Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Illinois Comprehensive Program Integrity Review

Final Report

December 2008

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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 onsite portion of the review was conducted at the offices of the Department of Healthcare and Family Services (HFS), but the MIG review team also visited the State's Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the HFS Office of Inspector General (HFS-OIG), which is primarily responsible for Medicaid program integrity oversight. This report describes four effective practices, one area of vulnerability and three compliance issues 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' Medicaid Program

The HFS administers the Illinois Medicaid Program. As of the State Fiscal Year (SFY) ending June 30, 2007, the program served 1,853,351 recipients and Medicaid expenditures totaled $11,931,794,135. The Federal medical assistance percentage for Illinois during SFY 2007 was 50 percent. HFS processed an average of 82.9 million claims annually in the past three SFYs. At the time of the review, HFS had 55,425 enrolled providers. The State requires all managed care providers to be enrolled with the Medicaid program. The State currently utilizes two different models of managed care: primary care case management (PCCM), in which providers are paid fee-for-service (FFS) with an additional fee to act as gatekeeper, and risk-based managed care through contracts with two managed care organizations (MCOs). In total, the two types of managed care have contracted with 21,039 providers. The combined recipient enrollment with MCOs is approximately 152,000, or 8.2 percent of all Illinois Medicaid recipients. Cost data provided by the State suggests that managed care enrollees account for approximately two percent of total Medicaid expenditures. Approximately 98 percent of Illinois' Medicaid expenditures were for recipients with FFS coverage.

Program Integrity Section

Within HFS, the organizational component dedicated to fraud and abuse detection activities is the HFS-OIG. At the time of the review, the HFS-OIG had 151 staff dedicated to identifying provider fraud, abuse and inappropriate payments. The review team noted that 23 positions in

the HFS-OIG were vacant. The HFS-OIG is divided into five bureaus: Administrative Litigation, Information Technology, Internal Affairs, Investigations, and Medicaid Integrity. The Bureau of Information Technology has a unit called the Provider Analysis Unit (PAU). The PAU researches, develops, and implements selection criteria to identify providers with potentially fraudulent behavior. The PAU selects and conducts monthly analyses of providers who have excepted out of the Surveillance Utilization and Review Subsystem (SURS). Additionally, the Bureau of Information Technology has a Fraud Science Team (FST). The FST develops fraud detection routines to prevent and detect Medicaid fraud, abuse, overpayments and billing errors. The FST works with the rest of HFS-OIG and Healthcare Family Services to identify vulnerabilities and solutions in the HFS payment system. There are also two major sub-units: Administrative Services, and Fraud and Abuse Executive. HFS-OIG also has a number of contracts for performance of program integrity-related functions. These include such activities as quality of care reviews, diagnostic related group coding reviews of inpatient billings, computer programming and data analysis for fraud detection routines, financial audits of long term care facilities, and certain recipient fraud investigation responsibilities. The table below presents the total number of audits and overpayment amounts collected for the last two SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary & Full Investigations	Number of State Administrative Actions or Sanctions	Amount of Overpayments Identified	Amounts Recouped (includes past settlement collections)
2006	14,323	2720	$ 25,356,655.90	$ 23,185,150.32
2007	19,536	4757	$ 25,570,468.48	$ 18,960,393.02

The "number of preliminary & full investigations" column includes any allegation of provider fraud, recipient fraud, or other unknown type referral that has been entered into the HFS-OIG case tracking system and is subject to review for a determination of further action.

Methodology of the Review

In advance of an onsite visit, the review team requested that Illinois complete a comprehensive review guide and supply documentation to support its answers to the review guide. The review guide included such areas as provider enrollment, claims payment and post payment review, managed care, SURS, and the MFCU. It also included a series of questions regarding all of Illinois' contracted MCOs. A five-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of February 26, 2008, the MIG review team visited the offices of HFS and the MFCU. The team conducted interviews with numerous HFS officials as well as the MFCU Director. To determine whether managed care plans were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's MCO contracts. The team conducted in-depth interviews with representatives from the two MCOs and met separately with HFS staff to discuss managed care oversight and monitoring efforts.

Scope and Limitations of the Review

This review focused on the activities of HFS-OIG and on program integrity-related provider enrollment functions performed by the Provider Participation Unit within HFS. Illinois operates both a stand-alone State Children's Health Insurance Program (SCHIP) program and a Title XIX expansion program. That portion of Illinois' SCHIP program operating as a Medicaid expansion program was included in this review. Because the SCHIP program utilizes the same FFS billing and provider enrollment policies as Illinois' Title XIX program, the same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program apply to SCHIP. Unless otherwise noted, HFS 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, financial, or collections information that HFS provided.

RESULTS OF THE REVIEW

Effective Practices

The State has highlighted several practices that demonstrate its commitment to program integrity.

