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Illinois Medicaid Fraud Control Unit: 2019 Onsite Review

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Report in Brief

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Unit Case Outcomes

Federal fiscal years (FYs) 2017–2019

- 141 indictments
- 151 convictions
- 52 civil settlements and judgments
- \$180.5 million in recoveries

Unit Snapshot

The Illinois Medicaid Fraud Control Unit (MFCU or Unit) is located within, and follows the law enforcement command structure of, the Illinois State Police.

At the time of our onsite review in November 2019, the Unit had a total of 43 employees across multiple office locations throughout the State. In addition, the Illinois Office of the Attorney General provided 11 attorneys—not covered under the MFCU grant—to prosecute the Unit's cases, an arrangement unique to Illinois.

Why OIG Did This Review

The Office of Inspector General (OIG) administers the MFCU grant awards, annually recertifies each Unit, and oversees the Unit's performance in accordance with the requirements of the grant. As part of this oversight, OIG conducts periodic reviews of Units and issues public reports of its findings.

In 2012, OIG found that the Illinois MFCU's organizational structure conflicted with Federal requirements. This onsite review examined this previously identified area of concern and the MFCU's performance and operations.

Illinois Medicaid Fraud Control Unit: 2019 Onsite Review

What OIG Found

We found that during FYs 2017–2019, the Illinois MFCU generally operated in accordance with applicable laws, regulations, and policy transmittals. However, we made six findings regarding the Unit's adherence to MFCU performance standards:

1. The Unit's organizational structure created several staffing challenges, raising concerns about its operational efficiencies.
2. The Unit's process for receiving referrals of patient abuse and neglect led to the Unit's screening of thousands of referrals that were unsuitable for investigation, diverting time and resources from viable cases.
3. The Unit did not always coordinate on or actively participate in cases with Federal partners, missing opportunities for sharing resources and training.
4. The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes.
5. Newly hired Unit investigators did not always complete new employee trainings, which could affect the Unit's overall effectiveness.
6. Although the Unit documented its periodic supervisory reviews in most of its case files, the Unit had difficulty adhering to its policy of conducting the reviews monthly.

What OIG Recommends and How the Unit Responded

To address these findings and further improve Unit operations, we recommend that the Unit (1) develop and implement a plan to address the challenges presented by the Unit's organizational structure (i.e., its location within the Illinois State Police, rather than within a State Attorney General's office like most other MFCUs); (2) establish minimum criteria for referrals of patient abuse and neglect to be sent to the MFCU; (3) establish a process to coordinate on cases and improve collaboration with Federal partners; (4) take steps to ensure that Unit staff report all convictions and adverse actions to Federal partners within the appropriate timeframes; (5) take steps to ensure that newly hired investigators complete new employee trainings; and (6) take steps to ensure that supervisory reviews of case files are conducted and documented in accordance with Unit policy. The Unit concurred with all six recommendations.

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BACKGROUND

Objectives

1. To examine a previously identified area of concern related to the organizational structure of the Illinois Medicaid Fraud Control Unit (MFCU or Unit).
 2. To examine the performance and operations of the Unit.
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Medicaid Fraud Control Units

The function of MFCUs is to investigate Medicaid provider fraud and patient abuse or neglect and to prosecute those cases under State law or refer them to other prosecuting offices.¹ Under the Social Security Act (SSA), a MFCU is a “single, identifiable entity of State government,” and must be “separate and distinct” from the State Medicaid agency and employ one or more investigators, attorneys, and auditors.² Each State must operate a MFCU or receive a waiver.³ MFCUs operate in 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.⁴

Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.⁵ In Federal fiscal year (FY) 2020, combined Federal and State expenditures for the Units totaled \$306 million, with a Federal share of \$229 million.⁶

¹ SSA § 1903(q)(3). Regulations at 42 CFR 1007.11(b) add that the Unit’s responsibilities may include reviewing complaints of misappropriation of patients’ or residents’ private funds in facilities. As of December 27, 2020, MFCUs may also investigate and prosecute patient abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, P.L. No. 116-260, Division CC, Section 207.

² SSA § 1903(q).

³ SSA § 1902(a)(61).

⁴ The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

⁵ SSA § 1903(a)(6). For a Unit’s first 3 years of operation, the Federal government contributes 90 percent of funding and the State contributes 10 percent of Unit funding.

⁶ OIG analysis of MFCUs’ FY 2020 reporting of expenditures.

OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award to each Unit and provides oversight of Units.^{7, 8} As part of its oversight, OIG recertifies each Unit annually and conducts periodic reviews or inspections.

In its annual recertification review, OIG examines the Unit's reapplication, the Unit's case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses a Unit's performance, as measured by the following: its adherence to published performance standards;⁹ its compliance with applicable laws, regulations, and OIG policy transmittals;¹⁰ and its case outcomes. See Appendix A for the 12 performance standards and our assessment of the Illinois MFCU's adherence to those standards.

OIG further assesses Units' performance through periodic reviews of selected Units. OIG selects Units for these reviews based on an annual risk assessment of all Units. Each of OIG's reviews may identify findings and result in recommendations for improvement. OIG may also make observations on Unit operations and practices, including identifying beneficial practices that may be useful to share with other Units. In addition, OIG provides training and technical assistance to Units, as appropriate, both during the review and on an ongoing basis.

Illinois MFCU

The Illinois MFCU, also known as the Medicaid Fraud Control Bureau, operates under the Division of Criminal Investigations within the Illinois State Police (ISP). Under the ISP, the MFCU conforms to a law enforcement command structure and has six offices across the Northern, Central, and Southern regions.¹¹ At the time of our review in November 2019, the Unit had 43 staff members across its 3 regions—1 director;

⁷ As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports, that detail MFCU income and expenditures.

⁸ The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

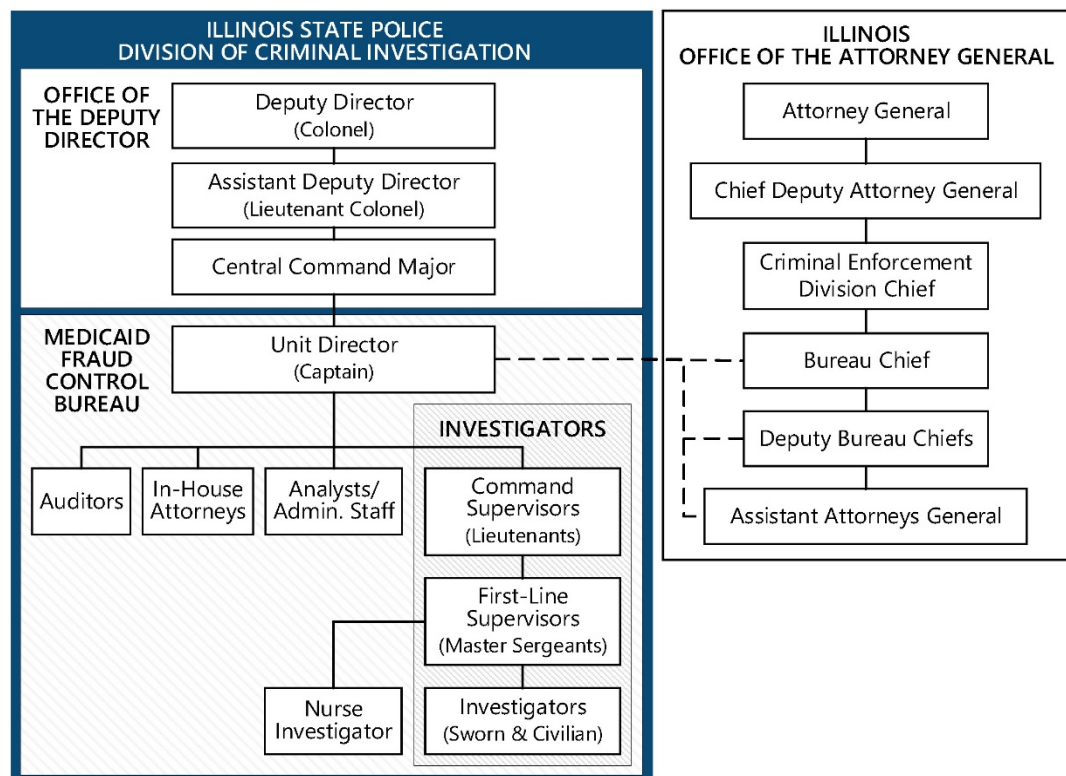
⁹ MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012) and can be viewed at <https://www.oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf>. OIG developed the performance standards in conjunction with the MFCUs, and the standards were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

¹⁰ OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals may be found at <https://www.oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp>.

¹¹ The Northern region includes a regional office in the Chicago suburb of Tinley Park and two satellite offices in Sterling and Des Plaines. The Central region includes an office in Springfield, the State's capital. The Southern region includes a regional office in Collinsville and a satellite office in Du Quoin.

24 sworn law enforcement investigators;¹² 8 civilian investigators, referred to as internal security investigators; 1 nurse investigator; 2 auditors; 2 in-house attorneys, including the assistant director or bureau chief; 4 analysts; and 1 administrative staffer.¹³ The Unit director is located in the Central region. Command supervisors report to the Unit director, and first-line supervisors report to a command supervisor. All other Unit investigators report to a first-line supervisor. The supervising auditor, supervising analyst, administrative staffer, and in-house attorneys report to the Unit director, regardless of their office location.¹⁴ See Exhibit 1 for an organizational chart of the Unit's reporting structure.

Exhibit 1: Organization and reporting structure of the Illinois MFCU (November 2019)



NOTE: The dotted line represents a working relationship, but not direct supervision.

Source: OIG analysis of Illinois MFCU and State Attorney General Office's organizational charts, position descriptions, and Unit responses, November 2019.

¹² The sworn law enforcement investigators include two command supervisors (one who supervises the Northern region and one who supervises the Central and Southern regions) and four first-line supervisors. One of the command supervisors and one of the first-line supervisors were in an acting capacity at the time of our review.

