IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

Iowa Department of Inspections and Appeals

Report of the FY 2013 Activities

of the

Investigations Division

December 10, 2013

The Iowa Department of Inspection and Appeals (DIA) is pleased to submit this report regarding the State Fiscal Year 2013 (SFY13) activities of the Investigations Division in accordance with House File 603, section 13, subsection 3, paragraph b, which states:

> "The department, in coordination with the investigations division, shall submit a report to the general assembly by December 1, 2013, concerning the division's activities relative to fraud in public assistance programs for the fiscal year beginning July 1, 2012, and ending June 30, 2013. The report shall include but is not limited to a summary of the number of cases investigated, case outcomes, overpayment dollars identified, amount of cost avoidance, and actual dollars recovered."

Background

The Iowa Department of Inspections and Appeals, Investigations Division, is responsible for maintaining public assistance program integrity and accountability through the prevention, detection, and investigation of public assistance fraud and overpayments. The Economic Fraud Bureau conducts public assistance applicant/recipient pre-eligibility, post-eligibility, and divestiture alleged fraud investigations. The Medicaid Fraud Control Unit conducts investigations of alleged Medicaid provider fraud and criminal investigations of alleged resident abuse and neglect in Medicaid-reimbursed health care facilities. The Overpayment Recovery Unit collects identified overpayments of public assistance payments.

Public assistance programs include the Medicaid program, the Family Investment Program (FIP), the Supplemental Nutrition Assistance Program (SNAP), Promise Jobs, HAWK-I, IowaCare, and Child Care assistance.

The Investigations Division is committed to building on our successes, employing all enforcement tools available to us, continuing our collaboration with local, state and federal partners, and maximizing our impact on protecting the integrity of government public assistance programs.

In SFY13, the Investigations Division received a total of **6,303 referrals** involving the State's public assistance programs. They completed more than **5,988 alleged fraud investigations** resulting in more than $38,661,389 in investigative recoveries. Investigative recoveries include civil judgments, criminal

restitution and cost avoidance estimates. Cost Avoidance is the mathematical calculation of: 1) what an application would have cost the State for a 6 to 12 month period if the application had been approved; or, 2) what a recipient receiving benefits would have continued to receive for 6 months if the recipient's case had not been closed or if the recipient had not been removed from the program.

Referrals by Program Area

	SFY11	SFY12	SFY13
Economic Pre-Eligibility	NA	NA	1434
Economic Post-Eligibility	4440	3445	4207
Divestiture	336	300	442
Medicaid Fraud	190	170	220
Total Cases	4966	3915	6303

Total Cost Recoveries*

	SFY11	SFY12	SFY13
Economic Pre-Eligibility	NA	NA	$2,958,978.13
Economic Post-Eligibility	$8,724,813.18	$5,311,021.49	$7,961,451.19
Divestiture	$3,560,835.28	$2,987,110.16	$3,723,320.51
Medicaid Fraud Control Unit	$22,752,914.13	$5,209,412.70	$24,017,638.78
Total	$34,898,801.50	$13,381,282.44	$38,661,388.61

* includes state and federal dollars identified plus cost avoidance

NOTE: Please refer questions regarding this report or regarding the Investigations Division to Beverly Zylstra at beverly.zylstra@dia.iowa.gov.

Economic Fraud Bureau

Economic Fraud investigations are broken into two categories: pre-eligibility investigations and post-eligibility investigations.

- Pre-eligibility investigations are cases referred for investigation and completed prior to the Department of Human Services (DHS) certifying that a client is eligible for assistance. Investigators assist in front-end detection by timely investigating referrals in error-prone cases and gathering more information regarding a client's circumstances. Positive pre-eligibility investigations prevent fraud at intake and before a dollar loss can occur and results in cost

avoidance. An investigation may also result in a civil or criminal prosecution that leads to program disqualification.

- Post-eligibility investigations are investigations completed after DHS has determined that a client is eligible for benefits. Positive post-eligibility investigations may result in civil or criminal prosecution and the establishment of a claim to recover the amount of benefits over-issued or the amount trafficked.

Cases may involve applicants/recipients who misrepresent their circumstances in order to be eligible for or to receive more benefits than they would receive based on their actual circumstances. This may include misrepresenting who is actually in the household and that all income and living expenses are included. Other cases may involve unintentional errors by the applicant/recipient in reporting income or other information. Some cases involved unintentional errors by DHS staff in determining the amount of eligibility benefits.

Prior to SFY13, DIA did not conduct pre-eligibility case investigations. Instead of the "pay and chase" approach that had been done, DIA identified the need to focus on conducting investigations early in the eligibility determination process before benefits were paid out. So, in June 2012, DIA and DHS leadership brought their respective agencies together and conducted a joint LEAN event. During the event, the two agencies created a new process for pre-eligibility investigations, streamlined the post-eligibility process and substantially improved communications between the two agencies. As a result, the total number of cases DHS referred to DIA increased by more than 3,000 in SFY13 compared to SFY12 and cost savings to the public assistance programs increased by $4,018,464 compared to SFY 12.

