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September 27, 2013

ALL-COUNTY LETTER (ACL) NO.: 13-83

TO: ALL COUNTY WELFARE DIRECTORS
ALL IHSS PROGRAM MANAGERS

SUBJECT: IMPLEMENTATION OF THE UNIFORM STATEWIDE PROTOCOLS
FOR PROGRAM INTEGRITY ACTIVITIES IN THE IN-HOME
SUPPORTIVE SERVICES (IHSS) PROGRAM

REFERENCE: ALL-COUNTY INFORMATION NOTICE (ACIN) NO. I-13-13,
DATED MARCH 21, 2013; ACL NO. 10-39, DATED
AUGUST 19, 2010; COUNTY FISCAL LETTERS (CFL)
NO. 09/10-33, DATED OCTOBER 29, 2009; 09/10-37, DATED
DECEMBER 10, 2009; 10/11-34, DATED NOVEMBER 23,
2010; 11/12-19, DATED SEPTEMBER 16, 2011; AND 12/13-14,
DATED SEPTEMBER 27, 2012.

This letter provides implementation guidelines for the *Uniform Statewide Protocols for Program Integrity Activities in the IHSS Program* (hereinafter referred to as “the protocols.”)

Background

On July 24, 2009, Assembly Bill 19, fourth extraordinary session (ABX4 19) amended components of the California Welfare and Institutions Code (WIC) Sections 12305.7, 12305.71, and 12305.82, requiring the California Department of Social Services (CDSS) to establish a State and county stakeholders’ workgroup to address key requirements pertaining to IHSS program integrity. The goal of this workgroup was to develop protocols clarifying state and county roles and responsibilities for the implementation and execution of standardized program integrity measures in the IHSS Program.

In March 2010, CDSS established the workgroup which included representatives from CDSS, the Department of Health Care Services (DHCS), the California Department of Justice Bureau of Medi-Cal Fraud and Elder Abuse, county program staff and district attorneys’ offices. In 2011, IHSS recipients and advocacy groups representing both IHSS recipients and providers were added to ensure sufficient

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

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 public input. The workgroup engaged in a robust dialogue addressing issues as they pertain to workload concerns, implementation specifics and challenges faced by small counties versus large counties.

The focus of the workgroup was to encourage a coordinated effort between all of the involved stakeholders to ensure a consistent approach towards program integrity activities. In March 2013, the workgroup completed the protocols which are available at: <http://www.cdss.ca.gov/agedblinddisabled/PG2170.htm>.

It is essential that each county develop its own policies and procedures clearly addressing how they will implement the components of the protocols.

Purpose

The purpose of the 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 program integrity and fraud prevention, detection, and coordinated investigation and prosecution in the IHSS Program. The protocols are intended to assist counties in developing and implementing policies and procedures to ensure consistency.

Applicability

The protocols apply to 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. The protocols are not intended to limit in any way the jurisdiction or ability of law enforcement agencies operating under separate authority.

Program Integrity Activities

The specific measures addressed in the protocols include program integrity training for county IHSS workers, unannounced home visits (UHV's), directed mailings to IHSS providers, and statewide communication and coordination for IHSS program integrity efforts between state and county offices.

The delineation between quality assurance and program integrity activities is defined in **ACL No. 10-39**; the appropriation for these program integrity activities is established in **CFL No. 09/10-33** under the heading IHSS Anti-Fraud Initiative County Investigation; claiming instructions first appear in **CFL No. 09/10-37**, and the allocation appears most recently (as of this writing) in **CFL No. 12/13-14** under the heading Program Integrity Administrative Activities – County Investigation.

Program Integrity Training

This training module has been developed and implemented, and is generally available through the IHSS Social Worker Training Academy in various regions throughout the state twice each year. The current training materials can be found at: <http://www.cdss.ca.gov/agedblinddisabled/PG1214.htm>, and each fiscal year's training schedule will be made available to counties as soon as it is finalized. This training is key to successfully conducting the other three program integrity measures of the protocols.

Implementation of the remaining three measures is addressed in this ACL. Specific information concerning these program integrity activities, including staffing, funding, and claiming information, can be found in the ACIN, ACL, and CFLs referenced above.

Unannounced Home Visits

The term "Unannounced Home Visit" refers specifically to program integrity UHVs as established in WIC Section 12305.71(c)(3). Neither the protocols nor this ACL shall preclude counties from conducting, nor dictate county procedures concerning, unscheduled visits to the home of a recipient for the purpose of conducting a needs assessment, reassessment, safety and welfare check, or any purpose other than program integrity UHVs.

The purpose of the UHV by county 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.

Implementation of the UHVs will occur over the period of October 1, 2013, through June 30, 2014. CDSS will use this transitional implementation period to evaluate the impact on counties in an effort to establish criteria guiding the acceptable size and frequency of UHV lists from CDSS, as well as the timeframe for counties to complete all UHVs on a list.

