249A.50 Fraudulent practices — investigations and audits — Medicaid fraud fund.

1. A person who obtains assistance or payments for medical assistance under this chapter by knowingly making or causing to be made, a false statement or a misrepresentation of a material fact or by knowingly failing to disclose a material fact required of an applicant for aid under the provisions of this chapter and a person who knowingly makes or causes to be made, a false statement or a misrepresentation of a material fact or knowingly fails to disclose a material fact concerning the applicant's eligibility for aid under this chapter commits a fraudulent practice.

2. The department of inspections, appeals, and licensing shall conduct investigations and audits as deemed necessary to ensure compliance with the medical assistance program administered under this chapter. The department of inspections, appeals, and licensing shall cooperate with the department on the development of procedures relating to such investigations and audits to ensure compliance with federal and state single state agency requirements.

3. *a.* A Medicaid fraud fund is created in the state treasury under the authority of the department of inspections, appeals, and licensing. Moneys from penalties, investigative costs recouped by the Medicaid fraud control unit, and other amounts received as a result of prosecutions involving the department of inspections, appeals, and licensing investigations and audits to ensure compliance with the medical assistance program that are not credited to the program shall be credited to the fund.

b. Notwithstanding section 8.33, moneys credited to the fund from any other account or fund shall not revert to the other account or fund. Moneys in the fund shall only be used as provided in appropriations from the fund and shall be used in accordance with applicable laws, regulations, and the policies of the office of inspector general of the United States department of health and human services.

c. For the purposes of this subsection, *"investigative costs"* means the reasonable value of a Medicaid fraud control unit investigator's, auditor's or employee's time, any moneys expended by the Medicaid fraud control unit, and the reasonable fair market value of resources used or expended by the Medicaid fraud control unit in a case resulting in a criminal conviction of a provider under this chapter or chapter 714 or 715A.

[C62, 66, §249A.15; C71, 73, 75, 77, 79, 81, §249A.7]

90 Acts, ch 1204, §63; 97 Acts, ch 56, §3; 2009 Acts, ch 136, §10; 2011 Acts, ch 52, §1; 2011 Acts, ch 127, §49, 89; 2013 Acts, ch 24, §14

C2014, §249A.50

2023 Acts, ch 19, §812, 1962, 1963

Referred to in §910.1

Fraudulent practices, see §714.8 – 714.14

See Code editor's note on simple harmonization at the beginning of this Code volume

Subsection 2 amended

Subsection 3, paragraph a amended