¹³ During our review period of FYs 2017–2019, the Unit spent \$23.6 million (with a State share of approximately \$5.9 million).

¹⁴ The remaining analysts and auditors report to their respective supervisors, except for one analyst, who reports to an investigator who is a first-line supervisor.

The Unit is one of four MFCUs that is not part of a State Attorney General's office.¹⁵ Through a memorandum of understanding (MOU) with the Attorney General's Office, the Unit relies on 11 attorneys from the Illinois Attorney General's Office to prosecute the Unit's cases of Medicaid fraud and patient abuse and neglect. These attorneys work exclusively on MFCU cases but report to the Attorney General's Office, are paid for by the ISP, and are not covered by the MFCU grant. The MFCU's two in-house attorneys do not prosecute cases; instead, they provide legal advice on cases and, among other duties, handle global civil fraud cases, which are False Claims Act cases that involve the U.S. Department of Justice and a group of MFCUs.^{16, 17}

Referrals. During FYs 2017–2019, the Unit reported receiving fraud referrals from several sources, including the Illinois Department of Healthcare and Family Services' Office of Inspector General (HFS-OIG), which serves as the program integrity unit for the State Medicaid agency; and the Department of Human Services/Department of Rehabilitation Services (DHS/DORS), which administers the State's home and community-based services (HCBS) waiver program.¹⁸ The Unit received a significant number of referrals related to personal care services from DHS/DORS. The Unit also reported receiving referrals of patient abuse and neglect from the Illinois Department of Public Health, which serves as the State survey and certification agency. The Department of Public Health conducts inspections to certify health care facilities for Medicaid compliance and investigates and validates referrals.¹⁹ Appendix B lists Unit referrals by source for FYs 2017–2019.

The Unit has different procedures for receiving referrals based on the referral source. Fraud referrals from the HFS-OIG and DHS/DORS are sent to the Unit via a secure email. A Unit analyst reviews the fraud referrals to determine to which MFCU region to send the referral and may conduct additional analyses to assist the command

¹⁵ The other three MFCUs that do not reside in an Attorney General's Office, or another office with State-wide authority to prosecute criminal cases, are those of the District of Columbia, Iowa, and Tennessee. While each of the four MFCUs have arrangements with other State, county, and Federal prosecutors to prosecute their cases, Illinois is the only MFCU that has a dedicated team of attorneys from the Attorney General's Office assigned to MFCU prosecutions.

¹⁶ The MFCU complies with staffing requirements, as the MFCU employs "[o]ne or more attorneys capable of prosecuting the Unit's health care fraud or criminal cases and capable of giving informed advice on applicable law and procedures and providing effective prosecution or liaison with other prosecutors." 42 CFR 1007.13(b)(1).

¹⁷ The National Association of Medicaid Fraud Control Units (NAMFCU) facilitates the settlement of global cases on behalf of the States.

¹⁸ Under the HCBS waiver program, States can provide care and services to Medicaid-eligible beneficiaries in their homes and other community-based settings, such as assisted living facilities. Examples of care and services include case management services, homemaker services, and personal care services, such as activities of daily living (e.g., bathing, light housework, and meal preparation). For HCBS waiver requirements, see 42 CFR pt. 441, subpt. G.

¹⁹ Illinois Department of Public Health, *Who Regulates Nursing Homes?* Accessed at <https://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/regulation> on August 12, 2020.

supervisor, who has the responsibility on behalf of the MFCU to determine whether to accept the referral. Referrals of patient abuse and neglect from the Department of Public Health are sent directly to the respective MFCU region, and an analyst enters the referrals into the Unit's case management system. A Unit supervisor determines whether to accept the referral and may involve the nurse investigator for issues pertaining to quality of care or standards of medical practice. Referrals of fraud and patient abuse and neglect from any other sources are entered into the Unit's case management system by an analyst in the receiving region and are reviewed by a command supervisor.

Investigations. Once the Unit accepts a referral, the command supervisor assigns an investigative team to the case. The investigative team consists of an investigator (sworn or civilian), an analyst, an attorney from the Attorney General's Office, and Unit support staff (e.g., auditor, in-house attorney), as appropriate. The investigative team completes an investigative plan, which outlines and assigns key investigative tasks to the team members and includes dates for regularly scheduled meetings to discuss progress and adjustments to the initial investigative plan. The Unit stores all case records—including opening documentation, interviews, summaries, case file reviews, and closing requests—in its electronic case management system. If the investigative team decides to prosecute a case following a full investigation, the team consults and obtains approval from the Unit director.

Prosecutions. After the Unit director approves a case for prosecution, the Unit must formally refer the case to the Attorney General's Office for a prosecutorial decision. If the Attorney General's Office accepts the case, it may prosecute the case in State court but must first obtain approval from the local district attorney because the Attorney General's Office does not have Statewide authority to prosecute cases. The Attorney General's Office may also pursue civil cases on the Unit's behalf in State court under the State's False Claims Act.²⁰ The Unit may also prosecute criminal cases and litigate civil cases in Federal court. The Unit may pursue those cases in collaboration with, or referral by, the U.S. Attorney's Offices or OIG. If the Attorney General's Office declines a case, the Unit may refer the case to another agency with prosecutorial authority, such as local law enforcement or Federal partners. There are three U.S. Attorney's Offices that operate in the State of Illinois, located in the Northern, Central, and Southern Districts. The MFCU has regions that correspond with these three U.S. Attorney's Offices.

²⁰ Illinois State Statutes 740 ILCS 175.

Illinois Medicaid Program

The Illinois Medicaid program is administered by the Department of Healthcare and Family Services (HFS). In FY 2020, Illinois' Medicaid expenditures were \$23.3 billion.²¹ The HFS administers the State's Medicaid fee-for-service and managed care programs.²² There are seven Medicaid managed care organizations (MCOs) in the State of Illinois.²³ In February 2021, 77 percent of Illinois' approximately 3.5 million Medicaid beneficiaries received their services through these 7 MCOs.²⁴

Medicaid Program Integrity. The HFS-OIG and the State's seven MCOs are primarily responsible for Medicaid program integrity efforts in Illinois. Under managed care, the HFS contracts with MCOs to process, pay, and monitor claims of providers in the MCOs' networks. Each MCO deploys Special Investigative Units that identify and investigate potential fraud and abuse in its networks and refer suspected cases of provider fraud or patient abuse to the HFS-OIG.²⁵ The HFS-OIG conducts administrative investigations on referrals received, including those from MCOs and from its hotline, and refers suspected fraudulent activity to the MFCU, as specified in an intergovernmental agreement between the HFS-OIG and the MFCU. The MFCU reviews all referrals from the HFS-OIG to determine whether credible allegations of fraud exist and notifies HFS-OIG in writing of its determination.

Previous OIG Reports and Oversight

In 2012, OIG conducted an onsite review of the Unit.²⁶ OIG found that the Unit's organizational structure for its attorneys, who did not report to the Unit director, conflicted with the Federal requirements implementing the principle that the Unit be a "single, identifiable entity," and found that the attorneys assigned to the Unit were ineligible for Federal Financial Participation.²⁷ The attorneys were housed in a

²¹ OIG, *MFCU Statistical Data for FY 2020*, March 2020 (not yet available online).

²² HFS, *Managed Care in Illinois*. Accessed at <https://www.illinois.gov/hfs/MedicalClients/ManagedCare/Pages/default.aspx> on April 23, 2020.

²³ DHS, *Managed Care Organizations*. Accessed at <https://www.illinois.gov/hfs/SiteCollectionDocuments/StatewideHealthChoiceIllinoisPlans.pdf> on March 10, 2021.

²⁴ On March 1, 2021, the State Medicaid agency reported that approximately 2,667,101 of its 3,479,292 beneficiaries were enrolled in MCOs in February 2021. The total number of beneficiaries enrolled in Medicaid for February 2021 may increase from 3,479,292 over the next few months as the agency processes retroactive enrollments.

²⁵ 42 CFR § 438.608.

²⁶ OIG, *Illinois State Medicaid Fraud Control Unit: 2012 Onsite Review*, OEI-07-12-00510, June 2013. Accessed at <https://oig.hhs.gov/oei/reports/oei-07-12-00510.asp> on March 29, 2020.

²⁷ The portion of funds reimbursed to States by the Federal government for its share of expenditures for the Federal Medicaid program, including MFCUs, is called the Federal Financial Participation. Federal Financial Participation is not available for the compensation of persons other than full-time professional employees of the Unit. 42 CFR § 1007.13 and 1007.19(e)(4).

different location in State government, the Attorney General's Office, and reported to a Bureau Chief (see Exhibit 1 on page 3). Given this organizational structure, OIG determined that the MFCU should not have used the MFCU grant to pay for these attorneys, as they were not MFCU employees. OIG recommended that the Unit develop and implement a corrective action plan to address noncompliance with the certification requirements, including the full-time employment rule for attorneys. Based on other findings in the report, OIG also recommended that the Unit (1) refer convicted providers to OIG for program exclusion within appropriate timeframes; (2) update the Unit's MOU with the State Medicaid agency to comply with Federal grant requirements; (3) ensure that all case files contain opening and closing documents, investigative memoranda, documented supervisory approvals, and documented periodic supervisory case file reviews; (4) ensure referrals for prosecution follow established protocols; (5) ensure investigations are related to Medicaid and repay grant funds for ineligible cases; (6) upgrade the Unit's case management system; (7) improve communication and cooperation with key stakeholders; and (8) establish training hour requirements for professional disciplines.

OIG assisted the Unit with developing the corrective action plan, which was approved by OIG in July 2013 but took effect in June 2015. As a result of the corrective action plan, the MFCU removed from the Federal grant the 10 attorneys who were employed and supervised by the Attorney General's Office.²⁸ Under its amended MOU with the Attorney General's Office, the MFCU agreed to designate ISP funds to pay for 11 attorneys from the Attorney General's Office to work exclusively on MFCU matters.²⁹ The MFCU also hired its own in-house attorneys, who report to the Unit director. By June 2015, OIG considered all of the recommendations to have been implemented by the Unit.