Counties are required to assign designated, trained staff responsible for conducting UHVs. Counties will also assign a county Point of Contact (POC) for program integrity issues, and keep CDSS informed as that POC changes. Those designated, trained program integrity staff will participate in all UHVs conducted by the county. As contained in ACL NO. 10-39, CDSS intended that the 78 county program integrity positions would conduct UHVs; however, counties will have flexibility to determine specifically who will be designated and how they will be trained in accordance with county policies and procedures. At a minimum, UHV staff training will include the program integrity training offered by CDSS through the IHSS Social Worker Training Academy; counties may supplement that training with any additional training that they deem appropriate.

CDSS will begin generating lists of recipients who meet UHV criteria, and distributing those lists to the program integrity contacts in counties by October 10, 2013. Typically, a recipient will meet UHV criteria based on some concern about the receipt or the quality of their services, their wellbeing, or other program integrity concerns.

Counties must conduct UHVs on all recipients listed by the end of the implementation period, or provide a clear explanation, based on specific knowledge of a case, why one or more of the identified recipients has not or should not be visited. Counties may add names to the UHV list if they have a clear reason for doing so. Reasons for adding names to the UHV list must be based on concerns about the receipt or the quality of services, recipient wellbeing, program integrity, risk of abuse and/or fraud, or referrals.

Counties will not, under any circumstances, conduct program integrity UHVs at random.

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. The UHV staff is encouraged to consult with the IHSS caseworker or supervisor as appropriate. In addition, reviewing the case file and discussing the UHV with the case worker prior to the UHV may provide information about when the recipient is most likely to be home, which may help select the best date and time for the UHV.

To the extent possible, the UHV and all calls and letters to the recipient shall be in the documented primary language of the recipient. If it is not possible to conduct the UHV in the recipient's primary language, an interpreter must be used at no cost to the recipient. Any telephone calls, letters, or UHVs attempted in a language other than the recipient's documented primary language shall not be counted against the three visits, two calls, and letter to which the recipient is entitled.

Communication and Coordination: Counties shall ensure that IHSS case workers (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, at their discretion, 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 a county designated 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 contact person and/or the recipient's case worker 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 against the three UHV attempts to which the recipient is entitled.

The UHV

UHV Accomplished: 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 (SOC 2247), 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.

UHV Not Accomplished: In the event that a county is unable to conduct a UHV based on unavailability of, or lack of cooperation from a recipient, that county shall closely adhere to these UHV follow-up procedures, in order, within 60 calendar days from the date of the initial UHV attempt:

- Mail a UHV Follow-Up Letter (Attachment A to the protocols) to the recipient's home. Alternately, the UHV Follow-Up Letter can be left at the recipient's home in an obvious location, such as in the door or in an area otherwise likely to be seen by the recipient upon their return.
- Call the recipient or authorized representative at the primary phone number in the case file. The telephone call must address:
 - The recipient's current address (confirm whether or not the recipient still resides at the address visited)
 - The recipient's wellbeing
 - The purpose of a UHV and the requirement for recipients to cooperate with the UHV
 - Any recurring commitments in the recipient's schedule that should be considered by the county UHV staff when planning future visits

The telephone call must not be used to schedule a UHV.

- Attempt a second time to conduct a UHV. To the extent possible, the second attempt should be made at a different time and/or day of the week than the first attempt.
- Call the recipient or authorized representative at the primary phone number in the case file.
- Attempt a third time to conduct a UHV. To the extent possible, the third attempt should be made at a different time and/or day of the week than the previous two attempts.

At the end of the 60 calendar day period, after the minimum follow-up procedures have been completed, if the county has been unable to complete the UHV because the recipient has been unavailable or uncooperative, send the recipient a Notice of Action (NOA) indicating termination from the IHSS Program. A NOA Code specific to this circumstance is being developed; appeal rights and aid paid pending remain in full effect.

The follow-up procedures must constitute a good faith effort by the county to complete a UHV.

Counties must use all available resources to ascertain whether the recipient attends school or participates in Community Based Adult Services (CBAS), or otherwise has commitments on certain days, or at certain times of the day. County UHV staff must

then make every reasonable effort to attempt UHVs at times that do not conflict with those commitments. After the UHV Follow-Up Letter is mailed or left at the home, no two contact efforts made on the same day can be counted against the minimum required contacts to which the recipient is entitled. While UHV staff may make two UHV attempts to the same home on the same day, the second attempt will not count as one of the three required UHV attempts unless it results in a completed UHV. Likewise, county UHV staff may attempt multiple calls to the same recipient on the same day, but a call will only count as the second required call *after* a second attempt has been made to complete the UHV.

