

2012

IHSS Uniform Statewide Protocols

For
Program Integrity
Activities



CDSS

California Department of Social Services
Adult Programs Division
December, 2012



EXECUTIVE SUMMARY

On July 24, 2009, ABX4 19 required the California Department of Social Services to establish a state and county stakeholders' workgroup to address the key requirements pertaining to IHSS program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for developing uniform statewide protocols for the implementation and execution of standardized program integrity measures in the In-Home Supportive Services (IHSS) Program. Toward that end, the legislation amended sections of the California Welfare and Institutions Code (WIC).

In March 2010 the California Department of Social Services (CDSS) formed the workgroup. The workgroup included representatives from CDSS, the Department of Health Care Services (DHCS), the California Department of Justice (DOJ) Bureau of Medi-Cal Fraud and Elder Abuse, counties, district attorneys' offices, and in 2011 IHSS recipients and advocacy groups representing IHSS recipients and providers were added to ensure sufficient diversity in addressing the protocols.. Over a two-year period the full workgroup met seven times. There were numerous subcommittee and focus group meetings, and CDSS conducted two public meetings to ensure full public input.

Many issues were discussed in these workgroups, subcommittee's, public forums that debated the legislation, addressed national and California best practices, county concerns to barriers related to caseload and workload, small county vs large county issues, recognition of coordination and communication gaps between county social workers, investigators, prosecutors and the state – that diminish the viability of preventive, early detection and program integrity efforts.

In establishing the policies, procedures, and implementation timelines for program integrity activities, best practices models were reviewed and elements identified for consideration by the workgroup whose key focus was on ensuring consistently appropriate levels of quality care are being provided, and the development of a balanced approach to program integrity activities that ensure all activities are conducted in a safe and respectful manner . *Of particular importance was the workgroup's intent to eliminate duplicated efforts among different agencies and minimize any inconvenience or disruption for IHSS program participants.*

Common Themes

These IHSS Uniform Statewide Protocols reflect the workgroup's guiding principles throughout the entire process. The guiding principles include the following: process transparency, recipient wellbeing, recipient and provider dignity, emphasizing program education and prevention, safe and respectful mitigation (stopping a problem before it starts), a commitment to ensuring that no one is unfairly targeted, cooperation, and minimal disturbance or confusion caused to the vulnerable members of the IHSS community.

The specific measures addressed by the workgroup included: unannounced home visits; directed mailings to groups of IHSS providers; program integrity training for county IHSS workers, and the development of statewide coordination, communication and data sharing for IHSS program integrity efforts between state and county offices.

Program integrity training curriculum was developed, and the ongoing training was provided for over 2,150 county IHSS workers as a part of the IHSS Social Worker Training Academy. As such, the training is not addressed further in these protocols. The remaining three measures are summarized as follows:

Unannounced Home Visits

Trained county IHSS staff will conduct visits to the home of a recipient where a potential program integrity issue has been identified. The date and time of the visit will not be announced to the recipient or the provider. In the course of the visit, county staff will verify the receipt and quality of services, verify the consumer's wellbeing, and briefly discuss program integrity with the recipient. If a recipient is unable, unavailable, or unwilling to participate in an unannounced home visit, the county will follow up with at least two more visit attempts, at least two phone calls, and send a letter over the next 45 to 60 days. These visits will only be conducted as the result of a specific, articulable program integrity concern, never at random.

Directed Mailings

Counties will conduct at least one mailing annually, directed to a specific group of IHSS providers. The mailing will be conducted using the standard template (attached) with the

reason for the mailing and county contact information added. To provide clarity for providers, the letter includes a list of common program integrity concerns.

Data Sharing and Statewide Coordination of Program Integrity Efforts

State and county agencies will follow a standardized process for reviewing IHSS program integrity complaints and forward them for investigation, if appropriate. County IHSS agencies will establish a designated point of contact to review complaints and determine which ones merit investigation. Counties who enter into memoranda of understanding (MOU) with DHCS may conduct their own investigations in accordance with those MOUs. Counties without MOUs will forward complaints to DHCS for investigation. Every consideration was given to minimizing duplication between agencies and to reducing the exposure of IHSS recipients and providers to redundant interactions with different investigating bodies.

These protocols will be disseminated through the Department's All-County Letter process, which includes one final opportunity for review and feedback.

Table of Contents

I. Overview

Authority
Purpose of Protocols
Applicability

II. The Measures

Unannounced Home Visits (UHV)

Definition.....	4
Purpose.....	5
Procedures.....	5
General.....	5
Preparation.....	6
Entry Granted.....	6
No Entry or Contact Denied.....	7
Follow-up and Reporting.....	7
Roles and Responsibilities.....	8
Forms/Letters.....	9

Directed Mailings

Definition.....	17
Purpose.....	17
Procedures.....	18
General.....	18
Preparation.....	18
Mailing.....	19
Communication and Coordination.....	19
Follow-up and Reporting.....	19
Procedural Exceptions.....	19
Unforeseeable Circumstances.....	19
Zero-Result Data Pulls.....	19
Roles and Responsibilities.....	20
Forms/Letters.....	20

Data Sharing and Statewide Coordination

Definition.....	25
Purpose.....	25
Fraud Referral Process.....	25
Fraud Complaint.....	26
Fraud Referral.....	26
Fraud Investigation.....	27
Roles and Responsibilities.....	27
Forms/Letters.....	28

DRAFT

OVERVIEW

WIC Section 12305.82(b)

(1) The department, in consultation with county welfare directors and other stakeholders, as appropriate, shall develop uniform statewide protocols for acceptable activities to be performed and acceptable measures to be taken by the department, the State Department of Health Care Services, and the counties for purposes of fraud prevention.

PURPOSE

The purpose of these protocols is to establish the basis for State and county policies, procedures, and timelines, and to provide instructions regarding acceptable activities to be performed, and acceptable measures to be taken for the purposes of fraud prevention, detection, and coordinated investigation and prosecution in the In-Home Supportive Services (IHSS) Program. These protocols are designed to assist counties in developing and implementing policies and procedures to ensure consistency.

APPLICABILITY

These protocols apply to the California Department of Social Services (CDSS), county welfare departments, and any other agencies operating under the authority established in WIC Sections 12305.7(e)(2), 12305.7(h), 12305.71(c)(3), 12305.71(c)(5), or 12305.82. These protocols are not intended to limit in any way the jurisdiction or ability of law enforcement agencies operating under separate authority.

THE MEASURES

Unannounced Home Visits

Directed Mailings

Data Sharing and Statewide Coordination

DRAFT

DRAFT

Unannounced Home Visits

WIC Section 12305.71(c) (3)

(A) As appropriate, in targeted cases, to protect program integrity, this monitoring may include a visit to the recipient's home to verify the receipt of services.

(B) The exact date and time of a home visit shall not be announced to the supportive services recipient or provider.