In addition to these recommendations, OIG, in its 2012 review, made an observation concerning turnover with the Unit director position. External stakeholders and Unit staff reported that the frequent turnover of the Unit director was problematic and impeded Unit productivity. The Unit employed six directors (some of whom were in acting capacity) during our 3-year review period (FYs 2009–2011). OIG noted the same observation in an earlier onsite report, issued in 2011. We found that the Unit had three directors during a 12-month period, which staff reported was affecting the Unit's continuity and ability to effectively carry out its mission.³⁰

²⁸ Subsequent to our 2012 onsite review, the Attorney General's Office added an additional attorney to work exclusively on MFCU matters, bringing the total to 11 attorneys.

²⁹ Although the attorneys in the State Attorney General's Office work solely on MFCU matters, they are not eligible for Federal Financial Participation under the Federal grant because they are not MFCU employees. In FY 2019, the ISP paid an estimated \$975,000 for the salaries of the attorneys in the State Attorney General's Office. OIG would have paid 75 percent of these salaries if these positions were a part of the MFCU.

³⁰ OIG, *Onsite Review of the State of Illinois Medicaid Fraud Control Bureau*, May 2011 (not available online).

Methodology

We conducted an onsite review of the Illinois Unit in November 2019. The review team consisted of OIG evaluators, OIG agents, and an OIG grant oversight analyst. Our review covered the 3-year period of FYs 2017–2019. The primary purpose of this review was to examine an area of concern related to the Unit’s organizational structure within the ISP and its relationship with the Attorney General’s Office and to examine the Unit’s operations and adherence to the 12 performance standards and applicable Federal laws, regulations, and policy transmittals. In examining the Unit’s operations and performance, we applied the published MFCU performance standards listed in Appendix A, but we did not assess every performance indicator for each of the 12 standards. See Appendix C for a detailed methodology.

We based our review on an analysis of data from eight sources: (1) Unit documentation, such as policies and procedures; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with Unit management; (5) survey of Unit staff; (6) review of a random sample of case files that were open at some point during the review period; (7) review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period; and (8) observation of Unit operations.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG’s direct administration of the MFCU grant program, but they are subject to the same internal quality controls as other OIG evaluations, including internal and external peer review.

CASE OUTCOMES

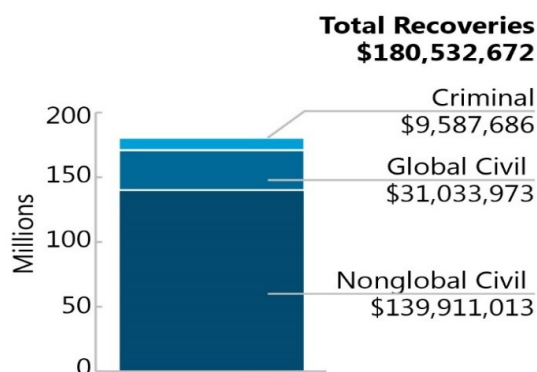
The Illinois Unit reported 141 indictments; 151 convictions; and 52 civil settlements and judgments for FYs 2017–2019.³¹

Of the 151 convictions, 120 involved provider fraud and 31 involved patient abuse or neglect. Our analysis showed that these statistical outcomes by the Illinois Unit were comparable to those of other similarly sized MFCUs.³²



The Unit reported \$180.5 million in total recoveries for FYs 2017–2019. The Unit reported total recoveries of \$180.5 million for FYs 2017–2019, with nonglobal civil recoveries representing nearly \$140 million. See Exhibit 2 for the source of the recoveries.

Exhibit 2: The Unit reported combined civil and criminal recoveries of \$180.5 million during FYs 2017–2019.



Source: OIG analysis of Unit statistical data FYs 2017–2019.

³¹ OIG provides information on MFCU operations and outcomes, but it does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgment and discretion in determining which criminal and civil cases to pursue.

³² In FY 2019, 9 other similarly sized MFCUs had staffs that ranged in size from 40 to 97 employees; the Illinois MFCU had a staff of 43 employees. Although comparison across similarly sized MFCUs provides context for the case outcomes of a particular MFCU, many factors other than the size of a MFCU's staff can affect case outcomes.

FINDINGS

We reviewed a previously identified area of concern related to the Illinois Unit's organizational structure, and we assessed the Unit's adherence to the MFCU performance standards. From this review, we identified six areas in which the Unit should improve its adherence to the MFCU performance standards—two of which also involved compliance with Federal regulations—and for which we are issuing recommendations. See Appendix A for our full assessment of the Unit's adherence with all 12 MFCU performance standards, including observations of Unit operations and practices.

The Unit's organizational structure created several staffing challenges, raising concerns about its operational efficiencies

The Unit's organizational structure within the ISP created staffing challenges and instability for the Unit. Under the ISP command structure, the Unit director's position was often used as a temporary means for law enforcement officials to advance through the ranks, resulting in frequent turnover of Unit directors. This turnover, which is a longstanding issue for the Unit, affected the Unit's ability to make long-term improvements to its operations. Further, the Unit's placement within the ISP, coupled with State-wide hiring restrictions, affected the Unit's ability to maintain approved staffing levels.

The Unit experienced significant turnover of directors, largely as a result of the ISP command structure, hampering the Unit's long-term improvements and straining relationships with stakeholders

Historically, the Unit has had frequent turnover in the director's position. From FYs 2009–2019, the Unit employed a total of 11 directors, some of whom were in an acting capacity. Of these 11 directors, 3 were employed during our review period of FYs 2017–2019, 1 of whom was serving in an acting capacity. The Unit hired the current director in January 2019. Following OIG's 2012 onsite review, the Unit reported that it had created a deputy director position to increase stability for the Unit and mitigate the impact of the frequent turnover of directors.³³ However, we found that despite this effort, the director turnover continued to negatively impact the Unit.

³³ As of January 2021, the current deputy director had been in that position for 7 years and had been employed with the MFCU for approximately 8 years beyond that.

In interviews, Unit staff and stakeholders attributed the director turnover to the ISP command structure and described the director's position as a "revolving door." According to Unit staff and stakeholders, the Unit director position was often used to provide senior law enforcement officials with an opportunity to maximize their pay and benefits before retirement or as a "stepping stone" to assist officials in rising through the ranks within the command structure. As a result, although all of the Unit's past directors had previous supervisory experience within the ISP, interview respondents reported that some of these directors were not equipped to fulfill the role of the Unit director, largely because they lacked knowledge and experience as to how to investigate and prosecute Medicaid fraud. Further, most Unit directors did not stay long enough with the Unit to invest in long-term improvements, thereby potentially impeding the Unit's success.

Some stakeholders reported that the turnover of directors had strained the Unit's relationships with some key stakeholders, including Federal partners, because the stakeholders had to rebuild their relationships with the director each time a new director came on board. Because Medicaid fraud cases often depend on the involvement of other State and Federal agencies—both to obtain strong referrals and to collaborate with other agencies in investigating and prosecuting cases—the frequent change in Unit leadership undermined the long-term relationships necessary to the success of the Unit. Stakeholders stated that over time, collaboration efforts with the Unit director decreased as a result of the director turnover. Stakeholders reported that on the other hand, this disruption to relationships was mitigated by regular contact with Unit supervisors and frontline staff, some of whom had been employed with the Unit for more than a decade.

During our onsite review, the current director acknowledged the Unit's history of leadership instability and expressed his intent to remain with the Unit until he becomes eligible for retirement in 2024. The director also stated his belief that a recent reorganization within the ISP should reduce future turnover of directors. In FY 2019, the Unit moved from the Operations Division within the ISP to the Criminal Investigations Division, which has only one colonel position. The Unit director believed that with limited promotional opportunities within the Criminal Investigations Division, there will be less director turnover in the future.

State-controlled hiring restrictions and the Unit's placement in the ISP affected the Unit's ability to maintain approved staffing levels, contributing to large caseloads

According to Performance Standard 2, a Unit should employ the number of staff included in its OIG-approved budget and commensurate with the State's Medicaid program expenditures. At the time of our review, the Unit employed 43 staff members, which was less than its OIG-approved staffing level of 60 employees.³⁴ For a MFCU with the level of State Medicaid expenditures that Illinois had in FY 2019, the average staff size would be between 65 and 82 staff members.³⁵

Performance Standard 2(e):
To the extent that a Unit maintains multiple office locations, such locations are distributed throughout the State, and are adequately staffed, commensurate with the volume of case referrals and workload for location.

We found that the Unit's number of employees decreased over the last decade, at the same time as the State Medicaid expenditures increased. From FYs 2010–2019, the State Medicaid expenditures increased from \$15.9 billion to \$19.4 billion. During the same period, the Unit's number of staff decreased from 69 employees to 43 employees (see Exhibit 3 on the next page).

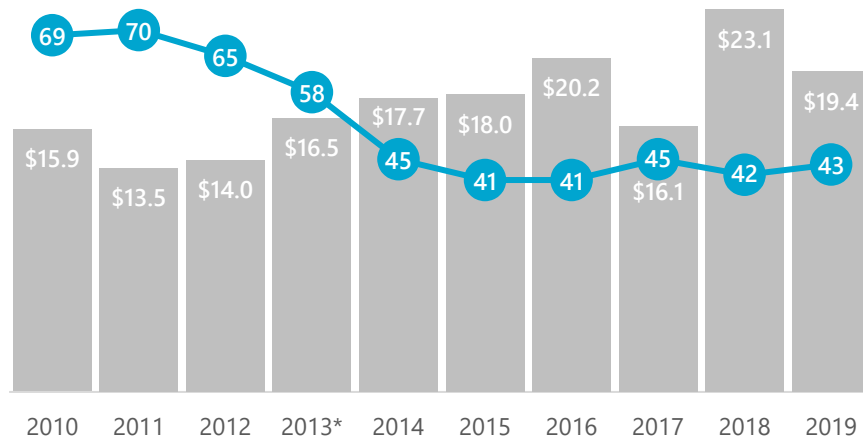
According to the Unit, the shift of 10 attorneys from the MFCU to the Attorney General's Office in 2013 contributed to this decrease in the Unit's staff size. These attorneys continued to work exclusively on the Unit's cases but were no longer considered to be Unit employees. However, even if one were to count the 11 non-Unit attorneys³⁶ in FY 2019, the resulting number (54) would still be below the average staffing levels (65 to 82 employees) for a State with a Medicaid program the size of Illinois'.