Counties may, at their discretion, make additional attempts (beyond the required three UHV attempts, two phone calls, and letter) to contact the recipient, the authorized representative, the provider, or other individual named in the case file as an alternate contact up until the end of the 60 calendar days after the initial UHV attempt. Whether or not the county is able to conduct additional efforts to contact the recipient, the requirement is fulfilled upon completion of the minimum follow-up procedures established in the protocols (three UHV attempts, two phone calls, and a letter). Counties are encouraged, but not required, to make additional efforts to contact the recipient prior to sending the termination NOA. Once the NOA is sent, an offer from the recipient to cooperate is not sufficient to stop the termination.

Whether or not the county UHV staff successfully completes a UHV, all efforts and findings must be documented using the SOC 2247. This form must be maintained with the case file, and is available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2247.pdf>, with instructions for its completion. It is imperative that counties complete the SOC 2247 as thoroughly as possible, carefully documenting each attempted contact with the recipient. Counties must document dates and times of contact attempts, the results of contact attempts, whether or not they left a message, the content of any messages left, and any contact received from the recipient or authorized representative.

As counties conduct the UHVs they will annotate the UHV list with applicable comments, and return the completed UHV list to CDSS upon completion, within the specified timeframe.

Annually, CDSS will validate, compile, and analyze the completed UHV data, and release a report to counties each September.

CDSS Responsibilities:

- Provide program integrity training to meet the minimum requirement for training UHV staff.
- Maintain all standard forms and update as necessary.
- Generate lists of recipients identified for UHVs.
- Monitor the size of UHV lists and filter as needed prior to sending to the program integrity POC in each county.
- Receive completed UHV lists from counties, validate, and then aggregate the data for inclusion in the annual report to counties.
- Provide technical assistance to counties as appropriate.

County Responsibilities:

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
 - training staff,
 - conducting and following up on UHVs, and
 - tracking and reporting UHV data in accordance with the protocols.
- Designate and train staff to begin conducting UHVs.
- Use the CDSS list of recipients identified for UHVs.
- Review case files and note pertinent information prior to conducting UHVs.
- Counties may add names to the list of recipients identified for UHVs if they have a clear reason for doing so.
- Conduct UHVs on all recipients listed, or provide a clear explanation, based on specific knowledge of a case, why one or more of the identified recipients should not be visited.
- Clearly document the completed UHV list to include the reasons why the county has opted *not* to conduct a UHV on an identified recipient.
- Clearly document on the completed UHV list any additional UHVs performed, including the reasons why those additional recipients were selected for UHVs.
- Adhere to follow-up procedures in the event that the UHV is not completed.
- At the end of the 60 calendar day period, after the follow-up procedures have been completed, if the county has been unable to complete the UHV because the recipient has been unavailable or uncooperative, send the recipient a NOA indicating termination from the IHSS Program.
- Thoroughly document UHV efforts and outcomes using the UHV Findings Report (SOC 2247), and follow up as appropriate.
- Counties will conduct the UHVs and electronically return the completed UHV list to the CDSS Quality Assurance and Improvement Bureau, at: ihss-pi@dss.ca.gov within the specified timeframe.

Directed Mailings

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

The purpose of directed mailings is to reach out to providers associated with cases which appear to suggest some program integrity concern (whether or not the concern is founded) and proactively educate those providers concerning common program integrity mistakes. 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.

Under separate cover, CDSS will disseminate the List of Approved Indicators for directed mailings to identified county program integrity contacts. Counties will select providers to receive directed mailings using the indicators list. If a county attempts to pull data using approved indicators and returns no results (a "Zero Results Data Pull"), the county will adhere to the following guidance:

- 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.

Prior to sending directed mailings to providers, counties will email their list of prospective providers on a spreadsheet to CDSS for review. At a minimum, this list must include the provider identification numbers, associated recipient case numbers, and the specific indicators used to select the providers. CDSS will review these lists against previous lists, and identify and report any duplication to the county. Counties will review the list of duplications and make case by case determinations whether or not to include each case in the mailing. The decision to include or omit any duplicate cases will remain solely with the county; the purpose of the CDSS review is only to ensure that counties are aware of any such duplication.

Counties will send the directed mailing to providers from the list, send copies to each recipient served by those providers, and then notify the CDSS Quality Assurance and Improvement Bureau of which providers were sent mailings, again using a spreadsheet as the reporting format. Counties will conduct at least one directed mailing annually, beginning in Fiscal Year (FY) 2013/14. If, based on some unforeseeable emergency, a county is not able to conduct a data pull or a directed mailing, they will adhere to the “Unforeseeable Circumstances” guidance outlined in the protocols and provided below. Examples of unforeseeable circumstances which prevent a county from conducting the directed mailing include events such as natural disasters that greatly diminish the county’s ability to conduct routine business for a prolonged period of time. Upon receipt of directed mailing data, CDSS will validate the data, compile, analyze, and include it in the annual report to counties.