(C) The department, in consultation with the county welfare departments, shall develop protocols for followup home visits and other actions, if the provider and recipient are not at the recipient's home at the time of the initial home visit. The protocols shall include, at a minimum, all of the following:

(i) Information sent to the recipient's home regarding the goals of the home visit, including the county's objective to maintain program integrity by verifying the receipt of services, the quality of services and consumer well-being, and the potential loss of services if fraud is substantiated.

(ii) Additional attempted visits to the recipient's home, pursuant to subparagraph (A).

(iii) Followup phone calls to both the recipient and the provider, if necessary.

WIC Section 12305.82

(f) The failure of a provider or a recipient to comply with program requirements may result in termination of his or her participation in the In-Home Supportive Services program, subject to all applicable federal and state due process requirements.

Definition

An unannounced home visit (UHV) is an unscheduled visit conducted by trained county IHSS staff in the home of an IHSS recipient who has been selected using specific indicators.

Purpose

The purpose of the UHV by county quality assurance (QA) staff is to ensure that the services authorized are consistent with the recipient's needs at a level which allows him/her to remain safely in his/her home, and to validate the information in the case file. It is a monitoring tool to safeguard recipient well-being by verifying the receipt of appropriate levels of services, and to ensure program integrity by reminding recipients of program rules and requirements and the consequences for failure to adhere to them, including the potential loss of services.

The intent of the protocols is to ensure that the UHVs are conducted in a consistent and coordinated manner over a reasonable time frame, and performed in a manner that is respectful of each recipient's unique needs and circumstances.

Procedures

General

The UHVs will be conducted in a professional manner by designated county staff that have completed appropriate training, and must be based upon recipient wellbeing, QA or program integrity concerns, indicators of risk for abuse and/or fraud, or referrals. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

In the event of suspected maltreatment or neglect, per Mandated Reporter protocols, all UHV staff are required to contact Adult Protective Services (APS) and/or Child Protective Services (CPS). In cases of urgent endangerment, UHV staff must contact law enforcement (911). In the event that fraud is suspected, referral of the case to the appropriate investigating agency will occur per established protocols.

The process, timeframes and respective roles and responsibilities for conducting UHVs; a standardized follow-up letter to recipients; the statewide UHV Reporting form, and instructions for documenting all UHV activities follow.

Preparation

Prior to conducting the home visit, county UHV staff shall review the case file and note pertinent information such as specific conditions or needs of the recipient. This may include physical/mental disabilities or documented circumstances that may place the UHV staff at risk. UHV staff is encouraged to consult with the IHSS caseworker or supervisor as appropriate. The UHV shall, to the extent possible, be conducted in the documented primary language of the recipient. If it is not possible to conduct the UHV in the recipient's primary language, a translator must be used at no cost to the recipient.

Communication and Coordination: Counties shall ensure that IHSS caseworkers (or supervisors) are notified prior to all UHVs of their assigned cases (unless there is a specific need for confidentiality) in order to avoid duplication of efforts and ensure that the recipient's unique needs are taken into consideration. Counties may also notify DHCS and county investigative staff.

Identity Verification: Counties shall ensure that all persons conducting UHVs possess and present/display photo identification issued by their department upon requesting entry to the home. UHV staff shall carry telephone contact information for the county designated UHV contact person. If the recipient requests to verify the visit/staff identity, telephone contact information shall be provided to the recipient and a telephone call to the designated UHV contact person shall be allowed. If the county is not able to verify the identity of the UHV staff person, the UHV may be delayed at the recipient's request. If the recipient denies entry to the UHV staff person based on a lack of proper identification, or based on county inability to verify the UHV, that UHV shall not be counted towards the three UHV attempts to which recipients are entitled.

The UHV

Entry Granted: Counties shall ensure that when entry is granted, the UHV staff informs the recipient of the purpose of the UHV and provides general and/or specific information regarding program requirements and the consequences for failure to adhere to them. The UHV staff shall also ask questions regarding the recipients' services and the quality of those services. Using the IHSS UHV Findings Report, UHV staff shall observe plain-view areas of the home to help determine whether the recipient is receiving appropriate levels of quality care to remain safely in the home.

No Contact or Entry Denied: In the event that contact is not made or entry is denied, UHV staff must perform all of the following activities to make contact within 45-60 calendar days:

- A minimum of two additional UHVs not conducted on the same day.
- A minimum of two telephone calls to the recipient, not conducted on the same day. Additional phone calls may be made to the provider or the recipient's emergency contact at the county's discretion.
- A letter sent to the recipient's home stating the purpose of the UHV and stating that unsuccessful attempts were made to contact the recipient at home and/or by telephone (*Attachment A*).

Counties shall ensure that the minimum requirements above are completed within the required timeframe. Additional methods of contact may be conducted at the county's discretion.

If, after all required attempts of contact have been made, no UHV has been conducted, counties shall send the recipient a Notice of Action (NOA) indicating that the recipient's IHSS is being discontinued, as failure to participate in a UHV constitutes a recipient's failure to comply with program requirements.

The NOA shall contain the reason for the discontinuation of services and the applicable law. Once the NOA is issued, the process continues to termination. Counties shall ensure that the IHSS caseworkers (or supervisors) are notified that the NOA has been issued. Counties shall ensure that there are policies and procedures in place to address the timely documentation and termination of services to prevent an overpayment from occurring. Counties shall also ensure that once the NOA has been issued, the recipient cannot stop the process or restart services until the fair hearing process is completed.

Follow-up and Reporting

Counties shall ensure that all of the following reporting requirements are completed:

- The UHV staff shall document all UHV attempts and visits on the IHSS UHV Findings Report (*Attachment B*).

- The county shall communicate UHVs conducted and the outcomes to CDSS by completing the UHV list that they receive from CDSS, and attaching copies of completed UHV Findings Reports.
- The county shall initiate any required administrative actions subsequent to UHVs including reassessments, referrals, and notices of termination of services.

Roles and Responsibilities

CDSS shall:

- Develop and distribute to counties a list of IHSS recipients who have been identified to receive a potential UHV based on targeted indicators reviewed by the state. Instructions for completing and documenting the UHV will accompany the list.
- Review county actions/findings upon the completion of the UHVs and conduct a post UHV follow-up review of targeted cases in Case Management Information and Payrolling System (CMIPS) to evaluate outcomes.
- Serve as the central repository for all UHV tracking data.
- Establish reporting requirements.
- In select cases, CDSS staff may accompany county UHV staff upon State or county request.

County Agencies shall:

- Use these protocols to develop and implement policies and procedures for conducting UHVs. The policies and procedures must include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper UHV protocols.
- Conduct UHVs.
- Use the CDSS list of identified potential recipients as well as any additional recipients identified by the county for whom an UHV would be appropriate based on targeted indicators.
- Prepare for the UHV in accordance with “Preparation” section listed above in Procedures.

