Iowa Department of Inspections and Appeals

Investigations Division

State Fiscal Year 2015
Activities Report

December 2015

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

Contents

Administrative Overview

The Iowa Department of Inspection and Appeals (DIA) is pleased to submit this report regarding the State Fiscal Year 2015 (SFY15) activities of the Investigations Division in accordance with House File 659, which states:

> *The department, in coordination with the investigations division, shall submit a report to the general assembly by December 1, 2015, concerning the division's activities relative to fraud in public assistance programs for the fiscal year beginning July 1, 2014, and ending June 30, 2015. 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

Located within the DIA, the 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 division is comprised of the following areas:

- Economic Fraud Control Bureau – conducts public assistance applicant/recipient pre-eligibility, post-eligibility, and divestiture alleged fraud investigations.
    - Electronic Benefit Transfer (EBT)/Program Integrity Unit – conducts investigations related to the misuse and trafficking of EBT cards.
    - Divestiture Unit –conducts investigations into transfers of assets by a person (within five years of applying for or receiving Medicaid benefits) to determine if that transfer was made inappropriately in order to obtain or maintain benefit eligibility according to Iowa Code 249F.
- Medicaid Fraud Control Unit (MFCU) – conducts investigations of alleged Medicaid provider fraud and criminal investigations of alleged resident abuse and neglect in Medicaid-reimbursed health care facilities.
- Public Assistance Debt 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.

Additionally, the Division has three other areas that are included in this section for reference. As their work product does not fall within the parameters of House File 659, they are included here in order to provide a comprehensive picture of the Division.

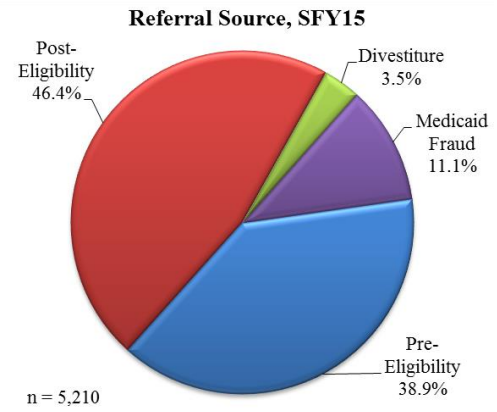
- Human Services Audits – reviews and verifies facility billing and personal allowance accounts, ensures state billings accurately reflect the facility census and ensure expenditures of local Iowa Department of Human Services (DHS) office administrative expense claims and official receipts are in accordance with the criteria set forth by state law, rules, and procedures.
- Professional Standards Unit – investigates professional practice complaints on the behalf of the Iowa Department of Public Health for 19 different licensure boards regulating 39 professions. These investigations assist the licensing boards to maintain their mission of protecting the public health, safety, and welfare by licensing qualified individuals and enforcing Iowa's statutes and administrative rules fairly and consistently.
- Abuse Coordinating Unit – operates Iowa's dependent adult abuse program within the state's facilities and programs, in accordance with Iowa Code chapter 235E.

Statistics at a Glance

Referral Sources

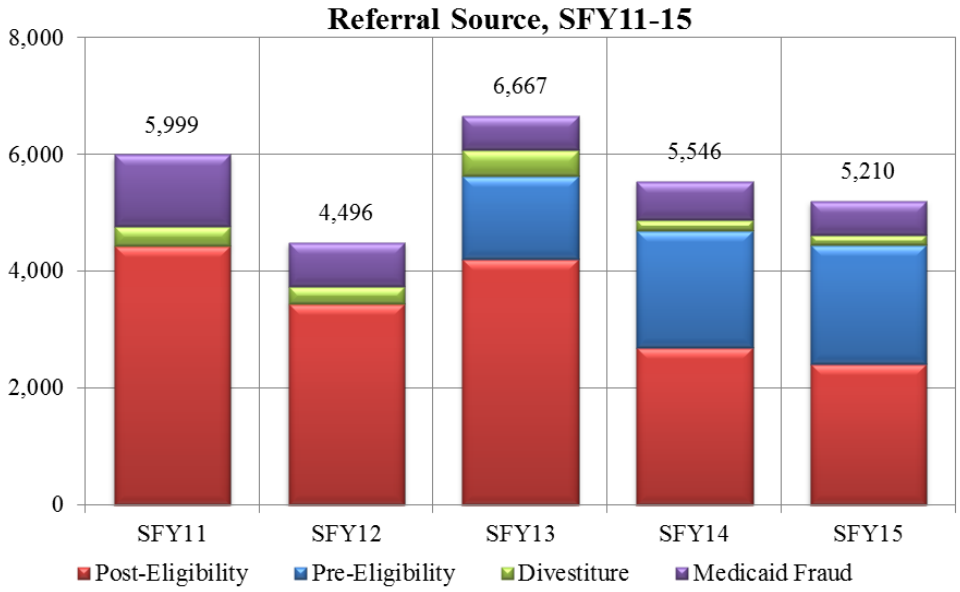
During SFY15, the Investigations Division received a total of 5,210 referrals involving the State's public assistance programs.