³⁴ Following our 2012 onsite review, the Attorney General's Office assigned an additional attorney to work on MFCU cases, bringing the total to 11 attorneys. The Unit's 43 employees did not include these 11 attorneys.

³⁵ OIG does not prescribe MFCUs' staffing levels. We assessed the Unit's staffing levels using a linear regression model to compare Medicaid expenditures to actual staff.

³⁶ The 11 non-Unit attorneys consisted of the 10 who were moved in 2013 and 1 additional attorney. (See also footnote 34.)

Exhibit 3: The Unit's number of staff decreased while the State Medicaid expenditures increased during FYs 2010–2019.



*The Unit shifted 10 attorneys from the MFCU grant to the Attorney General's Office in 2013.
Source: OIG analysis of Unit Annual Statistical Reports and Unit-provided documentation, FYs 2010-2019.
State Medicaid expenditures are reported in the billions of dollars.

Unit management expressed the need for additional staff across all professional disciplines but reported that State-controlled hiring freezes and budget deficits made it difficult to reach full staffing levels across all departments in the ISP. Unit management reported that the Unit's limited staff size impeded the Unit's capacity to investigate cases of fraud and patient abuse and neglect. We found that to keep up with the workload, many investigators across the Unit worked overtime and covered other roles in addition to their own positions. For example, a Unit supervisor in the Unit's Northern region stated that because of staffing shortages, he had 10 investigators doing the job of 22 investigators. Similarly, an investigator in the Unit's Central region described how one of the supervisors in the region had performed the duties of two supervisors for the past 2 years. An investigator in the Unit's Southern region also explained that these staffing limitations sometimes affected the timeliness of cases. In OIG's professional judgment, the Unit's staffing shortages could limit the type and complexity of cases that the Unit is able to investigate.

Unit staff also reported that the MFCU faced recruiting challenges, which further affected the Unit's ability to reach full staffing levels. For example, Unit staff reported difficulties in attracting qualified candidates because the MFCU's mission is not well-known among ISP personnel. Further, the ISP does not offer courses on health care fraud, so sworn officers are less likely to gain relevant training in the police academy prior to applying to the Unit.³⁷ Staff explained that the lack of knowledge of the MFCU's work would make candidates less likely to apply for a position with the MFCU, as they would be unaware whether the job would be a good match. We found that

³⁷ The MFCU must hire sworn investigators from within the ISP. However, the Unit can hire its other staff (e.g., auditors and civilian investigators) from outside the ISP.

despite these recruiting challenges, the Unit did not have any ongoing efforts to educate the ISP on the MFCU's mission and role in investigating Medicaid fraud and patient abuse and neglect.

The Unit's process for receiving referrals of patient abuse and neglect led to the Unit's screening of thousands of referrals that were unsuitable for investigation, diverting time and resources from viable cases

Unlike in most other States where the referring agency screens potential cases of patient abuse and neglect before referring them to the MFCU, the Illinois Unit requested that the Department of Public Health—the Unit's largest source for such referrals—forward all referrals to the Unit without first screening them for credibility or need for investigation. During FYs 2017–2019, the Unit reported receiving 4,563 referrals of patient abuse or neglect, 95 percent of which (4,352) were from the Department of Public Health. We found that only 4 percent of the referrals of patient abuse or neglect from the Department of Public Health (190 of 4,352) resulted in the Unit's opening of an investigation.

4,352

unscreened referrals of patient abuse and neglect were sent to the Unit during FYs 2017–2019; about 4 percent resulted in investigations.

Because the Department of Public Health did not screen the referrals prior to sending them to the Unit, many of the referrals were missing key information (e.g., names or dates of incidents) or were not within the Unit's jurisdiction (e.g., complaints about cold food or cleanliness of facilities). Consequently, the Unit reported that reviewing these referrals was time-consuming—supervisors were spending several hours per week screening referrals that were unsuitable for investigation, which diverted time and resources from viable cases. In interviews, one supervisor reported working overtime on the weekends to keep up with the large quantity of referrals that needed screening.

During OIG's previous onsite review in 2012, we found that the Unit received 4,879 referrals of patient abuse and neglect from the Department of Public Health during FYs 2009–2011. The Unit reported that following the 2012 onsite review, the MFCU's efforts to educate the Department of Public Health on referrals temporarily improved the quantity and quality of referrals, but over time, the Unit started receiving unscreened referrals again.

Shortly after our onsite visit in November 2019, the Unit reported working with the Department of Public Health to establish a standard for screening referrals of patient abuse or neglect before forwarding them to the MFCU. The Unit reported that the standard, which will be included in an MOU with the Department of Public Health, will outline minimum criteria that referrals must meet in order to be sent to the Unit.

The Unit did not always coordinate on or actively participate in cases with Federal partners, missing opportunities for sharing resources and training

Performance Standard 8(b) states that Units should cooperate and, as appropriate, coordinate with OIG and other Federal agencies on cases being pursued jointly; cases involving the same suspects or allegations; and cases that are referred to the Unit by OIG or another Federal agency.³⁸ Although most Federal partners reported positive interactions with the Unit, we found that the Unit did not always coordinate with Federal partners on cases involving the same suspects and allegations.³⁹ In law enforcement, such coordination is known as “deconfliction.”

Performance Standard 8:
The Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other healthcare fraud.

During our review period, the Unit investigated 35 cases jointly with OIG—17 cases in the Unit’s Southern region, 9 cases in its Northern region, and 9 cases in its Central region. However, in cases in which the MFCU was conducting investigations without Federal involvement, the MFCU did not always take the necessary steps to deconflict those cases with Federal partners. Although the Unit reported deconflicting on certain cases, OIG agents who work with the MFCU expressed to us the need to deconflict all MFCU cases with OIG to avoid duplicative and overlapping actions.

OIG agents working with the MFCU’s Northern region reported that they had minimal interaction with Unit staff outside of the nine cases worked jointly. The agents believed that the Unit’s constrained resources (e.g., staffing shortages) contributed to a lack of regular dialogue between the agencies and resulted in OIG’s investigating few cases jointly with the MFCU. Further, the OIG agents in that region reported challenges arising from the MFCU’s placement within the ISP. Unlike the Illinois MFCU, MFCUs are typically located within a State Attorney General’s office. Specifically, the OIG agents believed that the Unit’s placement in the ISP constrained the MFCU’s ability to investigate complex Medicaid fraud cases, thereby reducing opportunities for collaboration. In contrast to the situation in the Northern region, OIG agents working with the Unit’s Central and Southern regions reported that they had a close working relationship with Unit staff in those regions.

Similarly, we found that the Unit’s Northern region did not actively participate on cases with the U.S. Attorney’s Office for the Northern District of Illinois, but the Unit’s Central and Southern regions had strong collaboration with the U.S. Attorney’s

³⁸ Effective May 2019, Federal regulations require that MFCUs make available all information in their possession about an investigation or prosecution to OIG or other Federal investigators and prosecutors upon request. The Unit should also establish regular meetings or communication with OIG investigators and other Federal prosecutors. 42 CFR § 1007.11(e).

³⁹ OIG’s previous onsite review in 2012 found that the Unit’s Northern region did not consistently communicate or collaborate with the U.S. Attorney’s Office or OIG.

Offices for the Central and Southern Districts. Officials in the U.S. Attorney's Office for the Northern District reported that they had not had any regular contact with the Unit's Northern region in over 3 years. In contrast, we found that the Unit's Central and Southern regions communicated and shared information regularly with the U.S. Attorney's Offices for the Central and Southern Districts. However, officials in the Central District reported that the Unit declined to participate in civil fraud cases because of the perception that the Illinois Attorney General's Office would not prosecute such cases.

The lack of collaboration with Federal partners in the Unit's Northern region limited the Unit's possibility of receiving fraud referrals from OIG and the U.S. Attorney's Office in that region, and potentially affected the Unit's ability to achieve criminal convictions and civil settlements and judgments. Further, not working joint cases with Federal partners in all the regions created missed opportunities for the Unit to access and share resources (e.g., equipment and personnel) more effectively with other law enforcement agencies. The Unit also missed valuable opportunities for training with and receiving guidance from other agencies on investigating Medicaid fraud, particularly complex cases.

The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes

Performance Standard 8(f) states that the Unit should transmit to OIG all pertinent information on convictions within 30 days of sentencing, including charging documents, plea agreements, and sentencing orders, so that convicted individuals can be excluded from Federal health care programs.⁴⁰ The Unit must also report any adverse actions against health care practitioners, providers, or suppliers to the National Practitioner Data Bank (NPDB) within 30 calendar days of the date of the adverse action.^{41, 42} We found that the Unit did not always report convictions to OIG or adverse actions to the NPDB within the appropriate timeframes, and some were not reported at all until after we identified them during our onsite review.

⁴⁰ Effective May 21, 2019, 42 CFR § 1007.11(g) requires the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court. Convictions include those obtained either by Unit prosecutors or non-Unit prosecutors in any case investigated by the Unit.

⁴¹ 45 CFR § 60.5. Examples of final adverse actions include, but are not limited to, convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(g)(1).

⁴² Performance Standard 8(g) states that the Unit should report "qualifying cases to the Healthcare Integrity & Protection Databank [HIPDB], the National Practitioner Data Bank, or successor data bases." The HIPDB and the NPDB merged in 2013; therefore, we reviewed the reporting of adverse actions under NPDB requirements. See 78 Fed. Reg. 20473 (April 5, 2013).