Economic Eligibility Cases

	SFY11	SFY12	SFY13
Pending cases at the beginning of the Fiscal Year	1257	1007	722
Cases Referred to DIA	4440	3445	5641
Cases Completed	4690	3730	5550
Pending cases at the end of the Fiscal Year	1007	722	813

Investigative Recoveries in Pre- and Post- Eligibility Cases

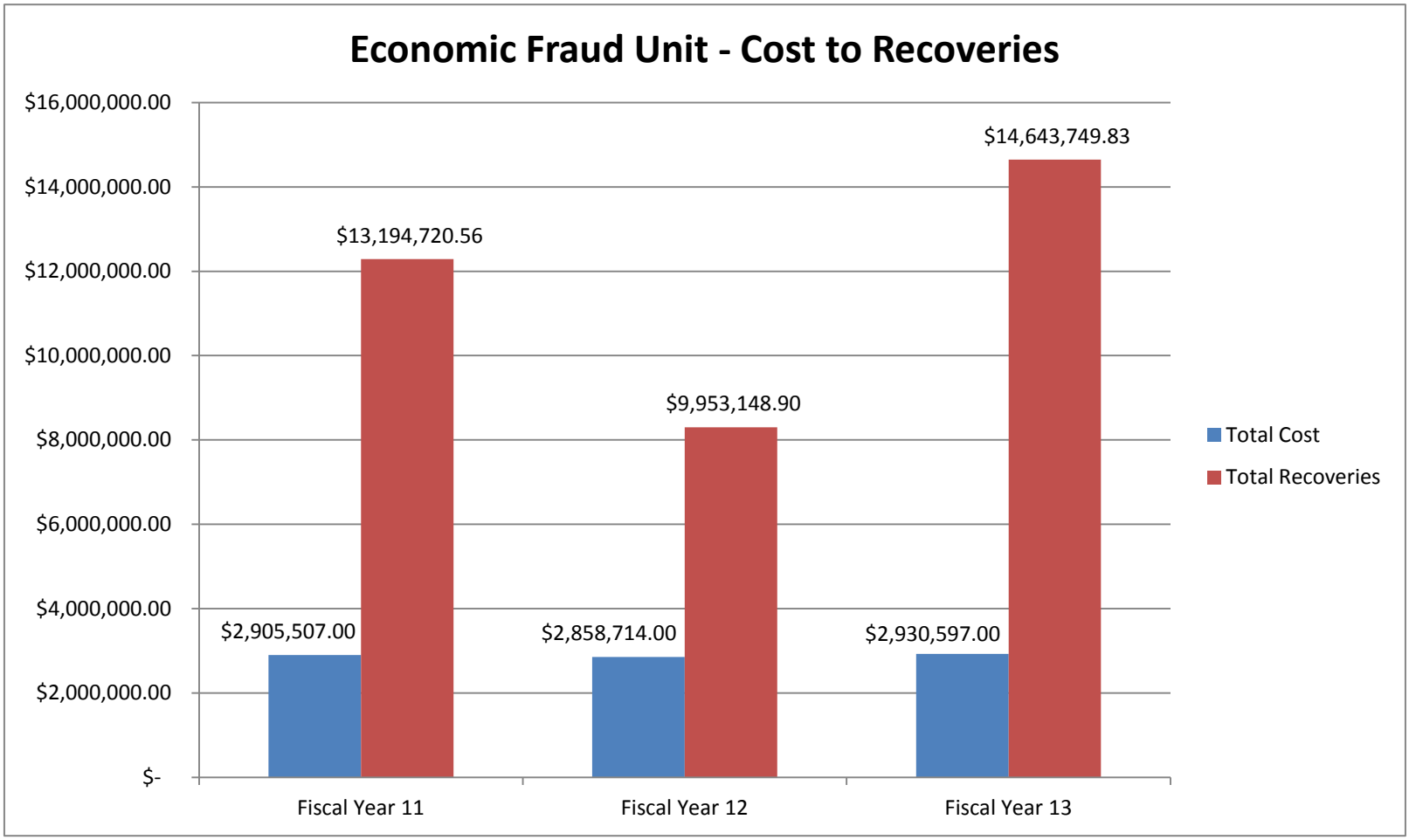
	SFY11	SFY12	SFY13
Family Investment Program (FIP)	$732,665.86	$567,762.14	$910,325.18
Food Assistance Program (SNAP)	$5,545,441.92	$3,556,649.86	$5,778,521.34
Medical Assistance (Title XIX)	$1,678,064.41	$1,567,135.43	$3,292,676.80
IowaCare	$0.00	$40,145.25	$0.00
HAWK-I	$352,028.31	$199,197.47	$81,562.44
HUD	$9,204.00	$7,086.00	$0.00
Promise Jobs	$108,207.48	$90,708.20	$0.00
Childcare	$1,161,854.57	$885,540.21	$824,093.45
State Supplementary Assistance (SSA)	$46,418.73	$51,814.18	$33,250.11
Total	$9,633,885.28	$6,966,038.74	$10,920,429.32