As illustrated to the right, economic eligibility referrals (both pre and post) comprised approximately 85.3% of the SFY15 referrals.



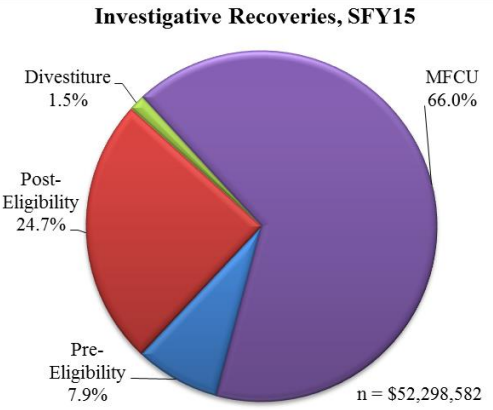
A comparison of referrals by program area over the last five years is illustrated on the following page[1].

[1] Note that pre-eligibility investigations were not separated from post-eligibility investigations until SFY13.



Investigative Recoveries

During SFY15, the Division recognized $52,298,582 in investigative recoveries, comprised of civil judgments, criminal restitution, and cost avoidance estimates.

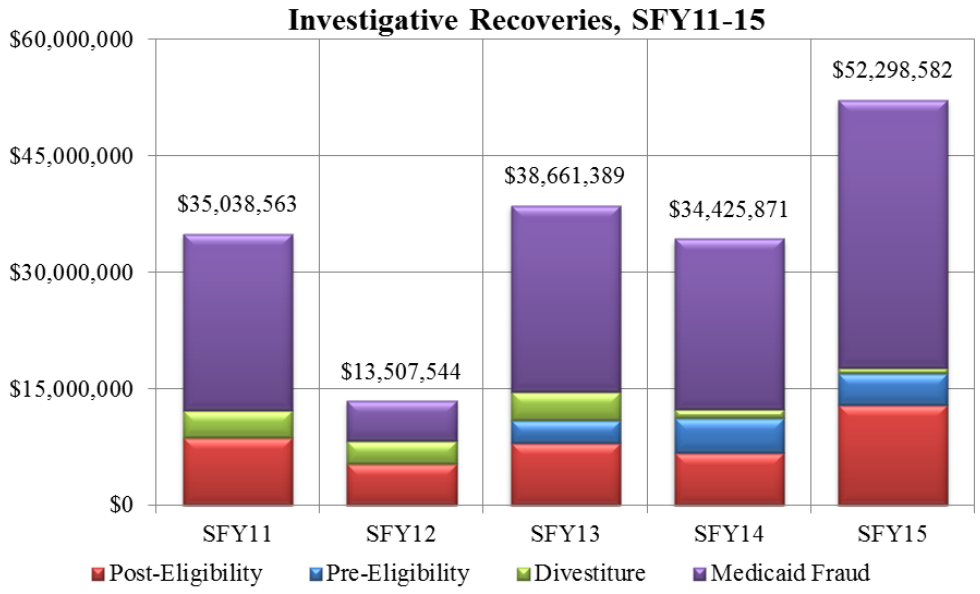


MFCU and post-eligibility recoveries accounted for the majority of dollars, represented by 66.0% and 24.7%, respectively, as illustrated to the right.

The three categories of investigative recoveries are defined as follows:

- Civil judgements – A valid court order establishing a debt (from an overpayment of public assistance benefits) that a recipient must pay back to the State.
- Criminal restitution – a repayment to the state that results from a criminal conviction of a benefit recipient who was prosecuted for fraudulently receiving benefits.
- Cost avoidance – the mathematical calculation of either:
    - What an application would have cost the State for a six month period if the application had been approved; or
    - What a recipient receiving benefits would have continued to receive for six months if the recipient's case had not been closed or if the recipient had not been removed from the program.