Case Tracking System

HFS-OIG utilizes a centralized case tracking system that consolidates case management functions for all OIG investigative, audit, and review activities. The system enables staff to utilize historical information to inform current fact-finding efforts, and interfaces with other HFS information systems as well as their medical data warehouse. Documents are scanned or imported into the system to create electronic case files, and letters are automatically generated. Additionally, the system facilitates communication and joint decision making regarding provider sanctions, as well as tracking of external agency actions (e.g., criminal prosecutions, global settlements).

State Sanctions Database

Illinois is one of a growing number of States that maintains its own sanctions database. The system tracks providers who have been or are currently in the process of being sanctioned by HFS, and also includes HHS-OIG exclusions and reinstatements. The database is updated monthly. HFS uses the system to screen providers during initial enrollment, within 7 days after enrollment, and on a monthly basis.

Additionally, the CMS review team identified two practices that are particularly noteworthy.

HFS exercises strong oversight of transportation and durable medical equipment (DME) providers

HFS engages in a number of laudatory practices in connection with its non-emergency medical transportation (NEMT) and DME providers. HFS conducts site visits on all NEMT providers, during which the State verifies the address and inspects licenses. New

transportation providers are also subject to mandatory criminal background checks, and are placed on probation for 180 days, during which time HFS-OIG monitors their claims. All DME providers also receive onsite reviews, during which the State checks inventory to determine whether it is reasonably related to billings. Moreover, both NEMT and DME providers must reenroll in the Medicaid program on a periodic basis.

HFS requires managed care providers to be enrolled with HFS
States that delegate delivery of some medical services to MCOs often lack sufficient oversight of the providers serving managed care enrollees, and sometimes do not even know the identity of their MCOs' providers. HFS requires that all MCO providers be enrolled with the Medicaid program. By requiring that all MCO providers be enrolled with HFS, the State is able to maintain centralized control over the screening and credentialing process, and better ensure the integrity of its programs.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to required provider disclosures of ownership and control information, business transaction information, and criminal conviction information.

HFS provider enrollment applications do not capture ownership, control, and relationship information.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, 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 five 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. Moreover, 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.

While the State's MCO contract solicits required disclosures from MCOs, HFS provider enrollment applications do not capture all of the required disclosures. The agency's forms do not capture the addresses of the specified subcontractors or those persons with ownership or controlling interests, nor do they capture information on familial or business relationships between disclosing entities as is required by § 455.104(a)(2) and (a)(3). Therefore, the inter-relationships of entities, related organizations, and subcontractors cannot be easily established, and HFS cannot always determine when a provider seeking to enroll in Medicaid has an ownership or control interest in excluded related organizations or subcontractors.

***Recommendation*:** Modify provider enrollment applications to capture appropriate ownership and control information.

HFS' provider enrollment agreements do not require providers to disclose certain business transactions.

42 CFR § 455.105(a) stipulates that a Medicaid agency's provider agreements must require providers, upon request, to furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors. Although Illinois' provider enrollment agreements broadly require providers to comply with all applicable Federal laws and regulations, they do not include any explicit reference to the specific requirements of 455.105(a).

***Recommendation*:** Modify the provider agreement to require providers to supply business transaction information identified in 42 CFR § 455.105(a).

HFS' provider enrollment applications do not capture required criminal conviction information.

The regulation at 42 CFR § 455.106(a) 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 HHS-OIG within 20 working days whenever such disclosures are made.

While Illinois' provider enrollment applications require a provider to certify that none of its employees, partners, officers, or shareholders owning at least five percent of the provider is currently serving a sentence for a conviction of any Medicaid or Medicare program violations, the provider enrollment applications fail to ask about past convictions. This omission was also noted in a prior CMS review of Illinois' program integrity function, conducted in 2000.

***Recommendation*:** Modify provider enrollment applications to meet the full criminal conviction disclosure requirements of the regulation.

Vulnerabilities

The review team identified one area of vulnerability in Illinois' program integrity practices regarding verification of receipt of billed services.

HFS' MCOs do not have a method for verifying with recipients whether services billed by providers were received.

Under 42 CFR § 455.20(a), the State must have a method for verifying with recipients whether services billed by providers were in fact received. The State continues to be responsible for ensuring this requirement is met when it has contracted service delivery to an MCO. While Illinois' MCOs do conduct customer satisfaction surveys, documentation provided by the MCOs did not include any information indicating that the requirements of § 455.20(a) are being met.

***Recommendation*:** Develop and implement procedures to verify with MCO enrollees whether services billed by providers were received.

CONCLUSION

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

- a robust case tracking system
- a State sanctions database against which providers are regularly screened
- increased oversight of transportation and DME providers
- mandatory enrollment of managed care providers.

CMS encourages HFS to continue these effective practices and to look for other opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, one area of vulnerability was identified. CMS encourages HFS to closely examine the area of vulnerability that was identified in the review.

It is important that these issues be rectified as soon as possible. To that end, we will require HFS 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 that 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 areas of non-compliance or vulnerability will take more than 90 calendar days from the date of the letter. If HFS 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 area of vulnerability, and building on its effective practices.