The Unit did not report 34 percent of its convictions to OIG within 30 days of sentencing, and several of these were not reported until after we identified them during our review

Of the Unit's 151 convictions during FYs 2017–2019, we found that the Unit reported 51 convictions (34 percent) to OIG more than 30 days after sentencing. Specifically, the Unit reported 13 convictions within 31 to 60 days after sentencing, 6 convictions within 61 to 90 days after sentencing, and 32 convictions more than 90 days after sentencing. Late reporting of convictions to OIG delays the initiation of the program exclusion process, which may result in improper payments to providers by the Medicaid program or other Federal health care programs as well as possible harm to beneficiaries.⁴³

Of the 32 convictions reported more than 90 days after sentencing, we found that 9 convictions had still not been reported to OIG at the time of our onsite review and would not have been reported unless OIG identified them during the review. Unit management explained that they incorrectly believed that the Unit was not required to report any financial exploitation cases to OIG. Subsequent to our onsite review, the Unit reported that it was in the process of reporting all outstanding convictions to OIG.

The Unit did not report 77 percent of its adverse actions to the NPDB within 30 days of the adverse action, and most of these were not reported until after we identified them during our review

We found that the Unit reported 117 of its 151 adverse actions (77 percent) to the NPDB more than 30 days after the action occurred during FYs 2017–2019.⁴⁴ Of the 117 late reports, the Unit reported 5 adverse actions within 31 to 60 days after the action, 6 adverse actions within 61 to 90 days after the action, and 106 adverse actions more than 90 days after the action. The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse action made against them.

Of the 106 adverse actions reported after 90 days of the action, we found that 90 adverse actions had still not been reported to the NPDB at the time of our onsite

⁴³ The 2012 OIG onsite review found that the Unit failed to report 58 percent (56 of 97) of its convictions to OIG, and Medicaid claims data showed that a single provider, who had not been reported to OIG for program exclusion, received \$20,000 from the Medicaid program before being excluded.

⁴⁴ 45 CFR §60.5. Examples of adverse actions include but are not limited to convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(a) and (g)(1).

review. Unit management explained that they incorrectly believed that OIG's new reporting portal system, which became active in April 2018, replaced the requirement of reporting separately to OIG and the NPDB. Thus, the Unit did not submit any adverse actions to NPDB after April 2018. Following our onsite visit, the Unit reported that it was in the process of reporting all outstanding adverse actions to the NPDB.

Newly hired Unit investigators did not always complete new employee trainings, which could affect the Unit's overall effectiveness

Performance Standard 12(a) states that the Unit should maintain a training plan for all professional disciplines (i.e., attorneys, auditors, and investigators) that includes an annual minimum number of training hours. In reviewing the Unit's training records, we found that the Unit maintained training plans for all professional disciplines. Unit investigators generally met their minimum number of training hours in their training plans.⁴⁵ However, newly hired Unit investigators did not always complete new employee trainings.⁴⁶ Failure to ensure that investigative staff receive all necessary training could limit the Unit's overall effectiveness, especially for new Unit investigators who did not have any prior Medicaid fraud experience.⁴⁷

Performance Standard 12(b):
The Unit ensures that professional staff comply with their training plans and maintain records of their staff's compliance.

According to the Unit's training plans, newly hired investigators complete three trainings, including a 2-day in-house training program provided by the MFCU, a Medicaid Fraud 101 course provided by the National Association of Medicaid Fraud Control Units (NAMFCU), and a Basic Investigator Course provided by the ISP, in addition to continuing education trainings and working alongside more experienced investigators for at least the first year. The Unit's in-house training program is an introduction to Medicaid fraud for all new professional staff and includes information on how to investigate specific types of providers, Federal governing regulations, relevant State agencies, and data analysis. The NAMFCU offers MFCU employees several 3-day training courses designed for MFCU employees with different levels of experience. The Basic Investigator Course by ISP provides

⁴⁵ Per the Unit's training plans, all investigators complete (contingent upon available funds and travel approval) 16 hours of continuing education, annually, on topics related to Medicaid fraud, investigative strategies, technical investigative services, or career development or certification requirements. Most investigators met their annual training hours in calendar years (CYs) 2017–2019, with training completions ranging from 92 to 100 percent among investigators.

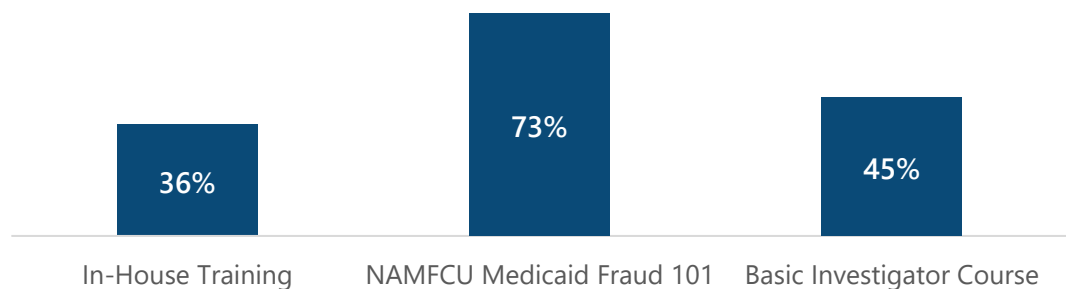
⁴⁶ In our analysis, we included only staff who were employed with the Unit for at least 11 of 12 months during each CY. Although we reviewed training records, we did not otherwise evaluate staff's professional qualifications. Not meeting the training plan requirements does not suggest that the professional staff are unqualified.

⁴⁷ None of the Unit's 32 investigators had prior Medicaid fraud experience, although Unit staff reported that 3 investigators had prior experience investigating other types of health care fraud.

all investigators with basic investigative tools and is a component of the Field Training Agent program, which includes guidance and direction from more experienced investigators.

The Unit's training records showed that not all new investigators completed the three trainings within the specified timeframes.⁴⁸ Specifically, we found that 36 percent (4 of 11) of the new investigators did not complete the in-house training program, 73 percent (8 of 11) did not attend the NAMFCU Medicaid Fraud 101 course, and 45 percent (5 of 11) did not complete the Basic Investigator Course within specified timeframes (see Exhibit 4). Initial training is important to provide new investigators with on-the-job Medicaid fraud experience, given that many investigators lack such prior experience. Until new investigators are sufficiently trained and gain hands-on experience, they will likely be unable to investigate complex fraud, which could affect the types of cases that the Unit is able to investigate.

Exhibit 4: Percentage of newly hired investigators who did not complete new employee trainings on time during CYs 2017–2019



Source: OIG analysis of Unit training records during CYs 2017–2019. Our assessment of the Unit's annual training was by CY because that is how the Unit calculated its annual training hours.

In interviews, Unit management reported a number of challenges that affected the Unit's ability to ensure that investigators completed new employee trainings. For example, the Unit explained that the in-house training program relied on outside agencies, such as HFS-OIG and State Long-Term Care Ombudsmen, and that scheduling those presenters every time the Unit hired a new investigator was time intensive. The Unit also reported that in October 2019, the Illinois Governor's Office issued travel restrictions for out-of-State trainings, such as those offered by the NAMFCU, which limited the number of staff that could attend such trainings. The Unit stated that with the new travel restrictions, the number of staff allowed to attend an out-of-State NAMFCU training decreased from eight to two. Unit management explained that there were exceptions to these restrictions and that the Governor's Office may approve more Unit staff to travel out-of-State if the training meets certain criteria (e.g., if the training is required), and the Unit requests approval in advance. As of January 2020, all new investigators who had yet to attend the NAMFCU

⁴⁸ New investigators should complete the Basic Investigator Course within 6 months of assignment to the Unit and the in-house training and NAMFCU Medicaid Fraud 101 within 1 year of assignment to the Unit.

Medicaid Fraud 101 training were on a waiting list for approval by the Governor's Office to attend that training.

Although the Unit documented its periodic supervisory reviews in most of its case files, the Unit had difficulty adhering to its policy of conducting the reviews monthly

According to Performance Standard 7(a), supervisory reviews should be conducted periodically, consistent with Unit policies and procedures, and noted in the case files. The Unit's policies and procedures manual states that the Unit should conduct supervisory reviews with a first-line supervisor every 30 days on all open cases.⁴⁹ For the cases that were open longer than 30 days, we estimated that 48 percent of case files contained documentation of a supervisory review consistent with Unit policy (i.e., every 30 days or more frequently). We estimated that the remaining 52 percent of case files did not meet the Unit's monthly supervisory review policy; 45 percent lacked documentation of monthly supervisory reviews (i.e., they were conducted less frequently), and 7 percent lacked documentation of any supervisory review.⁵⁰ Periodic supervisory reviews of case files are important because they provide the Unit with oversight and can help ensure timely completion of cases. However, in OIG's experience, conducting and documenting official case file reviews as frequently as monthly may present an unwarranted burden on investigators, as well as supervisors. We found that the intervals at which the Unit aimed to conduct supervisory reviews—i.e., monthly—were more frequent than that of other MFCUs, which typically conduct their supervisory reviews on a quarterly basis, and likely contributed to the Unit's difficulty in meeting its own policy guidelines. See Appendix D for the point estimates and confidence intervals for the case file reviews.

⁴⁹ The Unit also conducts regional reviews, on a quarterly basis, of a random sample of both acting and pending cases, performed by a command supervisor and the Unit director. According to Unit policy, the intent of these reviews is to ensure accuracy of reporting and completeness of all active case files.

⁵⁰ The 2012 OIG onsite review found that the Unit's case files lacked documentation of supervisory reviews and recommended that the Unit ensure that periodic supervisory reviews be documented. In response, the Unit developed case opening and closing forms that require a supervisor's approval and signature and clarified in its policies and procedures that supervisory reviews should be conducted monthly and properly documented.

RECOMMENDATIONS

From the data we reviewed, we identified several areas in which the Unit should further improve its adherence to the MFCU performance standards and for which we are issuing recommendations. We found that the Unit's organizational structure within the ISP created staffing challenges and instability for the Unit, which affected its ability to make long-term improvements. The Unit's placement within the ISP contributed to frequent turnover of the Unit director, affected the Unit's ability to maintain staffing levels, and impeded the Unit's recruitment of sworn law enforcement officers with health care fraud experience.