A comparison of investigative recoveries by program area over the last five years is illustrated below.



Economic Fraud Control Bureau

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

Pre-eligibility

Pre-eligibility investigations are cases referred for investigation and completed prior to the 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 additional information regarding a client's circumstances. Positive pre-eligibility investigations prevent fraud at intake and before a dollar loss can occur, resulting in a cost avoidance figure. An investigation may also result in a civil or criminal prosecution that leads to program disqualification.

Post-eligibility

Post-eligibility investigations are investigations completed after the 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 (sold or traded for personal use).

Investigations 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 all income and living expenses of the household. Other investigations may involve unintentional errors by the applicant/recipient in reporting income or other information.

Process improvement

As noted earlier, the DIA did not conduct pre-eligibility investigations prior to SFY13. Prior to that time, the DIA received referrals from the DHS only after benefits had been issued, which often resulted in additional resources being utilized to identify and recover benefits that had already been provided. There was an identified need to focus on conducting investigations early in the eligibility determination process before benefits were paid out.

In June of 2012, DHS Director Palmer and DIA Director Roberts brought the two agencies together to conduct a Kaizen event. During the event, the two agencies created a new process for pre-eligibility investigations, streamlined the post-eligibility process, and substantially improved inter-agency communications. As a result, the total number of cases the DHS referred to the DIA increased by nearly 2,200 in SFY13 when compared with SFY12, and cost savings to the public assistance programs increased by $25,153,844 compared to SFY12.

It should be noted that the two agencies will be reviewing this formal process during a follow-up week long Kaizen event during December of 2015.

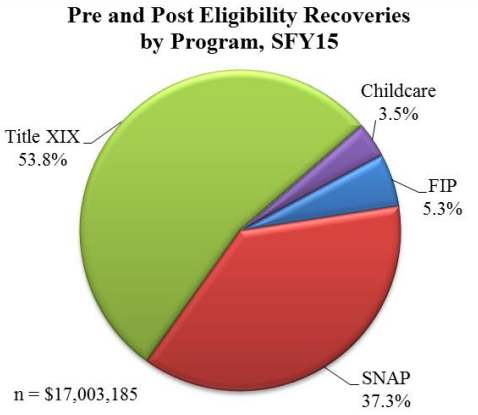
Investigation activity

During SFY15, the Division closed 4,796 investigations, and has closed an average of 4,670 investigations per year over the last five fiscal years:

	SFY11	SFY12	SFY13	SFY14	SFY15
Pending cases at the start of the SFY	1,257	1,007	722	813	932
Cases referred to DIA	4,440	3,445	5,641	4,703	4,446
Cases closed	4,690	3,730	5,550	4,584	4,796
Pending cases at the end of the SFY	1,007	722	813	932	582

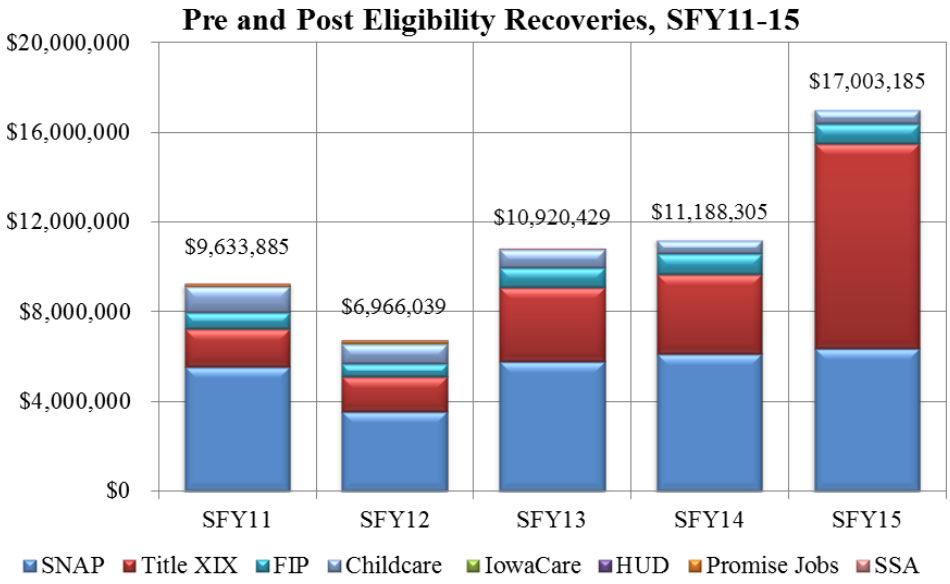
Investigative recoveries in pre and post-eligibility

During SFY15, the Division recovered $17,003,185 as a result of pre and post-eligibility investigations.