- Clearly document the reasons why the county, based on specific knowledge or understanding of the staff caseload, has *not* conducted a UHV on an identified recipient and include that reasoning in the completed report.
- Notify CDSS of additional UHVs identified and performed.
- Document outcomes/findings and perform follow-up activities.
- Coordinate with CDSS on county directed UHVs and include them in the reports.
- Designate staff to conduct UHVs.
- Develop training and ensure that it includes the adoption of forms/letters, established minimum requirements, policies and procedures for conducting UHVs, and reporting requirements.
- Ensure staff training requirements are met.
- Make training available to outside staff (i.e. law enforcement) at county discretion.

Law Enforcement:

May accompany UHV staff upon county request, document outcomes/findings of the UHV and consult UHV staff regarding resulting fraud referrals.

Forms and Letters

A UHV Follow-Up Letter and Findings Report (with instructions) are attached.

Attachment A

Unannounced Home Visit

Follow-Up Letter

<On County Letterhead>

TO: Mr./Mrs./Ms. Recipient
1234 Your Street
Any town, CA, 92126-1234

FROM:

SUBJECT: **PROGRAM INTEGRITY CONCERNS IN THE IN-HOME SUPPORTIVE SERVICE (IHSS) PROGRAM**

An unannounced visit was attempted at your home, and you were either not available or did not allow the county staff entry. The purpose of the unannounced visit is to ensure that you are receiving IHSS, the quality of those services, your well-being, and to remind you of program rules and requirements.

In the IHSS program, you are responsible for managing your provider and the services you receive. Our goal is to increase your knowledge so that you will become a better-informed recipient.

Please be reminded that you are required to participate and cooperate in home visits. Some visits may be announced and other visits may be unannounced. Following program rules can help prevent overpayment collection actions, prevent termination from the IHSS program, and/or protect you from civil or criminal legal actions.

In addition to cooperating with home visits, please remember to do the following:

Only sign your own name on each timesheet.

Always accurately represent your level of need.

Only put the hours that were actually worked on the timesheet.

(Hours while you are in the **hospital** or **nursing home**, unless authorized by your caseworker, or if you are **incarcerated** cannot be paid for.)

Always report all members living in your household.

Report if you are going to be out of your home for an extended period of time.

Please contact _____ <designated representative name and phone> to verify your address, phone number, availability, and best way to contact you. This will help us to complete the visit. The person making the unannounced home visit will be trained county staff, will have a county badge or ID, and must show this to you before you are required to permit entry into your home.

If you feel that you have been mistreated or discriminated against, contact <insert contact information here>. If you suspect fraud occurring in the IHSS program, please contact the Department of Health Care Services fraud hotline at 1-888-717-8302.

NARRATIVE

E. CASE FILE AND VISIT SUMMARY

F. FINDINGS AND RECOMMENDATIONS

DRAFT

Instructions

IHSS Recipient Name: Enter the name of the recipient the UHV is concerning.

Recipient Number: Enter the CMIPS recipient number.

Authorized No. Hours: Enter the number of hours the recipient is currently authorized.

Recipient Phone No.: Enter the phone number listed to contact the recipient.

Alt. Phone No.: Enter an alternate phone number for the recipient.

Date of Last Face-to-Face: Enter the date of the last recorded face-to-face contact the county had with the recipient.

No. of Providers: Enter the number of eligible providers listed in CMIPS for this recipient.

Recipient ID Verified: Check here if the recipient's ID is verified during the UHV.

UHV Staff Name: Enter the name of the person conducting the UHV.

County: Enter the County where the UHV is being conducted.

Reason for UHV: Enter the reason the case has been triggered for a UHV. Please elaborate in the comment section as needed.

UHV Staff Phone No.: Enter the phone number of the person conducting the UHV.

SECTION A – CASE FILE INFORMATION (PROVIDE DETAILS IN SECTION E)

Severely Impaired: Check here if the recipient is listed as severely impaired in CMIPS.

Protective Supervision: Check here if the recipient is currently authorized to receive protective supervision.

Case/Narrative Notes Reviewed: Check here if any case file narratives or notes were viewed. **NOTE:** Any case file information directly affecting the UHV should be noted in Section E.

FI Rank 5 Service(s): Record any services for which the recipient is currently assessed as a rank 5. **NOTE:** This will indicate which services the recipient cannot perform on his/her own. For example, if the recipient is a rank 5 in mobility, s/he would not be able to answer the door without someone present to assist.

Primary Language: Record the primary language of the recipient as listed in the case file.

SECTION B – UNANNOUNCED HOME VISIT SUMMARY (DATE AND TIME) (PROVIDE DETAILS IN SECTION E)

1st Home Visit: Record the date and time the first UHV was attempted, whether or not it was successful.

2nd Home Visit: Record the date and time the second UHV was attempted, whether or not it was successful.

3rd Home Visit: Record the date and time the third UHV was attempted, whether or not it was successful.

1st Recipient Phone Call: Record the date and time the first phone call was made to the recipient, whether or not it was successful.

2nd Recipient Phone Call: Record the date and time the second phone call was made to the recipient, whether or not it was successful.

1st Recipient Letter Sent: Record the date the first recipient letter was sent.

Completed Visit: Check if the provider was present and the ID of the provider was verified. Document the provider's name.

SECTION C – FINDINGS OF THE VISIT (PROVIDE DETAILS IN SECTION F)

Program Integrity Concerns Unsubstantiated: Check here if *no* program integrity concerns were substantiated.

Program Integrity Concerns Appear Valid: Check here if *any* program integrity concerns were substantiated.

Services Appear to be Authorized Beyond Need – Check here if it appears the authorized services documented in the case file are beyond the current need of the recipient.

Services Appear to be Authorized Below Need – Check here if it appears the authorized services documented in the case file are below the current need of the recipient.

Sufficient Services Not Being Provided – Check here if it appears that the recipient is not receiving the level of services they require. This may be the result of the recipient being under assessed or assessed services not being sufficiently provided.

Verified the Receipt of Services: Check here if it was verified that the recipient is receiving all authorized services.

Verified the Quality of Services: Check here if it was verified that the recipient is receiving quality services.

Verified the Recipient's Well-Being: Check here if the recipient's well-being was verified.

SECTION D – RECOMMENDATIONS (PROVIDE DETAILS IN SECTION F)

IHSS Complaint Referred to: (APS, CPS, DA/SIU, DHCS, DOJ, Other) – If a referral was made, check the box of the agency the referral was made to. Multiple agencies may be chosen. **NOTE:** Also check the box indicating who the complaint is against. Both the provider and recipient may be checked if appropriate.

Recommendation for Reassessment to: Check here if, based on the UHV, a reassessment is recommended to:

Increase Hours: Check if a reassessment is recommended because it appears that the recipient's needs exceed the assessed hours.

Decrease Hours: Check if a reassessment is recommended because it appears that the assessed hours exceed the recipient's needs.

Terminate Services: Check if a reassessment is recommended because it appears that the recipient does not need IHSS.

Overpay Recovery / Administrative Action: Check here if information was obtained that would necessitate Overpay Recovery or an Administrative Action. This may include changes to the case that do not require a reassessment, such as changes to living arrangement, proration, etc.