Divestiture Unit

The Divestiture Unit identifies and recovers assets that an individual has transferred in an attempt to improperly or illegally qualify for state public assistance funding. This unique program focuses on recovering transferred assets and ensuring these assets, rather than Medicaid funds, are used to support the original asset owner.

Divestiture Cases

	SFY11	SFY12	SFY13
Pending cases at the beginning of the Fiscal Year	247	300	308
Cases Referred	336	300	442
Cases Completed	283	292	343
Pending cases at the end of the Fiscal Year	300	308	407
Divestiture Recoveries	$3,560,835.28	$2,987,110.16	$3,723,320.51



Overpayment Recovery Unit

Once DIA staff has identified illegally or inappropriately obtained benefits, several measures may be taken to recover the identified state-paid benefits or overpayment. An overpayment is any food program, cash, medical or vendor payment made by the Department of Human Services which is more than a person is eligible for and is received by, or on behalf of that person. The most common reasons for overpayments are:

a. A client or their representative (either intentionally or unintentionally) did not provide correct or complete information to the field office.

b. A client or their representative (either intentionally or unintentionally) did not report changes in their circumstances due to income, household composition, lump sum payments or other benefits, employment status or receipt of property that directly affects their eligibility.

c. Alteration of a benefit check, medical card or Electronic Benefit Transfer card.

d. Client reported changes that affect eligibility are not updated, and the client continues to receive benefits based on information previously obtained.

Overpayments, if not paid in full by check or money order when a judgment is entered, can be collected by the following methods:

a. Monthly payments can be set up by contacting the Overpayment Recovery Unit and agreeing to an approved payment plan.

b. Grant reductions from open TANF (cash) cases are credited to TANF overpayments. Allotment reductions from open SNAP (food program) cases are credited to SNAP overpayments. In the above programs only, overpayments categorized as fraud have 20 percent reductions and all other overpayment program types have 10 percent reductions. No benefit reductions are permitted from any other program.

c. State tax refunds and US Treasury (federal) payments may be offset. State offsets will be applied to both public assistance and food program overpayments. US Treasury offsets are applied only to food program overpayments.

d. Wage and bank garnishments and recorded property liens may be initiated if timely payments are not made.

The Overpayment Recovery Unit collected $3,876,861.91 in SFY13. This was an increase of $477,259.98 or 14% when compared to SFY12.

Total Overpayment Collections

State Fiscal Year	Total Collected
SFY11	$3,518,141.57
SFY12	$3,399,601.93
SFY13	$3,876,816.91

Medicaid Fraud Control Unit

Investigators and Auditors in the Medicaid Fraud Control Unit investigate allegations of Medicaid fraud by health care providers in the State of Iowa. They also investigate allegations of abuse and neglect of residents in long-term care facilities that receive Medicaid reimbursements, as well as allegations that residents have been defrauded of personal funds or possessions.

Common types of Health Care Provider fraud include:

1. Billing for services not rendered.
2. Billing for a non-covered service as a covered service.
3. Misrepresenting dates of service.
4. Misrepresenting locations of service.
5. Misrepresenting provider of service.
6. Waiving of deductibles and/or co-payments.
7. Incorrect reporting of diagnoses or procedures (includes unbundling).
8. Overutilization of services.
9. Corruption (kickbacks and bribery).
10. False or unnecessary issuance of prescription drugs.

Fraud Provider Cases

	SFY11	SFY12	SFY13
Pending cases at the beginning of the Fiscal Year	101	68	131
Cases Initiated	109	124	137
Cases Completed	142	61	75
Pending cases at the end of the Fiscal Year	68	131	193

Abuse and Neglect Cases

	SFY11	SFY12	SFY13
Pending cases at the beginning of the Fiscal Year	43	16	10
Cases Initiated	65	16	18
Cases Completed	92	22	8
Pending cases at the end of the Fiscal Year	16	10	20

Theft of Patient Funds Cases

	SFY11	SFY12	SFY13
Open Cases	30	20	11
Cases Initiated	16	12	7
Cases Completed	26	21	12
Caseload Balance	20	11	6

Investigative Recoveries In Medicaid Fraud Cases*

	SFY11	SFY12	SFY13
Identified	$22,752,914.13	$5,209,412.70	$24,017,638.78
Collected	$9,024,253.91	$1,741,298.60	$8,323,514.06

*This amount includes the State and Federal Shares