As illustrated to the right, Title XIX and SNAP investigative recoveries comprised approximately 53.8% and 37.3% of the SFY total, respectively.

A comparison of pre and post eligibility investigative recoveries by program area over the last five years is illustrated below. Similar to SFY15, Title XIX and SNAP investigative recoveries account for the largest portion of pre and post eligibility recoveries over the last five years, averaging 81.8% of the total.



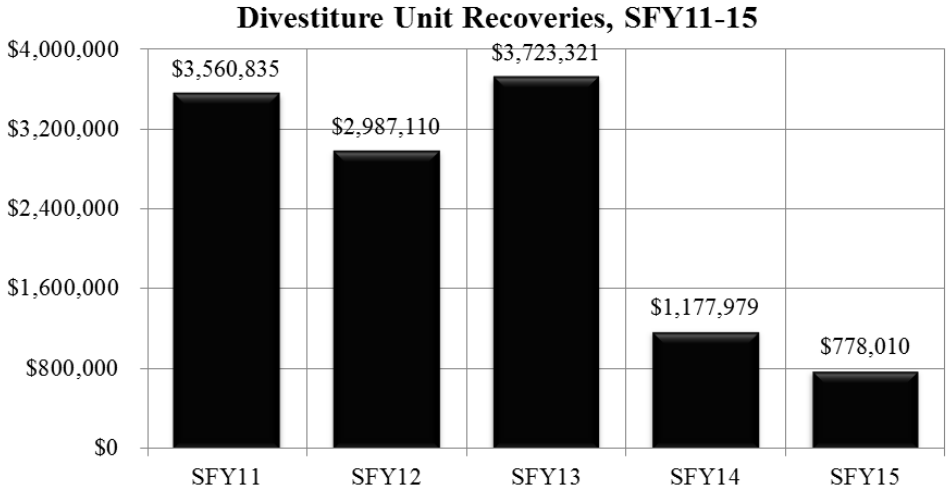
Divestiture Unit

The Divestiture unit operates within the Economic Fraud Control Bureau to identify and recover 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.

During SFY15, the Divestiture unit closed 265 cases; a summary of the unit's caseload for the last five years is summarized on the following page:

	SFY11	SFY12	SFY13	SFY14	SFY15
Pending cases at the start of the SFY	247	300	308	407	321
Cases referred to DIA	336	300	442	184	184
Cases closed	283	292	343	270	265
Pending cases at the end of the SFY	300	308	407	321	240

During SFY15, those 265 case closures resulted in $778,010 in investigative recoveries; a summary of the unit's recoveries for the last five years is illustrated below:



Public Assistance Debt Recovery Unit

Once the DIA staff have 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 DHS which is more than a person is eligible for and is received by, or on behalf of that person.

Overpayments

The most common reasons for overpayments include:

- A client, either intentionally or unintentionally, failed to provide correct or complete information to the field office.
- A client, either intentionally or unintentionally, failed to 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.

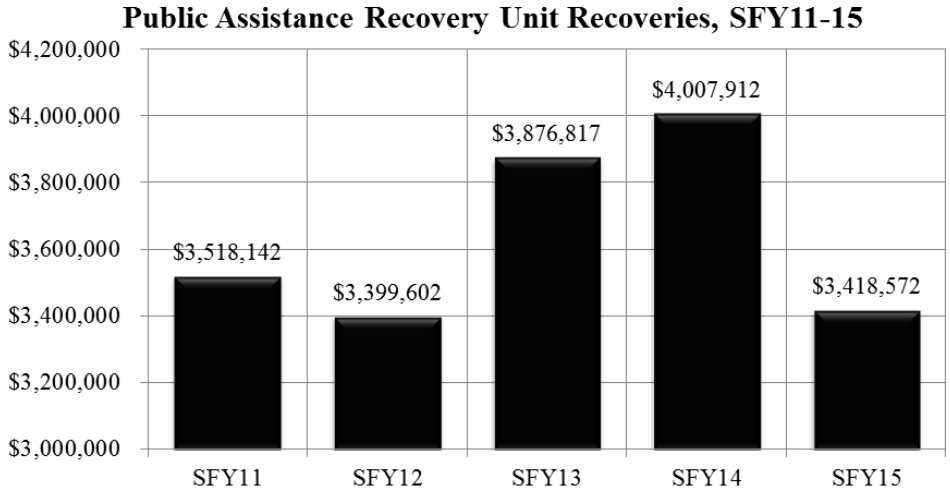
- Alteration of a benefit check, medical card or EBT card.
- A client reported changes that affect eligibility are not updated, and the client continues to receive benefits based on information previously obtained.