We also found that the Unit did not always work effectively with its State and Federal partners. Specifically, the Unit's referral process with the Illinois Department of Public Health led to the Unit receiving thousands of unscreened referrals of patient abuse and neglect, most of which did not result in the Unit opening a case, diverting time and resources from viable cases. The Unit also did not routinely coordinate on cases with Federal partners and worked few cases jointly with them. We found that the lack of joint cases was a missed opportunity for the Unit to share resources and train with other law enforcement agencies. Further, the Unit did not report all of its convictions and adverse actions to Federal partners within the appropriate timeframes, potentially delaying the process for excluding providers from the Federal health care programs.

Additionally, we found that the Unit did not consistently follow its own policies. We found that several of the Unit's investigators hired during our review period did not always complete new employee trainings as outlined in their training plans. We also found that, although the Unit documented its periodic supervisory reviews in most of its case files, the Unit had difficulty adhering to its policy guidelines of conducting the reviews monthly.

To address the issues identified in this report and further improve Unit operations, we make six recommendations to the Illinois MFCU.

We recommend that the Illinois MFCU:

Develop and implement a plan to address the challenges presented by the Unit's organizational structure

The Unit should determine whether its current organizational structure under the ISP is the best arrangement for its operations. The Unit should work with the Attorney General's Office or other State officials to develop a plan to address the challenges identified in this report. If the Unit finds that its current structure under the ISP is not the most effective arrangement, the Unit should consider changes to its structure, including whether placement in another State agency, such as the State Attorney

General's Office, which is typical in most other States and territories, would be more effective. The Unit should consult with OIG prior to implementing the plan to ensure that the Unit complies with Federal regulations and addresses the findings in this report. Once the plan is implemented, the Unit should work with OIG's MFCU oversight division to ensure full adherence with the plan.

Establish minimum criteria for referrals of patient abuse and neglect to be sent to the MFCU

The Unit should finalize its MOU with the Department of Public Health to establish minimum criteria for when the Department of Public Health should send referrals of patient abuse and neglect to the MFCU. The minimum criteria would provide the Department of Public Health with the necessary tools to screen referrals (a common practice for administrative agencies in other States) and to determine whether a referral should be sent to the Unit or elsewhere. We expect that establishing criteria for referrals will reduce the number of inaccurate and incomplete referrals and thereby promote Unit efficiency and case flow. Once the minimum criteria are established, the Unit should assess the effectiveness of the minimum criteria and provide training or make revisions as necessary.

Establish a process to coordinate on cases and improve collaboration with Federal partners

The Unit should establish a process consistent with Federal regulations for ensuring that it coordinates and deconflicts all of its cases with OIG. Specifically, the Unit should share a list of all of its active cases with OIG on a regular basis. In addition, the Unit should investigate more cases jointly with OIG and actively participate in more cases with the U.S. Attorney's Office, which could provide beneficial training opportunities for Unit investigators on different types of cases. To further improve communication and encourage joint casework, the Unit should inquire about receiving trainings from OIG's Office of Investigations and the U.S. Attorney's Offices.

Take steps to ensure that Unit staff report all convictions and adverse actions to Federal partners within the appropriate timeframes

The Unit should take steps to ensure that it consistently reports all convictions to OIG within 30 days of sentencing and all adverse actions to the NPDB within 30 days of the action. The Unit could provide training to staff on reporting convictions and adverse actions to Federal partners and could implement automated reminders to alert Unit staff when to report the convictions or adverse actions.

Take steps to ensure that newly hired investigators complete new employee trainings

The Unit should monitor new investigators' training plans to ensure that they complete new employee trainings. Training completion should be documented in a way that allows supervisors to stay current on the status of staff's training. The Unit should also work with the ISP and other State authorities, as necessary, on an exemption to allow the Unit to send more than two staff at a time to the NAMFCU trainings.

Take steps to ensure that supervisory reviews of case files are conducted and documented in accordance with Unit policy

The Unit should ensure that supervisors conduct and document reviews of case files consistent with Unit policy. We recognize that conducting case file reviews as frequently as monthly, which is the Unit's current policy, may present an unwarranted burden on investigators and supervisors. The Unit could consider changing, in its policies, the frequency of the supervisory reviews from a monthly to a quarterly schedule. A schedule with less frequent case file reviews may assist the Unit in meeting internal policies but would not preclude the Unit from continuing to meet monthly to discuss cases, which may be necessary when there are new investigators who need training in health care fraud.

UNIT COMMENTS AND OIG RESPONSE

The Illinois MFCU concurred with all six of our recommendations.

First, the Unit concurred with our recommendation to develop and implement a plan to address the challenges presented by the Unit's organizational structure. The Unit reported that it is working on revising the job description and reporting structure for the Unit's deputy director, which will establish additional responsibilities for the deputy director that will provide the Unit with more stability and improve its working relationships with State and Federal partners. The Unit also reported that it plans to engage with the Illinois Attorney General's Office regarding ideas that could further promote the Unit's success. The Unit reported that to improve recruitment of investigators, it plans to enhance its visibility and promote its mission and accomplishments to other agencies within the ISP.

Second, the Unit concurred with our recommendation to establish minimum criteria for when the Department of Public Health should send referrals of patient abuse and neglect to the MFCU. The Unit reported that in January 2020, the Unit and the Department of Public Health finalized the minimum criteria for these referrals.

Third, the Unit concurred with our recommendation to establish a process to coordinate on cases and improve collaboration with Federal partners. The Unit reported that it plans to establish a more formal process to communicate regularly and deconflict cases with Federal partners.

Fourth, the Unit concurred with our recommendation to take steps to ensure that Unit staff report all convictions and adverse actions to Federal partners within the appropriate timeframes. The Unit reported that it is revising its notification protocol to help eliminate any delay in reporting to OIG and the NPDB.

Fifth, the Unit concurred with our recommendation to take steps to ensure that newly hired investigators complete new employee trainings. The Unit reported that it has established the technological capability to host trainings remotely, which will allow staff across the State to receive training. The Unit also reported that it has improved its training logs to ensure easy access, entry, and verification of training requirements.

Sixth, the Unit concurred with our recommendation to take steps to ensure that supervisory reviews of case files are conducted and documented in accordance with Unit policy. The Unit reported that although supervisory reviews were conducted in accordance with its policy, the supervisory reviews were not always reflected in its case management system. The Unit reported that it will modify its case management system to make it easier for supervisors to document the 30-day supervisory reviews.

For the full text of the Unit's comments, see Appendix E.

APPENDIX A

Performance Assessment

We assessed the Illinois MFCU's adherence to the 12 MFCU performance standards, including its compliance with applicable laws, regulations, and policy transmittals. From this review, we found that the Unit generally operated in accordance with applicable laws, regulations, and policy transmittals. However, we made six findings regarding the Unit's adherence to the MFCU performance standards, two of which also involved compliance with Federal regulations (they are presented here and as findings in the report). We also made observations about Unit operations and practices. The complete MFCU performance standards, including performance indicators, were published at 77 Fed. Reg. 32645 (June 1, 2012), and appear on OIG's website at <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>.

STANDARD 1

A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation

From the information we reviewed, the Illinois MFCU generally complied with applicable laws, regulations, and policy transmittals. However, we identified compliance concerns related to the Unit's coordination with Federal partners and with its reporting of convictions and adverse actions to Federal partners, as described under Performance Standard 8 below.

STANDARD 2

A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Finding

The Unit's organizational structure created several staffing challenges, raising concerns about its operational efficiencies. See page 10.

STANDARD 3

A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

Observation

The Unit maintained policies and procedures. The Unit maintained a Policy and Procedures Manual specific to the MFCU's functions and jurisdiction. This manual is referred to as the Medicaid Fraud Control Bureau Handbook. The Unit's handbook is separate from the ISP-wide handbook and addresses the Unit's specific requirements that are not

addressed in the ISP handbook. The Medicaid Fraud Control Bureau Handbook is available to Unit staff electronically and was last updated on September 17, 2019.

STANDARD 4

A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Finding

The Unit's process for receiving referrals of patient abuse and neglect led to the Unit's screening of thousands of referrals that were unsuitable for investigation, diverting time and resources from viable cases. See page 14.

STANDARD 5

A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation

Nearly all case files contained documentation of supervisory approval of case openings and closings. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, review the progress of cases, and take action as necessary to ensure that each stage of the investigation and prosecution are completed in an appropriate timeframe. Our review found that nearly all of the sampled case files contained documentation of supervisory approval of case opening and closings. An estimated 99 percent of case files had supervisory approval to open the case for investigation. At the time of our review, 67 percent of cases were closed, and we found that all of the closed cases had approval to close. See Appendix D for the point estimates and the confidence intervals for the case file reviews.

STANDARD 6

A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observations

The Unit's case mix included both cases of fraud and cases of patient abuse or neglect, but the Unit worked a disproportionate number of cases involving personal care services. Of the 986 cases that were open during FYs 2017–2019, 86 percent (844 cases) involved provider fraud and 14 percent (142 cases) involved patient abuse or neglect. Although the Unit's open criminal fraud cases covered 30 different provider types (e.g., nursing facilities, physicians), 70 percent of the Unit's fraud cases involved personal care services (PCS) attendants. A common type of fraud scenario involving PCS attendants is a "conflict case," in which a PCS attendant claims to have provided services, such as meal preparation or light housework, to a Medicaid beneficiary during the same hours that the

PCS attendant worked at another place of employment (e.g., doctor's office, convenience store).⁵¹

Unit management attributed the high number of PCS fraud cases to stakeholders referring a disproportionate number of PCS referrals to the Unit. While investigation of PCS fraud is important, Performance Standard 6(c) states that the Unit should allocate its resources among provider types based on levels of Medicaid expenditures or other risk factors. Subsequent to our review, the Unit reported taking steps to help increase a broader mix of provider fraud referrals from its key stakeholders. For example, the Unit recommended that the State Medicaid agency, HFS-OIG, allow MCOs to simultaneously report referrals to the Unit and the HFS-OIG, which should increase the number and types of fraud referrals that the Unit receives.