Information and Referral Provided – Specify: Give specifics of all information or referrals provided during the UHV, such as referrals for alternative resources.

Terminate for Non-Compliance: Check here if recommending termination of the recipient's case for non-compliance with program requirements.

Follow-Up: Check here if it is necessary to follow-up on the case for any reason.

No Further Action: Check here if no further action on the case is necessary.

Sign and Date Report: The UHV worker should sign and date the report.

SECTION E – NARRATIVE – CASE FILE AND VISIT SUMMARY

For each contact, provide the date, time, and specific details; include all descriptions of interactions (including messages left on machines) from section C.

SECTION F – NARRATIVE – FINDINGS AND RECOMMENDATIONS

Record detailed findings and recommendations from section D.

DRAFT

Directed Mailings

WIC Section 12305.7

(h) The department, in consultation with the county welfare departments and other stakeholders, as appropriate, shall develop protocols for the implementation of targeted mailings to providers, to convey program integrity concerns.

WIC Section 12305.71(c)

(5) In accordance with protocols developed pursuant to subdivision (h) of Section 12305.7, distribute targeted program integrity mailings to providers. The purpose of the targeted program integrity mailings is to inform providers of appropriate program rules and requirements and consequences for failure to adhere to them.

Definition

A directed mailing is a standard template letter with required information and customizable areas, including a plain-English reason why the provider received the letter, and county contact information.

Purpose

The purpose of directed mailings is to convey program integrity concerns, inform IHSS providers of appropriate program rules and requirements, and express the consequences for failing to adhere to them. The goal is to increase the participants' knowledge and create a better informed provider of IHSS services in an effort to reduce errors, fraud, and abuse in the IHSS program.

The intent of these protocols is to ensure that the directed mailings are conducted in a consistent and coordinated manner and that there is an established process including the selection of, mailing and post mailing data analysis in place to inform providers of the appropriate program rules and requirements and the consequences of the failure to adhere to them. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

Procedures

The directed mailing is sent to a specific group of In-Home Supportive Services (IHSS) providers based on some attribute (indicator) that they share, such as providers who claim excessive hours of services per month, providers who are also recipients, or providers who submit timesheets inconsistently. By directing the mailers to specific groups, information is sent to the appropriate audience.

General

Counties shall select indicators from the indicator list provided by CDSS (distributed under separate cover), and conduct data pulls to determine each mailing group and create a directed mailing list of providers who all share the indicator.

Preparation

- Counties shall send CDSS the list of providers to receive the directed mailings electronically (Excel spreadsheet format) prior to mailing.
- CDSS shall cross reference the county mailing list against previous mailings, and ensures that the county is aware of any duplication or repeat mailings.

- Counties shall review the returned list and determine, for each repeat name, whether or not to include in the mailing.
- Counties shall customize the letter (*Attachment C*) to include a reason for the mailing from the reasons list and county contact information, and then conduct the mailing.

Mailing

Counties shall ensure that the directed mailings containing the required elements are sent to all providers in the directed mailing group, and that a copy of the directed mailing is sent to each recipient assisted by those providers.

Communication and Coordination

In order to coordinate and track the mailings and minimize unintentional duplication, counties shall electronically (Excel spreadsheet format) send CDSS a final list of providers and recipients who were sent directed mailings for tracking and analysis.

Follow-up and Reporting

Counties shall conduct a minimum of one directed mailing to a specific group of IHSS providers per year.

CDSS shall conduct periodic post-mailing analysis and issue annual reports tracking any measurable impact of the directed mailings.

Procedural Exceptions

Unforeseeable Circumstances

If a county experiences an unforeseeable emergency which prevents it from conducting a data pull or its required annual directed mailing, it may request that CDSS conduct the data pull or directed mailing on its behalf. Counties may request a data pull based on a specific indicator, or leave it to CDSS to select an indicator. CDSS will, to the extent possible, conduct data pulls and directed mailings within a reasonable timeframe upon county request.

Zero-Result Data Pulls

If a county conducts a data pull and gets no results, it shall conduct a second data pull based on a different indicator, or different combination of indicators. If the second data pull also returns no results, the county shall conduct a third data pull using an indicator or a combination of indicators which have not yet been tried. If the third pull results in no matches, the county

shall notify CDSS. CDSS will evaluate the obligation of that county to send a directed mailing for that year, and *may* conduct a data pull for the county at its discretion. On the second consecutive year that a county conducts three zero-result data pulls, CDSS *shall* conduct a data pull and send the resulting set to the county, who shall use the set to conduct a directed mailing.

Roles and Responsibilities

CDSS shall:

- Function as the central repository for all directed mailing data.
- Upon request and as able, assist counties with data mining and mailing as appropriate.

County Agencies shall:

- Use these protocols to develop and implement policies and procedures for conducting directed mailings. The policies and procedures must include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper UHV protocols.
- Prepare directed mailing lists, and coordinate with CDSS to match against previous lists prior to mailing to avoid unintentional duplication.
- Report directed mailings and any outcomes to CDSS.
- Develop training and ensure that it includes the adoption of forms/letters, established minimum requirements, policies and procedures for conducting UHVs, and reporting requirements.
- Ensure staff training requirements are met.
- Request CDSS assistance when appropriate.

Forms/Letters

A Directed Mailings Letter and a sample of Directed Mailings Letter Reasons are attached.

Attachment C

<On County Letterhead>

**Important Program Integrity Information from the
In-Home Supportive Services (IHSS) Program**

If you are an IHSS provider, you are receiving this letter because we are providing program information to all providers <insert reason here>. California statute requires that we send this letter to remind you of IHSS program requirements, and the consequences for failing to follow the requirements. Our goal is to increase knowledge of the IHSS program and create a better-informed population in an effort to reduce errors, fraud, and abuse within the program.

If you are an IHSS recipient, this is a copy of a letter we have sent to your provider. Please note that your receipt of this letter is to provide information *only* and will not result in termination of your benefits or a change in your provider status.

In the IHSS program, recipients are the employers of their providers, and responsible for managing their services. Providers and recipients are required to comply with program rules and requirements. Following program rules can help prevent overpayment collection actions, termination from the IHSS program, and/or civil or criminal legal actions. Please remember that it is illegal to perform certain activities with the intent to defraud. Some of those activities include:

Signing someone else's name on a timesheet or paycheck, unless you are the authorized representative for that person.

Misrepresenting an IHSS recipient's level of need.

Claiming hours which were **not actually worked**.

Claiming hours worked while the recipient is in the **hospital** or **nursing home**, unless authorized by the caseworker, or **incarcerated**.

Requiring the provider to share the IHSS paycheck with the recipient.

If you have any questions or concerns about the information in this letter, please contact <insert the appropriate county contact information here>.

If you suspect fraud in the IHSS program, please contact The Department of Health Care Services fraud hotline at **1-888-717-8302**.