Overpayment collection

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

- Monthly payments can be set up by contacting the Public Assistance Debt Recovery Unit and agreeing to an approved payment plan.
- 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% reductions and all other overpayment program types have 10% reductions. No benefit reductions are permitted from any other program.
- 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.
- Wage and bank garnishments and recorded property liens may be initiated if timely payments are not made.

During SFY15, the Public Assistance Debt Recovery Unit collected $3,418,572; the five-year trend is illustrated below.



Medicaid Fraud Control Unit

Medicaid is a jointly funded federal and state health insurance program that provides healthcare to more than 560,000 Iowans. As Medicaid is both a federal and state funded program, the State of Iowa is required by Federal law to have a Medicaid Fraud Control Unit (MFCU) which is responsible for policing those federal and state dollars.

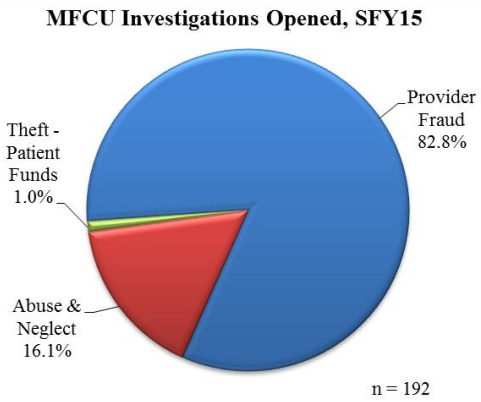
Investigators and auditors in the Medicaid Fraud Control Unit (MFCU) investigate allegations of Medicaid fraud by health care providers in the State of Iowa. They also investigate allegations of abuse and neglect of residents in health-care facilities as well as allegations that residents have been defrauded of personal funds.

Common types of health care provider fraud may include:

- Billing for services not rendered;
- Billing for a non-covered service as a covered service;
- Misrepresenting dates of service;
- Misrepresenting locations of service;
- Misrepresenting provider of service;
- Waiving of deductibles and/or co-payments;
- Incorrect reporting of diagnoses or procedures (includes unbundling);
- Overutilization of services;
- Corruption (kickbacks and bribery); and/or
- False or unnecessary issuance of prescription drugs.

