

FRAUD

Fraud Policy

When IHSS Program staff have reason to suspect that eligibility was established and/or payment was made fraudulently, an investigation of the facts must be completed. When appropriate, a referral must be made to the Public Assistance Fraud Division (PAFD) (MPP 30-769.3) on cases where the overpayment amount is believed to be more than \$1,500. For amounts under \$1,500, the overpayment procedure outlined in Part I of this chapter will be followed.

Definition

Fraud exists when a person, on behalf of him/herself or others, has knowingly and with the intent to deceive or defraud:

- Made a false statement or representation to obtain benefits, obtain a continuance or increase of benefits, or avoid a deduction or a denial of benefits.
- Failed to disclose a fact which, if disclosed, could have resulted in a denial, reduction, or discontinuance of benefits; and/or
- Accepted benefits to which he/she was not entitled, or accepted an amount of benefits knowing it was greater than the amount to which he/she was entitled. (See MPP 30-769.3)

Non-Fraud Related Allegations

In and of itself, failure to conform to community standards does not constitute fraud. For example, allegations of drug/alcohol abuse are not considered fraud-related. Situations in which the recipient/provider routines differ from the authorization in the case do not necessarily mean “fraud.” For example:

- Averaging the needs of a recipient, whose health fluctuates requiring a specific service one day, and not another, is not fraud.
- Agreement between the recipient and the provider for a short term adjustment in services delivered to meet the temporary and acute need of the recipient or provider are not considered fraud as long as the provider is not claiming pay for hours not worked.

Fraud Detection and Prevention - IHSS staff responsibilities

Reporting Responsibility

IHSS Social Work staff will:

- Ensure that the applicant/recipient or authorized representative understands his/her responsibility for promptly reporting a change in any factor that would affect the determination of eligibility or the share-of-cost.
- Ensure that the applicant/recipient or authorized representative understands that failure to report changes in a timely way can result in the denial or discontinuance of IHSS benefits, and a referral to the District Attorney for investigation of the IHSS case for fraud. Also, he/she could be responsible for repayment of any services received for which he/she was not eligible.
- Ensure that the recipient and the provider understand his/her responsibility for providing all services for which he/she was hired, and accurately reporting the hours worked on the

timesheet. The recipient and provider will sign form HHSA 12-58 and HHSA 12-58A to indicate he/she is aware of these responsibilities.

Review of Reporting Responsibilities

IHSS Social Workers will:

- Review reporting responsibilities at least once a year with the recipient or the recipient's authorized representative and the provider during the annual re-determination, using form HHSA 12-58 and HHSA 12-58A.
- Document in the case record whether or not the recipient and the provider demonstrated an understanding of these responsibilities.

Social Worker Responsibility

It is the responsibility of the Social Worker to:

- Take prompt action on any information or circumstance that could affect eligibility or require a change in the share-of-cost.
- Inform the Medi-Cal Worker (if applicable) of any information related to Medi-Cal eligibility.
- Obtain all verifications required to determine IHSS eligibility.
- Review verifications for authenticity or inconsistencies.
- Resolve issues with the recipient to the fullest extent possible when conflicting, inconsistent, incomplete, or otherwise questionable information is provided.
- Complete the IHSS Fraud Referral form 12-50 initiating a fraud referral if the Social Worker is unable to clarify the inconsistent or questionable information.
- Reduce and/or discontinue IHSS services when it has been determined that there is ineligibility for some or all of the recipient's IHSS benefits.

During the application or reassessment process, the Social Worker will evaluate the following types of inconsistencies as indicators of potential fraud:

- The applicant claims to have a *chronic* functional impairment, has not received IHSS for the past 30 days, and cannot provide a reasonable explanation as to how his/her need for assistance with the "activities of daily living" was met prior to receiving/applying for IHSS services.
- The applicant/recipient's home and furnishings do not seem to be consistent with the lifestyle of a person whose income is under the IHSS allowed income per month. The recipient does not provide a reasonable explanation as to how he/she acquired or could afford a more expensive lifestyle.
- During the assessment, the Social Worker *views all rooms of the home* (as required) and observes that the furnishings and personal effects are inconsistent with the recipient's statements regarding household composition.
- The recipient's statement of functional limitations is not supported by Social Worker observations and/or medical information.

Clerical Responsibilities:

When the Social Worker completes an SOC 311 to terminate a provider with a retroactive effective date, Clerical will:

- Check to see if the provider has been paid for any hours worked after that date.