The Unit pursued few nonglobal civil fraud cases. Performance Standard 6(e) states that Units should seek to maintain, consistent with their legal authority, a balance of criminal and civil fraud cases. Illinois enacted a False Claims Act in 1991, which provides the Unit with a basis to pursue its own nonglobal cases.⁵² However, only 1 percent of the Unit's cases (10 of 849) during FYs 2017–2019 were nonglobal civil fraud cases.⁵³ Nonglobal cases involve primarily State rather than Federal litigation; are pursued separately by Units or with other law enforcement partners; and are not coordinated by the NAMFCU. In interviews, Unit staff reported a willingness to work civil fraud cases and expressed frustration that despite receiving referrals with potential for civil remedies, the Unit did not have more civil case outcomes. Some staff had the perception that the Attorney General's Office was not interested in pursuing civil fraud cases.

STANDARD 7

A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Finding

Although the Unit documented its periodic supervisory reviews in most of its case files, the Unit had difficulty adhering to its policy of conducting the reviews monthly. See page 20.

Observation

The Unit generally maintained case files in an effective manner, but some practices did not allow for efficient access to case information. According to Performance Standard 7(e), the Unit should have an

⁵¹ OIG, *MFCUs: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services*, OEI-12-16-00500, December 2017. Accessed at <https://www.oig.hhs.gov/oei/reports/oei-12-16-00500.pdf> on October 20, 2020.

⁵² Illinois State Statutes §§ 740 ILCS 175/1-8.

⁵³ The Unit's nonglobal civil recoveries totaled \$140 million. Of those recoveries, \$135 million derived from a case that is part of a larger, ongoing 2005 lawsuit filed against 47 pharmaceutical companies.

information management system that manages and tracks case information from initiation to resolution. The Unit used an electronic case management system to record and track all case information. We determined that overall, the Unit adequately maintained case files, but we observed some practices that did not allow for efficient access to case information. For example, we found that some case files lacked descriptive names, which made it difficult to locate specific documents and fully review the Unit's investigation processes in their entirety. We also found that Unit staff did not consistently label joint cases in the electronic system and that descriptive information to document the involvement of the joint agency was sometimes missing. Without such information, we found it difficult to determine the level of involvement of the partner agency for some cases. Further, only an estimated 45 percent of case files included documentation that the Unit communicated its closing decision to the referring agency. Notifying the referring agency that the Unit has closed a case helps ensure that the referring agency can pursue other administrative actions, as appropriate. See Appendix D for the point estimates and confidence intervals of the case file reviews.

STANDARD 8

A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Findings

The Unit did not always coordinate on or actively participate in cases with Federal partners, missing opportunities for sharing resources and training. See page 15.

The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes. See page 16.

STANDARD 9

A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation

The Unit made several recommendations to the State Medicaid agency during our review period. The Unit recommended that the State Medicaid agency amend its contracts with the MCOs to require MCOs to cooperate with the Unit, particularly on issues related to methods for identifying, investigating, and referring suspected Medicaid fraud. To reduce fraud in home health agencies, the Unit also recommended that the State Medicaid agency limit the number of vendors approved to sell electronic timekeeping systems for health care workers used by home health agencies and to require home health employees to watch an announcement about Medicaid fraud before they submit their weekly hours into a vendor's system. None of these recommendations had been implemented by the State Medicaid agency at the time of our review.

STANDARD 10	A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.
Observation	The Unit's intergovernmental agreement with the Medicaid agency reflected current practice, policy, and legal requirements. The ISP and the HFS, the Medicaid agency, had a current intergovernmental agreement, executed in January 2019. The agreement reflected all policy and legal requirements, as well as current practices, between the parties.
STANDARD 11	A Unit exercises proper fiscal control over its resources.
Observation	From our limited review, we identified no deficiencies in the Unit's fiscal control of its resources. From the Unit's responses to a detailed fiscal-controls questionnaire, we identified no issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel. In our inventory review, we located 30 of the 30 sampled inventory items.
STANDARD 12	A Unit conducts training that aids in the mission of the Unit.
Finding	Newly hired Unit investigators did not always complete new employee trainings, which could affect the Unit's overall effectiveness. See page 18.

APPENDIX B

Illinois MFCU Referrals Received, by Source, for FYs 2017–2019

Exhibit B-1: Illinois Unit referrals received during FYs 2017–2019, separated by source and FY

	FY 2017		FY 2018		FY 2019		3-Year Total		
Referral Source	Fraud	Abuse & Neglect ¹	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Fraud	Abuse & Neglect	Total
Adult Protective Services	0	0	0	0	0	0	0	0	0
Anonymous	0	1	0	0	0	0	0	1	1
Dept. of Human Services/Dept. of Rehabilitation Services (DHS/DORS)	35	1	83	0	92	0	210	1	211
Dept. of Public Health	6	1,368	6	1,402	2	1,582	14	4,352	4,366
HHS—Office of Inspector General (OIG)	6	1	1	0	6	0	13	1	14
Local Prosecutor	1	0	0	0	1	0	2	0	2
Long-Term Care Ombudsman	1	0	0	0	0	0	1	0	1
Managed Care Organizations	0	10	0	14	0	9	0	33	33
Medicaid Agency Program Integrity Unit (HFS-OIG)	27	0	21	0	15	0	63	0	63
Other Law Enforcement	4	2	4	3	1	4	9	9	18
Private Citizens	108	25	89	27	114	53	311	105	416
Private Health Insurer	0	0	0	0	1	1	1	1	2
Provider	6	25	5	19	2	10	13	54	67
Provider Association	1	0	2	0	0	0	3	0	3
Other	6	0	9	6	2	0	17	6	23
Total	201	1,433	220	1,471	236	1,659	657	4,563	5,220

Source: OIG analysis of Unit Annual Statistical Reports for FYs 2017–2019.

¹The category “Abuse & Neglect” includes referrals regarding misappropriation of patient funds.

APPENDIX C

Detailed Methodology

We collected and analyzed data from the eight sources below to examine an area of concern related to the organizational structure of the Illinois MFCU and to assess the Unit's performance and operations. We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards.

Data Collection and Analysis

Review of recertification data, case outcome data, and Unit documentation.

Prior to the onsite review, we analyzed the Unit's recertification data for FYs 2017–2019, including (1) the annual reports, (2) the Unit director's recertification questionnaires, (3) the Unit's agreement with the State Medicaid agency (HFS), (4) the Medicaid agency's program integrity director questionnaires (HFS-OIG), and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's annual statistical reports, which allowed us to determine the total number of the referrals that the Unit received from a variety of sources. This also allowed us to determine the Unit's case outcomes—indictments, investigations, criminal convictions, civil settlements and judgments, and monetary recoveries (criminal, global civil, and nonglobal civil)—for FYs 2017–2019. We examined prior OIG findings and recommendations and reviewed the Unit's implementation of those recommendations.

As part of our review of Unit staff levels, we assessed the Unit's staff levels using a simple linear regression model to compare Medicaid expenditures to actual staff. We also examined other Unit documentation to determine the length of each staff member's employment with the Unit during our review period. Additionally, we reviewed the Unit's annual training to assess staff's adherence to the training plans and determine whether staff received adequate training.

We also reviewed Unit policies and procedures and held discussions with Unit management during the onsite review to gain a better understanding of those documents. We confirmed with the Unit director that the information we had was current, and we requested any additional data and clarification as needed.

Review of Unit financial documentation. We conducted a limited review of the Unit's control over its fiscal resources. Prior to the onsite review, we analyzed the Unit's response to an internal-controls questionnaire and conducted a desk review of the Unit's financial status reports. We followed up with Unit officials to clarify issues identified in the internal-controls questionnaire. We also selected a purposive sample of 30 items from the current inventory list of 676 items maintained in the Unit's office and verified those items onsite.

Interviews with key stakeholders. In October and November 2019, we interviewed nine key stakeholders, including officials in the HFS-OIG, Department of Public Health, U.S. Attorney's Office, DHS/DORS, and Illinois State Long-Term Care Ombudsman. We also interviewed Special Agents from OIG's Office of Investigations in Chicago and Kansas City. We focused these interviews on (1) the Unit's relationship and interactions with these entities, (2) any areas in which stakeholders believed the Unit had opportunities for improvement, and (3) practices that may be beneficial to the Unit's operations or to other Units. After the onsite review, we followed up with stakeholders as needed.

Interviews with Unit management. We conducted structured onsite interviews with Unit management, including the director, attorneys, and investigative supervisors. We also interviewed attorneys from the Attorney General's Office who work on Unit cases. Finally, we interviewed the Central Command Major, who is the supervisor of the Unit director. We asked them questions related to the following: (1) Unit operations, (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance, (3) opportunities for the Unit to improve its operations and/or performance, (4) clarification regarding information obtained from other data sources, and (5) the Unit's training and technical assistance needs. Subsequent to the onsite review, we followed up with the Unit director, in-house attorney, Central Command Major, and the Attorney General Bureau Chief to clarify certain data we collected onsite and to gather additional information.

Survey of Unit staff. In early November 2019, we conducted an online survey of 35 Unit staff members within the Unit's professional disciplines (i.e., investigators, auditors, and attorneys), support staff, and attorneys from the Attorney General's Office who work on Unit cases. Our questions focused on (1) operations of the Unit; (2) opportunities for improvement; and (3) practices that contributed to the effectiveness and efficiency of Unit operations and/or performance. The survey also sought information about the Unit's compliance with applicable laws and regulations.