Directed Mailings Letter

Reasons

Below are sample reasons for use in the Directed Mailing letter

“If you are an IHSS provider, you are receiving this letter because we are providing program information to all providers...

...who work so many hours.”

...who work for more than one recipient.”

...who live so far from their recipients.”

...who submit timesheets inconsistently.”

...who request more replacement timesheets than most.”

...whose IHSS paychecks have been sent to an out of state address.”

...who are also IHSS recipients.”

DRAFT

Data Sharing and Statewide Coordination

WIC Section 12305.82

(a) In addition to its existing authority under the Medi-Cal program, the State Department of Health Care Services shall have the authority to investigate fraud in the provision or receipt of in-home supportive services. Counties shall also have the authority to investigate fraud in the provision or receipt of in-home supportive services pursuant to the protocols developed in subdivision (b). The department, the State Department of Health Care Services, and counties, including county quality assurance staff, shall work together as appropriate to coordinate activities to detect and prevent fraud by in-home supportive services providers and recipients in accordance with federal and state laws and regulations, including applicable due process requirements, to take appropriate administrative action relating to suspected fraud in the provision or receipt of in-home supportive services, and to refer suspected criminal offenses to appropriate law enforcement agencies for prosecution.

(b) (1) The department, in consultation with county welfare directors and other stakeholders, as appropriate, shall develop uniform statewide protocols for acceptable activities to be performed and acceptable measures to be taken by the department, the State Department of Health Care Services, and the counties for purposes of fraud prevention.

(2) The State Department of Health Care Services, the department, and the county may share data with each other as necessary to prevent fraud and investigate suspected fraud pursuant to this section. The information shall only be used for purposes of preventing and investigating suspected fraud in the In-Home Supportive Services program, and shall otherwise remain confidential.

(c) If the State Department of Health Care Services concludes that there is reliable evidence that a provider or recipient of supportive services has engaged in fraud in connection with the provision or receipt of in-home supportive services, the State Department of Health Care Services shall notify the department, the county, and the county's public authority or nonprofit consortium, if any, of that conclusion.

(d) If a county concludes that there is reliable evidence that a supportive services provider or recipient has engaged in fraud in connection with the provision or receipt of in-home supportive services, the county shall notify the department and the State Department of Health Care Services of that conclusion.

(e) Notwithstanding any other provision of law, a county may investigate suspected fraud in connection with the provision or receipt of supportive services, with respect to an overpayment of five hundred dollars (\$500) or less.

(f) The failure of a provider or a recipient to comply with program requirements may result in termination of his or her participation in the In-Home Supportive Services program, subject to all applicable federal and state due process requirements.

Definitions

Complaint: Any program integrity concern/allegation identified or received by the state or county.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Triage: The process whereby the authorized representative of a law enforcement entity reviews a complaint of suspected fraud and determines whether or not the complaint becomes a fraud referral.

Fraud Referral: A complaint that has been triaged by a designated representative of law enforcement and referred to a law enforcement agency for fraud investigation.

Purpose

The purpose of data sharing and statewide coordination is to develop a coordinated and standard process for fraud referrals and investigations that fosters collaborative working relationships across jurisdictions. This includes a standard for deciding when to refer a case for fraud investigation.

Fraud Referral Procedures

The intent of the guidelines below is to provide a framework to enable CDSS, DHCS, DOJ, county welfare departments, county district attorney offices and any agency that may be involved in the IHSS program and/or fraud detection and prevention related to the program, to work together on fraud referrals and investigations.

This joint/collaborative effort will include implementing uniform statewide protocols in order to avoid duplication of effort, and coordinate fraud detection and prevention activities. These protocols address case referrals, a county's authority to investigate, data sharing, and authority to terminate a provider or recipient's participation in the IHSS program. The county must designate a representative of a law enforcement entity who will review the fraud complaint and determine if it is appropriate for investigation. These protocols are designed to assist the counties in developing and implementing individual policies and procedures to ensure consistency.

Fraud Complaint

Counties shall use the Complaint of Suspected Fraud form (SOC XXXX) (*Attachment D*) to report any incident of suspected or reported fraud in the IHSS program. County IHSS workers at all levels are responsible for reporting any incident of suspected or reported fraud (at this stage referred to as the fraud complaint) and must complete sections A through D of the Complaint of Suspected Fraud form as completely as possible. The county agency worker who discovers, receives, or is assigned to the complaint shall be responsible for:

- reviewing the form for accuracy and completion,
- gathering any missing information from the Reporting Party,
- filling in any additional information obtained, and
- gathering any relevant supporting documentation such as copies of any time sheets and paid warrants for the period in question.

The agency worker shall submit the form and supporting documentation, referred to as the fraud complaint package to the designated representative of a law enforcement entity for triage.

Fraud Referral

The county must identify a representative of a law enforcement entity to conduct triage on fraud complaints, complete Section E of the Complaint of Suspected Fraud form, and refer cases to law enforcement for investigation when appropriate. The fraud complaint package must be sent to the appropriate law enforcement entity for triage as soon as is practical. Any follow up correspondence, proof of mailing etc. should be kept with a copy of the package in the case file. Once a complaint has been triaged, it will either be determined appropriate for referral, or not appropriate for referral. Those complaints determined not appropriate for investigation will be returned to the originating county agency for possible administrative action. Complaints determined appropriate for investigation will become fraud referrals, and follow one of two paths, depending on whether or not the county has a Memorandum of Understanding (MOU) with DHCS.

Counties without an MOU with DHCS shall send all IHSS fraud referrals over \$500 directly to DHCS for investigation. If a county receives a complaint which appears to be under \$500, refers the complaint for county investigation and it is subsequently determined to involve over \$500 in fraud, the county will confer with DHCS to decide jurisdiction for the continued investigation.

Counties who have a MOU with DHCS will abide by the terms of that MOU. A sample MOU is included (*Attachment E*).

Fraud Investigation

The law enforcement agency shall conduct an investigation, determine the outcome of the referral, complete Section E of the complaint form, and either: (1) forward the completed investigation for prosecution; or (2) return it to the originating county agency for possible administrative action as appropriate. Please refer to the Fraud Referral Process Flowchart (*Attachment F*).

Roles and Responsibilities

CDSS shall:

- Refer all complaints to DHCS.
- Define required elements of statistical data reporting.
- Collect, analyze and report on data from counties, DHCS, and DOJ on a routine basis.

DHCS shall:

- Act as a resource to counties.
- Ensure the timely investigation of cases referred by counties.
- Report findings/outcome of investigations to originating county.
- Audit county investigations as appropriate.
- Reserve the right to take any case involving suspected fraud in an amount over \$500.
- Report statistical data to CDSS on a quarterly basis.

DOJ, Bureau of Medi-Cal Fraud shall:

Assist counties with investigations/prosecutions of provider fraud, at the request of the county or DHCS.

Counties with MOUs shall:

- Agree to all stipulations and meet the requirements outlined in their MOU.
- Maintain copies of all complaints, referrals and reports for three years from the last date of aid or services.
- Make copies available to DHCS upon request.