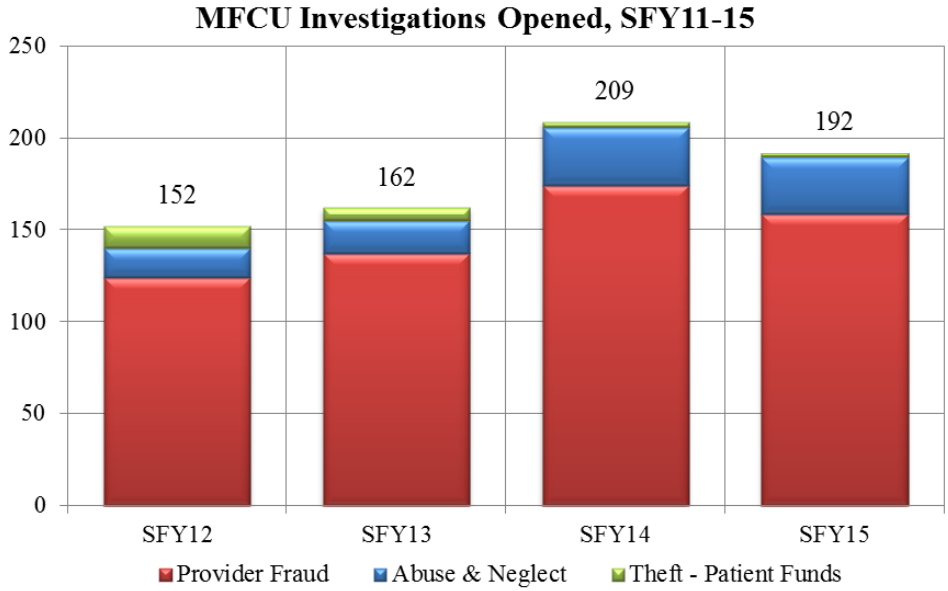
Investigations opened

During SFY15, the MFCU received 580 complaints of Medicaid fraud, suspected patient abuse or neglect, or theft of patient property. Of the complaints received, 192 resulted in a formal investigation being opened, with 82.8% of the opened investigations relating to suspected provider fraud, as illustrated to the right.



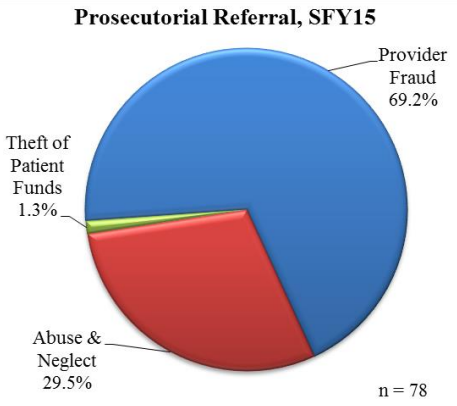
Although the majority of complaints received by the MFCU involved abuse or neglect, most of those complaints are handled by local law enforcement, allowing the MFCU to focus more on complaints of provider fraud.

An analysis of types of investigations opened by MFCU over the last five years is illustrated below. Similar to SFY15, investigations involving allegations of provider fraud represent the largest portion over the last four years, averaging 83.1% of the total.

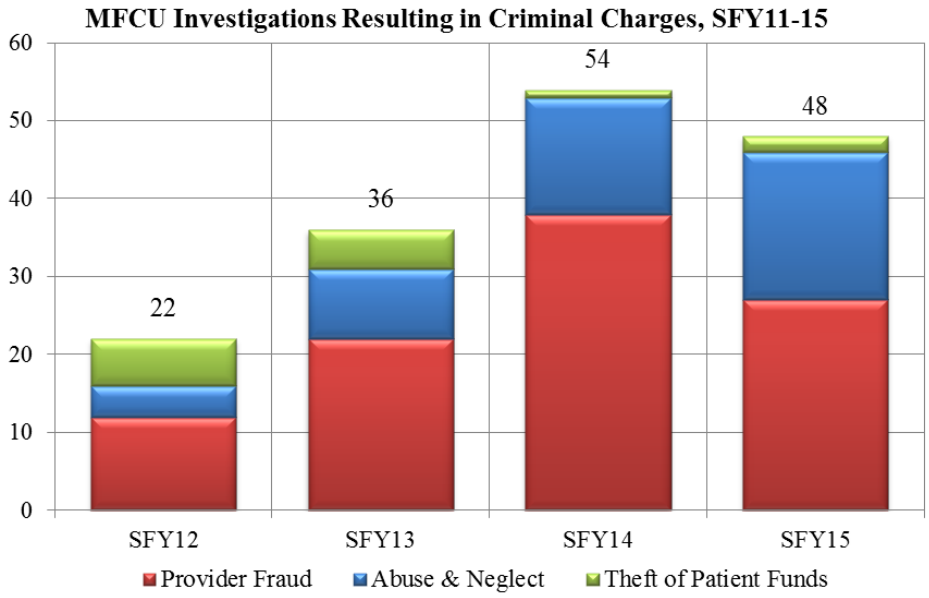


Prosecutorial referral & charges

Once the MFCU completes an investigation, a determination is made regarding which cases it will refer to county attorneys for criminal prosecution. During SFY15, 78 cases were referred for criminal prosecution, as illustrated to the right.



Of those 78 referrals, the prosecuting authority pursued charges on 48 cases, with the historical trending over the last four years illustrated on the following page:



During SFY15, criminal convictions were obtained in 47 charged cases, with 24 convictions involving provider fraud and 23 involving patient abuse or neglect[2]. Additionally, the MFCU referred 37 cases to the Iowa Medicaid Enterprises' Program Integrity Unit for administrative recovery during SFY15.

Looking Forward

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.

[2] Note that the number of criminal convictions may include cases that were opened, referred, or charged during a previous fiscal year.