Onsite review of case files. We asked the Unit to provide us with a list of cases that were open at any point during FYs 2017–2019, and we asked the Unit to include the current status of those cases; whether the case was criminal, civil, or global; and the date on which the case was opened and closed, if applicable. The total number of cases that met these parameters was 863. We then excluded a total of 323 cases from our review because they were either global cases, cases involving fugitives, or duplicate cases. We excluded the global cases because they are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. From the 540 remaining case files, we selected a simple random sample of 88 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. While onsite, we found two additional ineligible cases (i.e., global cases) that we excluded from our review, which were not previously correctly categorized by the Unit. With the assistance of OIG agents, we reviewed the Unit's processes for monitoring the opening, status, and

outcomes of these 86 cases. We also reviewed the Unit's approach to investigating and prosecuting cases that were open at some point during FYs 2017–2019.

Review of Unit submissions to OIG and the NPDB. We reviewed all convictions submitted to OIG for program exclusion and all adverse actions submitted to the NPDB during FYs 2017–2019 and assessed the timeliness of these submissions.

Onsite review of Unit operations. While onsite, we examined the Unit's workspace and operations to identify any instances of nonadherence to performance standards and/or instances of noncompliance with applicable Federal laws, regulations, and OIG policy transmittals. We also evaluated the security of the Unit's case files and the functionality of the Unit's electronic case management system. Our examination of the Unit's workspace and operations while onsite did not result in any findings.

APPENDIX D

Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Exhibit D-1: Estimates for All Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases That Had Supervisory Approval To Open	86	98.8%	93.9%	99.8%
Percentage of All Cases Closed at the Time of Our Review	86	67.4%	57.2%	76.5%
Percentage of All Closed Cases That Had Supervisory Approval To Close	58	100.0%	94.1%	100.0%
Percentage of All Cases Open Longer Than 30 Days	86	96.5%	90.5%	99.2%
Percentage of All Closed Cases in Which the Unit Communicated Its Closing Decision to Referring Agency	58	44.8%	32.6%	57.6%

Source: OIG analysis of Illinois Unit case files, 2019.

Exhibit D-2: Estimates for Case Files Open Longer Than 30 Days

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases Open Longer Than 30 Days That Had Documentation of Supervisory Reviews Consistent With Unit Policy (i.e., Every 30 Days or More Frequently)	83	48.2%	37.9%	58.5%
Percentage of All Cases Open Longer Than 30 Days That Did Not Have Documentation of Supervisory Reviews Consistent with Unit Policy	83	51.8%	41.5%	62.1%
Percentage of All Cases Open Longer Than 30 Days That Lacked Documentation of Monthly Supervisory Reviews (i.e., They Were Conducted Less Frequently)	83	44.6%	34.4%	55.0%
Percentage of All Cases Open Longer Than 30 Days That Lacked Documentation of Any Supervisory Review	83	7.2%	2.9%	14.5%

Source: OIG analysis of Illinois Unit case files, 2019.



ILLINOIS STATE POLICE

Office of the Director

JB Pritzker
Governor

Brendan F. Kelly
Director

March 2, 2021

Ms. Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections
Office of the Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, D.C. 20201

RE: Illinois Medicaid Fraud Control Unit: 2019 Onsite Review

Dear Deputy Inspector General Murrin:

Thank you for your correspondence and draft report entitled: *Illinois Medicaid Fraud Control Unit: 2019 Onsite Review*, OEI-06-19-00510. We also want to thank you for the efforts, cooperation, and communication from the onsite team. We appreciate the opportunity to improve Illinois' Medicaid Fraud Control Unit in support of its mission to aggressively investigate and deter cases of fraud, abuse and neglect in order to safeguard the Medicaid system from unscrupulous providers along with promoting proper medical care and a safe environment for all long-term care residents in Illinois.

As instructed, we are taking this opportunity to respond to the recommendations made by the onsite team and included in the final draft report. According to the draft report, the Illinois Medicaid Fraud Control Unit was found to have generally operated in accordance with the applicable laws, regulations, and policy transmittals. However, there are six findings and recommendations for the Unit, which we will address individually.

Finding #1: The Unit's organizational structure created several staffing challenges, raising concerns about its operational efficiencies.

Recommendation #1: Develop and implement a plan to address the challenges presented by the Unit's organizational structure.

Concur: The Unit operates under 42 CFR §1007.7 (c). - *The Unit has a formal working relationship with the office of the State Attorney General, or another office with statewide prosecutorial authority, and has formal written procedures for referring to the State Attorney General or other office suspected criminal violations and for effective coordination of the activities of both entities relating to the detection, investigation, and prosecution of those violations relating to the State Medicaid program.*

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The Unit has a formal agreement with the Illinois Attorney General's Office that dedicates 11 prosecutors to work exclusively on Medicaid Fraud cases. The prosecutors with the Attorney General's Office comply with the Intergovernmental Agreement and formal written procedures whereby the Attorney General's Office assumes the responsibility for prosecuting criminal and civil matters and are involved in investigations, case reviews, training and meetings with the Medicaid agency and other involved agencies. The Unit's operational structure within an agency other than the State Attorney General is appropriate under federal Regulations, and the current structure of the Unit complies with §1007.7 (c). The Unit will continue the close working relationship it has with the Illinois Attorney General's Office Medicaid Fraud Bureau and will engage in discussions regarding ideas that will promote the continued success of the Unit.

The Unit concurs that organizational structure within the Agency could be improved. During the review period, one Director held the position for approximately three years, and upon his retirement, a Unit Lieutenant was named "Acting Director" until the new Director was named. Often an Acting Commander will assume responsibilities during the selection of a replacement, but it is only an interim designation. In 2017, the Unit created the Assistant Bureau Chief position to help improve consistency. The Assistant Bureau Chief provides stability within the unit and improved working relationships with the state and federal partners to assist the Director's position providing continuity within the Unit and with state and federal partners.

To address the finding, the Unit reviewed the Assistant Bureau Chief's job description and recently submitted it to the Illinois State Police (ISP) Command to incorporate additional responsibilities that were not previously noted. The proposed job description adopts a reporting structure within the ISP Table of Organization that includes the attorney positions and the Statewide Support position. The Assistant Bureau Chief position was also created to be a working partner with the 11 Illinois Attorney General's Office prosecutors that are dedicated to the Unit.

The Unit concurs that the desired staffing levels have not been met. The Unit will continue to make requests for non-sworn personnel through the State-controlled budgetary approval process and requests for additional sworn personnel through ISP Management. In an effort to expand recruitment and broaden professional development, the Unit will promote the work of the Unit to the other agency bureaus thereby improving awareness and the visibility of the Unit to experienced investigators. The Unit will submit highlights and mission functions using ISP Division of Criminal Investigation internal publications.

The Unit will re-establish relationships with key stakeholders, including Federal partners with the Director, Assistant Bureau Chief, and command personnel.

Finding #2: The Unit's process for receiving referrals of patient abuse and neglect led to the Unit's screening of thousands of referrals that were unsuitable for investigation, diverting time and resources from viable cases.

Recommendation #2: Establish minimum criteria for referrals of patient abuse and neglect to be sent to the MFCU.

Concur: The Unit recognized that referrals from the Illinois Department of Public Health (IDPH) were not screened adequately, causing an increased volume lacking necessary and relevant information. The Unit and IDPH finalized the agreed minimum criteria for the referrals on January 30, 2020.

Finding #3: The Unit did not always coordinate on or actively participate in cases with Federal partners, missing opportunities for sharing resources and training.

Recommendation #3: Establish a process to coordinate on cases and improve collaboration with Federal partners.

Concur: The Unit will establish a more formal process with Federal points of contact and meet on a regular basis. The Unit will establish a process to communicate and deconflict cases with Federal Partners.

Finding #4: The Unit did not always report convictions or adverse actions to Federal partners within the appropriate timeframes.

Recommendation #4: Take steps to ensure that Unit staff report all convictions and adverse actions to Federal partners within the appropriate timeframes.

Concur: The Unit was mistaken about the reporting of certain convictions. The Unit has been educated on reporting requirements. In addition, the Unit is revising notification protocol to help eliminate the delay in reporting to both the HHS/OIG and the National Practitioner Data Bank.

Finding #5: Newly hired Unit investigators did not always complete new employee trainings, which could affect the Unit's overall effectiveness.

Recommendation #5: Take steps to ensure that newly hired investigators complete new employee trainings.

Concur: The Unit now has WebEx capabilities that allow us to host training for all Unit personnel, solving the logistics challenge of training with multiple office locations. All staff received Medicaid Fraud related training in May 2020, and all new personnel have also received the Unit in-house Medicaid Fraud training. Training libraries have been added for Unit access. Additionally, training logs have been improved for easy access, entry, and verification of training requirements.

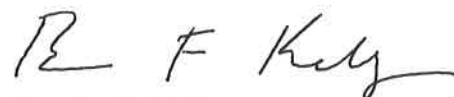
Finding #6: Although the Unit documented its periodic supervisory reviews in most of its case files, the Unit had difficulty adhering to its policy of conducting the reviews monthly.

Recommendation #6: Take steps to ensure that supervisory reviews of case files are conducted and documented in accordance with Unit policy.

Concur: Although supervisory reviews were conducted, they were not always reflected in the case management system. The Unit's case management system will be modified to make it easier for the command leaders to document the 30-day supervisory reviews.

Once again, we thank you for the opportunity to respond to the Final Draft of the 2019 Onsite Review Report for the Illinois Medicaid Fraud Control Unit. We thank you and your staff for reviewing and providing guidance for ways the Unit can improve operations for continued success.

Respectfully,



Brendan F. Kelly
Director

cc: Mr. Keith Peters, HHS-OIG

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Anthony Soto McGrath served as the team leader for this study, and Anna Brown and Kristen Calille served as the lead analysts. Medicaid Fraud Policy and Oversight Division staff who participated in the review include Keith Peters. Office of Evaluation and Inspections staff who provided support include Kevin Farber and Christine Moritz.

We would also like to acknowledge the contributions of other Office of Inspector General staff, including special agents from the Office of Investigations.

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, and Petra Nealy, Deputy Regional Inspector General, as well as in consultation with Richard Stern, Director of the Medicaid Fraud Control Policy and Oversight Division.

Contact

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