- Report statistical data to DHCS and CDSS on a quarterly basis. Effective FY 2011/12, all counties are required to submit fraud data to CDSS quarterly using the IHSS Fraud Data Reporting Form (SOC 2245) (*Attachment G*).

Counties without MOUs shall:

- Use these protocols to develop and implement policies and procedures for conducting the fraud referral process. The policies and procedures must include the adoption of forms/letters, establishment of minimum requirements, conducting of follow-up activities and reporting, and training in proper UHV protocols.
- Maintain copies of all complaints, referrals and reports for three years from the last date of aid or services.
- Send all complaints that become referrals to DHCS.
- Cooperate with DHCS investigations.
- Report statistical data to CDSS on a quarterly basis using the IHSS Fraud Data Reporting Form (SOC 2245).
- Develop training and ensure that it includes the adoption of forms/letters, established minimum requirements, policies and procedures for conducting UHVs, and reporting requirements.
- Ensure staff training requirements are met.

All Counties shall:

- Ensure that the fraud reporting process and contact information is clearly visible on their website.

Forms/Letters

An IHSS Complaint of Suspected Fraud Form (with instructions) and a DHCS sample MOU are attached.

Attachment D

IHSS Complaint of Suspected Fraud Form

PLEASE FILL IN AS MUCH INFORMATION AS POSSIBLE

Recipient Name:	Recipient SSN:	DOB:	Complaint Against Recipient <input type="checkbox"/>
			Complaint Against Provider <input type="checkbox"/>
Provider Name:	Provider SSN:	DOB:	Relationship to Recipient:
County:	IHSS Recipient Address:	Provider Address:	

A. REPORTING PARTY

Name: _____ Phone Number: _____

Email: _____

How many people live in the recipient's home: _____

Relationship to IHSS participant: _____

How did you become aware of this information: _____

Name of person taking complaint/Agency: _____ Date: _____

B. REASON FOR COMPLAINT Deceased: Recipient Provider Recipient Residing in a Care Facility or Hospital

Date of Death: _____

Name of Facility: _____

 In Jail: Recipient Provider

Date of Stay: _____

Dates: _____

Provider Issues:

 Being paid for services not provided Stealing from recipient County employee is IHSS provider Abuse/neglect/maltreatment of recipient Other (specify): _____

Recipient Issues:

 Seen performing strenuous activities (such as yard work, sports, lifting heavy object etc.) Does not appear to need services Other (specify): _____ Seen driving Seen working If yes, where: _____**C. NARRATIVE DESCRIPTION****Actions observed, date observed, etc.:**

D. CASE FILE INFORMATION – for county use only

Recipient Name: _____ IHSS Case No.: _____

Recipient Authorized Hours: _____ Date of Last Face to Face: _____

- Severely Impaired
 Protective Supervision

Number in Household: _____
 Married

Program service(s) in question: _____

Rank in service(s): _____ SSN Verified
 Caseworker Contacted for Information Name of Person Completing: _____

Enclosures:

- RELA RELB RELC PSUM
 Timesheets Paid Warrants (copy of front and back)
 PELG Other (specify): _____

E. INITIAL REFERRAL – for investigator use only

- Sent to DHCS Sent to DA/SIU for Investigation
 No Action (provide explanation in section G) Sent to DOJ
 Sent for Administrative Action Referred to APS/CPS

Date Referred: _____ Approximate Case Amount: \$ _____

If Not Sent to DHCS:

- MOU with DHCS Under \$500

F. DETERMINATION:

- Administrative Action Reassessment, Date _____
 Reduced Hours; _____ Hours Reduced
 Termination of Services; _____ Hours Saved in Termination
 Overpayment Recovery in the Amount of \$ _____
 To DA for Prosecution for Violation of PC(s): _____
 To DOJ for Prosecution for Violation of PC(s): _____
 No Action – Case not Viable (provide explanation in section G)

G. EXPLANATION OF NON-VIABILITY

Add information obtained that rendered case non-viable:

Investigator Signature: _____

Date: _____

Attach additional case file information.
Copy of complaint must be retained in county case file.

IHSS Complaint of Suspected Fraud Form

Instructions

IHSS Recipient Name: Enter the name of the recipient the complaint is concerning.

Recipient SSN: Enter the recipient's social security number (SSN) if known.

DOB: Enter the recipient's date of birth (DOB) if known.

Check one or both of the following options to indicate whom the complaint is against:

Complaint against recipient

Complaint against provider

IHSS Provider Name: Enter the name of the provider the complaint is concerning. If the complaint is concerning more than one provider, indicate this in section C.

Provider SSN: Enter the provider's SSN if known.

DOB: Enter the provider's date of birth (DOB) if known.

Provider Relationship to Recipient: Enter the provider's relationship to the recipient (i.e. mother, sister, neighbor, etc.), if known.

County: Enter the county where services are provided.

IHSS Recipient Address: Enter the IHSS recipient's address if known.

IHSS Provider Address: Enter the IHSS provider's address if known.

SECTION A – REPORTING PARTY

Name: Enter the name of the person filing the complaint.

Phone Number: Enter the phone number of the person filing the complaint.

Email: Enter the email of the person filing the complaint.

How Many People Live in the Recipient's Home: Record the number of people currently living in the recipient's home, if known.

Relationship to IHSS Participant: Record the relationship of the person filing the complaints to the recipient.

How Did You Become Aware of this Information: Record how the person filing the complaint knows of the information they are reporting.

Name of Person Taking Complaint/Agency and Date: Record the name of the person taking the complaint and the agency they are associated with (county agency, etc.) and the date the complaint was taken.

SECTION B – REASON FOR COMPLAINT

Check the box that best represents the focus of the complaint. Specify details as applicable.

SECTION C – NARRATIVE

Record any information pertinent to the complaint, things that were observed, dates, time, locations, etc.

SECTION D – CASE FILE INFORMATION – FOR COUNTY USE ONLY

Use the IHSS Case File information to provide the following information:

Recipient Name: Record the recipient's name.

IHSS Case No.: Record the IHSS recipient's case number.

Recipient Authorized Hours: Record the recipient's authorized case hours.

Date of Last Face to Face: Record the date of the last face to face listed in the case file.

Check any of the following applicable boxes:

Severely Impaired

Protective Supervision

Married

SSN Verified

Number in Household: Record the number of people listed as living in the recipient's household.

Program Service(s) in Question: Based on the complaint, record the IHSS services in question.

Rank in Service(s): Record the functional index (FI) ranking in the services in question.

Name of Person Completing: Record the name of the person completing the case file information.

Enclosures: Check the applicable boxes for any attached documents.

SECTION E INITIAL REFERRAL – FOR INVESTIGATOR USE ONLY

Check the box for the action taken on the case:

Sent to DHCS

Sent to DA/SIU for Investigation

Sent to DOJ

No Action (provide explanation in section G)

Sent for Administrative Action

Referred to APS/CPS

Date Referred: Record the date the referral was made.