- If so, the information is forwarded to the Social Worker to determine if a fraud referral/overpayment collection is appropriate.
 - If a fraud referral and/or overpayment collection is appropriate, the Social Worker will make the appropriate referrals.

IHSS Public Authority Responsibilities

It is the responsibility of the IHSS Public Authority to notify the Social Worker when:

- Someone is signing for the recipient, and there is no authorization on file.
- The handwriting of the provider and the recipient has similar characteristics.
- Hours claimed for the first pay period are more than 60% of the monthly total.

When batching timesheets, timesheets with the following unresolved issues will be sent to the Social Worker for clarification and follow-up, or returned to the provider to correct and resubmit.

- Do the hours add up?
- Are the signatures correct?
- Does the date of signature or mailing precede the last day of work?

Indicators Of Need For Fraud Investigation

When the Social Worker's investigation of inconsistencies and/or contradiction of facts surrounding recipient/provider eligibility does not result in a satisfactory explanation, a referral to the District Attorney's Public Assistance Fraud Division is in order. Listed below are examples of the types of unresolved inconsistencies that are referred to PAFD for further investigation of fraud/ineligibility.

Expenses Exceed Income

The Recipient's standard of living exceeds stated income/assets, and recipient has no reasonable explanation.

Inconsistent Signature

A signature appears different/altered from the authorized signature, and there is no reasonable explanation.

Active IHSS Case In Another County

The Recipient may be authorized IHSS services in more than one county. Clear CMIPS by Social Security number or Client Identification Number (CIN).

Misrepresentation Of Need

The Recipient represents that functional limitations exist that require IHSS service(s) to be provided. The Social Worker questions the Recipient's claim, as there are inconsistencies between what the Social Worker observes and what the Recipient states. This misrepresentation of the facts may be made in order to provide more "work" hours per day for a provider.

Collusion With Physician

A medical report is inconsistent with observation of a recipient's functioning and the Social Worker suspects that the recipient and the physician are overstating recipient's limitations in order to qualify for benefits.

Referrals For Prosecution

Overpayment situations where there is no reasonable explanation or extenuating circumstance, and the amount is over \$1500.00, must be referred to PAFD for possible prosecution. The following are *examples* of possible situations that would require a fraud referral for possible prosecution.

Residency

A Recipient is not:

- Residing in the United States
- Legally entitled to reside in the United States
- A California resident
- Intending to reside in California

Absence From Home

The Recipient is institutionalized, deceased, or not residing in own home and payment for IHSS services has been claimed on the timesheet during this period. Examples: visiting relatives, lengthy hospital stay, deceased.

Income/Property

The Recipient has failed to declare all income/property, or to report changes in income/property.

Services Paid – Not Provided

The provider has submitted claims and received payment from IHSS for providing services, but has not provided the services to the recipient.

Individual Provider Subcontracting

A person other than the authorized provider is providing services for less than minimum wage and the recipient and/or authorized provider is signing the timesheets, cashing the paychecks, and pocketing the difference.

Non-Medical Out-Of-Home Care (NMOHC)

Recipients receiving the board and care rate from Social Security are not eligible for IHSS services. Social Security must be notified by form DSS 07-94 and the case closed with timely notice to the recipient.

In this situation, IHSS may be the more suitable program for the recipient. If Social Security is notified they can (if appropriate) collect the overpayment directly from the recipient. If the recipient discontinues NMOHC then they can reapply for IHSS and Social Security will continue to collect the overpayment. There would be no overpayment for IHSS collection.

Overpayment

Payment was made for services which were authorized based upon inaccurate or misleading eligibility information provided by recipients, their representatives, or the provider to obtain benefits which they were otherwise not eligible to receive. Payment was made to the provider of

services for work that was not performed. Administrative error is subject to overpayment, but not prosecution for fraud.

Non-Fraud

If the Social Worker determines after a thorough review, that there is a reasonable explanation for the inconsistent or conflicting information that removes the suspicion of fraud:

- The Social Worker will enter the information and findings in the case narrative.
- Forward the case to the supervisor for his/her review and concurrence.

If the supervisor does *not* concur, the supervisor may choose to:

- Refer the case directly to PAFD.
- Forward the case to the IHSS Program Manager.

The IHSS Program Manager will determine if a fraud referral should be made.