or containing an incorrect NPI number.

11. ***42 CFR 455.450: Screening levels for Medicaid providers. The state must inventory their policies and procedures to verify that all required screenings of Medicaid providers are part of the enrollment and re-enrollment process and ensure that all screening activities are performed based on the provider's categorical risk level. These screening activities must also be performed for new practice locations and revalidations of enrollment.***

Status at time of the review: Corrected

Illinois reported to the CMS review team that all screening activities are performed based on the provider's categorical risk level.

12. ***42 CFR 455.460: Application fee. Develop and implement a process in compliance with all the requirements at 42 CFR 455.460 related to collecting applicable application fees for enrolling or re-enrolling Medicaid-only providers.***

Status at time of the review: Uncorrected

Illinois reported to the CMS review team that the state has not implemented a process in compliance with all the requirements at 42 CFR 455.460 related to collecting applicable application fees for enrolling or re-enrolling Medicaid only providers.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Illinois to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which may help address the risk areas identified in this report. Courses that may be helpful to Illinois are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html.
- CMS provides a fraud prevention toolkit located on CMS.gov that includes:
    - The 4Rs (Record, Review, Report, and Remember) brochure
    - Fact sheets on preventing and detecting fraud
    - Frequently Asked Questions
    - The CMS.gov website also contains information regarding the Center for Program Integrity and fraud prevention efforts in Original Medicare (FFS), Part C and Part D, and Medicaid. For more information on the fraud prevention toolkit, visit CMS.gov/outreach-and-education/outreach/partnerships/fraudpreventiontoolkit.
    - For the latest news and information from the Center for Program Integrity, visit CMS.gov/about-cms/components/cpi/center-for-program-integrity.html

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

Additionally, if the CMS focused review identified noteworthy and best practices in your state, they will be published and shared with others states so that they may consider those enhancements to their own state Medicaid programs.

CMS looks forward to working with Illinois to build an effective and strengthened program integrity function.