Approximate Case Amount: Record the estimated case amount in dollars.

If Not Sent to DHCS: Check one of the boxes for the reason the case was not sent to DHCS.

SECTION F DETERMINATION

Check the box for the determined outcome of the case:

Administrative Action

Reduced Hours (record the hours reduced)

Termination of Services (record the number of hours terminated)

Overpayment Recovery in the Amount of (record the amount of overpayment recovery)

Reassessment, Date (record the date of the reassessment)

To DA for Violation of PC (record the penal code section)

To DOJ for Violation of PC (record the penal code section)

No Action – Case not Viable (provide explanation in section G)

SECTION G EXPLANATION OF NON-VIABILITY

Record information obtained that rendered the case non-viable.

Investigator Signature: Investigator must sign off on the case regardless of the action taken.

Attachment E

Department of Health Care Services Memorandum of Understanding (SAMPLE)**I. PURPOSE**

As part of the commitment to deter and prosecute fraud and maintain program integrity within the In-Home Supportive Services (IHSS) Program, a Memorandum of Understanding (MOU) must be executed between the California Department of Health Care Services (DHCS) and {FILL IN COUNTY} County.

The intent of this MOU is to ensure the county agrees to all stipulations and meets the requirements outlined below. Once this memorandum of understanding is fully executed, the county may investigate complaints received regardless of the dollar amount associated with the case. Its purpose is to form a working relationship promoting communication and coordination between the county and DHCS and a standard for investigating and prosecuting fraud.

This Memorandum of Understanding sets out the responsibilities of all parties. The MOU identifies the work to be performed by the county and the DHCS. A work plan is identified in Attachment A.

II. RESPONSIBILITIES**County will:**

1. Commit to a zero tolerance stance on fraud.
2. Follow a standard triage process for all complaints received.
 - a. This standard process will include review by a law enforcement entity.
3. Develop a plan for triaging, referring and investigating fraud that identifies staff and elements necessary to include in a referral.
4. Pursue cases criminally versus solely administratively whenever possible.
 - a. Administrative actions may include: overpay recovery, hour reductions, case terminations, etc.
5. Maintain copies of all complaints, referrals, reports and any other pertinent documents for three years from the last date of aid or services.
6. Provide quarterly statistical data to DHCS and California Department of Social Services (CDSS).
7. Maintain a method *for*, and staff *to* investigate cases regardless of funding.
8. In the event the county is unable to operate according to the provisions in this MOU, they will utilize established DHCS referral modalities in accordance with statute.

California Department of Health Care Services will:

1. Be available to assist counties at any time.
2. Reserve the right to take any case over \$500 in the event the county fails to investigate/prosecute the case.
3. Establish standard documents to be included in referrals.
4. Provide quarterly statistical data to CDSS.

TITLE

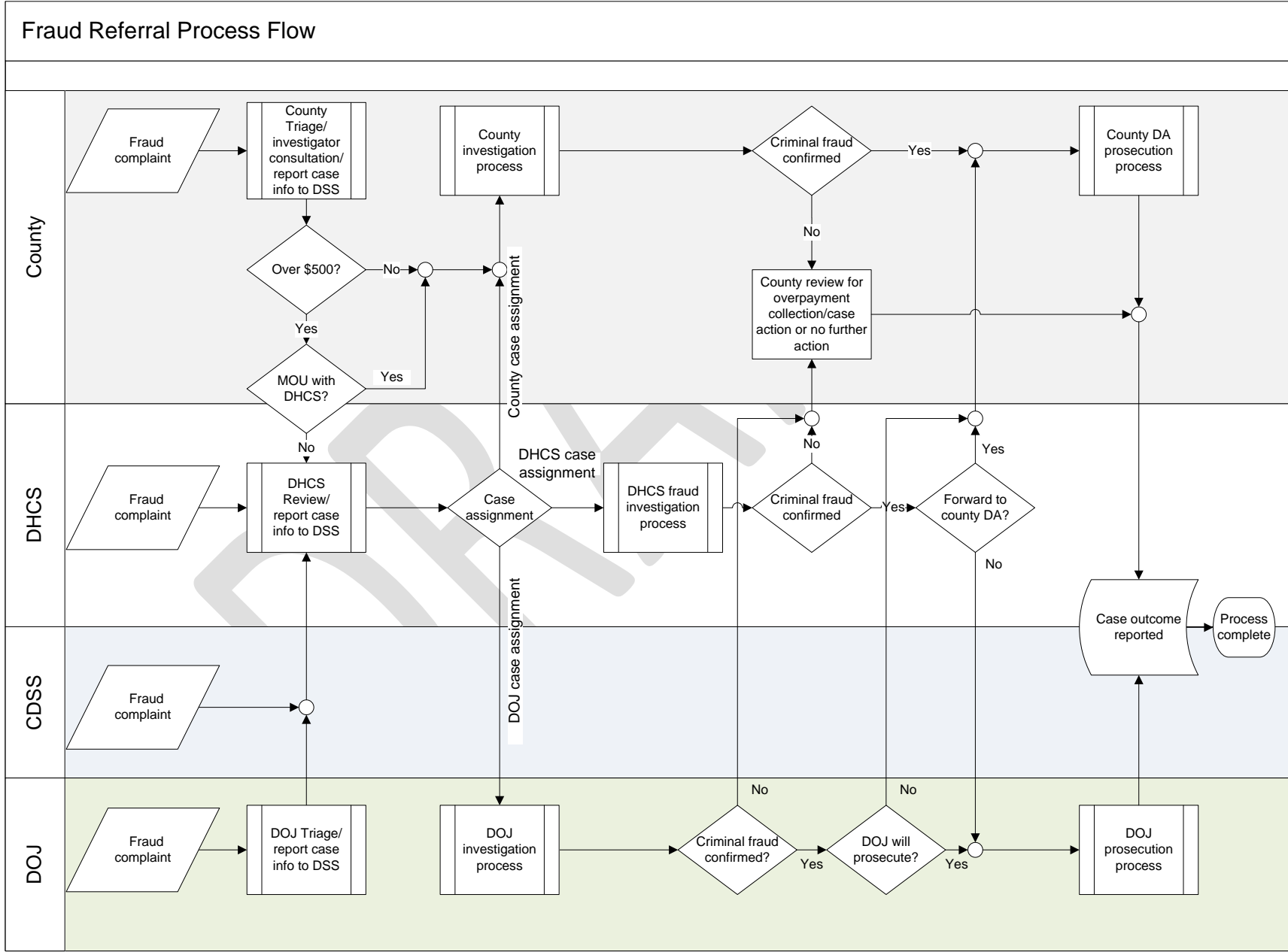
Name:

Signature:

Date:

DRAFT

Attachment F



Attachment GSTATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES**IN-HOME SUPPORTIVE SERVICES (IHSS)
FRAUD DATA REPORTING FORM**

County: _____

Date Completed: _____

Reporting Quarter and State Fiscal Year: _____

Section I. Fraud Complaints	
A	Total Number of Complaints Received
A.1.	Number of Complaints Received By Source
	Recipient
	Provider
	Family member
	County staff
	Neighbor
	Data matches
	Anonymous- phone
	Anonymous- mail
	Anonymous- website
	Other (Explain in Comments- section VI.1.)
A.2.	Number of Complaints By Outcome - Initial Review
	Referred for county investigation
	Referred for <u>S</u> state investigation
	Referred for administrative action
	Referred to APS/CPS
	Dropped, no action
Section II. Early Detection Savings	
A	Total Number of Cases Terminated/Reduced
A.1.	Number of Cases Terminated/Reduced as a Result of:
	Data matches
	Entirely overstated disability
	Partially overstated disability
	Household composition/proration
	Misrepresented program eligibility
B	Total Number of Hours Terminated/Reduced
B.1.	Number of Authorized Hours Terminated/Reduced as a Result of:
	Data matches
	Entirely overstated disability
	Partially overstated disability
	Household composition/proration
	Misrepresented program eligibility

SOC 2245 (4/12)

IN-HOME SUPPORTIVE SERVICES (IHSS) FRAUD DATA REPORTING FORM

Section III. Fraud Investigations - Completed	
A	Total Number of Investigations Completed
A.1.	Number of Investigations By Type
	Collusion (Provider & Recipient)
	Provider fraud
	Recipient fraud
	County staff
	Other (Explain in Comments - section VI.2.)
A.2.	Number of Investigations By Outcome
	Dropped, no action
	Referred for admin. action to IHSS
	Referred for prosecution to County DA
	Referred for prosecution to DOJ
A.3.	Amount Estimates by Outcome (\$)
	Estimated amount referred for admin. action to IHSS
	Estimated amount referred for prosecution
Section IV. Prosecutions - County	
A	Total Number of Cases Received for Prosecution
A.1.	Number of Cases by Outcome
	Cases declined by DA
	Plea deal, no conviction
	Cases dismissed
	Number of cases - with convictions
	Number of felony convictions
	Number of misdemeanor convictions
	Number of defendants prosecuted
	Number of Referrals to suspended and ineligible list
Section V. Totals (\$)	
A	Loss Identified to IHSS Program
B	Total Amount Identified for Collection through Court Ordered Restitution
C	Total Amount Identified for Collection through County Overpay Recovery
Section VI.I. Comments	
Section VI.2. Comments	

IHSS FRAUD DATA REPORTING FORM INSTRUCTION

Section I. Fraud Complaints

Definitions:

- **Complaint** – A complaint is any concern that comes in to the county; some will become referrals and some will not. Complaints may include a neighbor's general suspicions, a family member's concerns about the quality of a provider, or county staff's suspicion of fraudulent behavior.
- **County Staff** – Any employee at the county level, this may include: Child Protective Services (CPS), Adult Protective Services (APS), social workers, county investigative staff, District Attorney's Office, or Others.
- **Data Matches** – Data matches may originate at the State or county level and may include death match, hospital match, jail match, etc.
- **Administrative Action** – Any administrative action taken on a case and may include: overpay recovery, hour reduction, case termination etc.,

A. Total Number of Complaints Received – Record the total number of complaints received.

A.1. Number of Complaints Received by Source – The purpose of this section is to track where complaints are originating.

Record each complaint received in every applicable category. If the complaint was reported by a provider who is also a family member, record the complaint once for provider and once for family member. The total of A.1. must be greater than or equal to A.

A.2. Number of Complaints by Outcome – Initial Review – The action taken on the complaints after the initial review, grouped by outcome.

The review is conducted in accordance with your county's process. These are initial outcomes determined this quarter regardless of when the complaint was received. Record each complaint in every applicable outcome category. If a complaint was referred for county investigation and had an overpay recovery action initiated, mark "referred for county investigation" once and "referred for administrative action" once.

*Note: Counties must report all cases sent for investigation to the State. Once received for investigation, the State will report on those cases separately. If the State sends the case back to the county for investigation or prosecution, the county must resume reporting on the case.

Section II. Early Detection Savings

Definitions:

- **Early Detection Savings** – Any future savings achieved by terminating or reducing hours on a case.
- **Entirely/Partly Overstated Disability** – Recipient either completely or partially misrepresented his or her care needs.
- **Household Composition/Proration** – There was a misrepresentation regarding the people in the household or their usage of the household space.
- **Misrepresented Program Eligibility** – Recipient provided an incorrect citizenship status or misrepresented income/assets.

A. **Total Number of Cases Terminated/Reduced** – Record the total number of cases that were terminated or had authorized hours reduced as the result of a complaint.

A.1. Number of Cases Terminated/Reduced as the Result of: – Record each case that was terminated or had hours reduced in each category based on the cause for the termination/reduction.

B. **Total Number of Hours Terminated/Reduced** – Record the total number of monthly authorized hours that were terminated or reduced as the result of being identified by a complaint.

B.1. Number of Hours Terminated/Reduced as the Result of: – Record the number of monthly authorized hours that were terminated or reduced in each category based on the cause for the termination/reduction.

Section III. Fraud Investigations – Completed

A. **Total Number of Investigations Completed** – Record the number of completed investigations that were conducted this fiscal year.

A.1. Number of Investigations by Type – The number of complaints, grouped by the source of the fraud. Record each complaint by the person(s) suspected of committing fraud at the time the report is being completed. This may or may not be the same person(s) suspected when the original complaint was reported.

A.2. Number of Investigations by Outcome – The action taken on cases referred for investigation, grouped by outcome.

A.3. Amount Estimates by Outcome (\$) – The estimated amount of fraud involved in cases, grouped by outcome.

Section IV. Prosecutions – County**Definitions:**

- **Cases declined by the DA** – cases sent to the DA for prosecution that the DA declines to prosecute.
- **Plea deal, no conviction** – any cases that were plead out for restitution only, no conviction.

A. Total Number of Cases Received for Prosecution

A.1. Number of Cases by Outcome – Provide the number of cases with completed prosecutions in this quarter, grouped by outcomes. 1) These will be county-only prosecuted cases. 2) You may record a case more than once if it was convicted and referred to the suspended and ineligible list or if it resulted in both a misdemeanor and a felony.

Section V. Totals (\$)

A. **Loss Identified to IHSS Program** – Record the total overpay amount (gross) in all cases identified, whether or not they were sent for prosecution. This does not include extraneous costs such as court fees, hours for investigation, etc. Sections V.B. and V.C. do not need to equal V.A.

B. **Total Amount Identified for Collection Through Court Ordered Restitution** – Record the total amount of restitution ordered for repayment to the IHSS program.

C. **Total Amount Identified for Collection Through County Overpay Recovery** – Record the total net amount of overpayments identified as a result of a fraud investigation.

Section VI. Comments

Please use these sections to clarify if the “other” line is used in section I.A.1. or III.A.1.