CDSS Responsibilities:

- Provide Program Integrity training.
- Maintain the List of Approved Indicators for identifying groups of providers to receive a directed mailing, and update as appropriate.
- Disseminate the current List of Approved Indicators to the program integrity POC in each county.
- Receive counties’ pre-mailing list, and compare it against previous mailing lists.
- Receive and validate completed mailing lists, then aggregate the data for inclusion in the annual report to counties.
- Provide technical and practical assistance as appropriate.

County Responsibilities:

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
 - training staff,
 - conducting directed mailings, and
 - tracking and reporting directed mailings in accordance with the protocols.
- Select indicators from the indicator list provided by CDSS (distributed to county program integrity POC under separate cover), and conduct data pulls to create a directed mailing list of providers who all share the indicator.
- In the event that the county is unable to conduct a data pull or a directed mailing because of some unforeseeable emergency, contact CDSS for assistance.
- In the event that a data pull yields no results, counties will adhere to the “Zero Result Data Pulls” guidance.
- Email their list of prospective providers on a spreadsheet to CDSS for review prior to mailing.

- Customize the letter (*Attachment C to the protocols*) to include a reason for the mailing from the Reasons List and county contact information, and then conduct the mailing.
- Ensure that a copy of the directed mailing is sent to each recipient assisted by those providers.
- Conduct a minimum of one directed mailing per year, beginning in FY 2013/14.
- Mail to providers from the list, and then notify CDSS Quality Assurance and Improvement Bureau of which providers were sent mailings, again using a spreadsheet format for reporting.
- Email CDSS a final list of providers and recipients who were sent directed mailings for tracking and analysis, in order to coordinate and track the mailings and minimize unintentional duplication. At a minimum this list must include the provider numbers, associated recipient case numbers, and the specific indicators used to select the providers.

Statewide Communication and Coordination

The purpose of statewide communication and 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. The following definitions apply:

A complaint is any program integrity concern or allegation identified or received by the state or county.

Fraud is 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 is the process whereby designated county staff reviews a complaint of suspected fraud and determines whether or not the complaint will become a fraud referral.

A fraud referral is a complaint that has been triaged by designated county staff and determined appropriate for referral to a law enforcement agency for fraud investigation.

Fraud Referral Procedures

The intent of the guidelines below is to provide a framework to enable CDSS, DHCS, the 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 staff that 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 2248) (*Attachment D to the protocols*) 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 county staff for triage.

Fraud Referral

The county must identify staff 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 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. Complaints of \$500 or less can also be referred to DHCS, if counties choose not to investigate locally.

Counties who have a MOU with DHCS will abide by the terms of that MOU.

Fraud Investigation

The law enforcement agency shall conduct an investigation and determine the outcome, 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 to the protocols*).

CDSS Responsibilities:

- Provide Program Integrity training.
- Maintain all standard forms and update as necessary.
- Define required elements of statistical data reporting.
- Initiate data-sharing agreements with DHCS and DOJ.
- Function as the primary repository for IHSS fraud data.
- Validate fraud data collected from the counties, and then aggregate the data for inclusion in the annual report to counties.
- Provide technical assistance as appropriate.

DHCS Responsibilities:

- Act as a resource to counties.
- Ensure the timely investigation of cases referred by counties.
- Report findings/outcome of investigations to the 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 Responsibilities:

- Assist counties with investigations/prosecutions of provider fraud, at the request of the county or DHCS.
- Provide CDSS statistical data concerning IHSS fraud investigations and prosecutions, including outcome data, within a reasonable timeframe upon request.

County Responsibilities:

- Develop county-specific policies that are consistent with the protocols, and detailed procedures for:
 - training staff,
 - receiving, reviewing, and referring fraud complaints, and
 - tracking and reporting fraud data in accordance with the protocols.
- Identify staff to conduct triage on fraud complaints.

- Document suspected fraud using the Complaint of Suspected Fraud Form (SOC 2248) which has replaced the MC 609 for reporting suspected fraud in the IHSS Program. This form must be maintained with the complaint/referral package, and is available at:
<http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2248.pdf>.

- Complete the appropriate sections of the Complaint of Suspected Fraud form as completely as possible, and
 - review the form for accuracy and completion;
 - gather any missing information from the Reporting Party;
 - gather any relevant supporting documentation, such as copies of timesheets and pay warrants for the period in question.
- Submit the fraud complaint package to the designated county triage staff.
- The county triage staff shall conduct triage on fraud complaints, complete Section E of the Complaint of Suspected Fraud form, and refer cases to law enforcement when appropriate.
- Refer complaints determined appropriate for investigation along the appropriate path (as outlined below), depending on the amount of overpayment involved, and whether or not the county has an MOU with DHCS.
 - Counties seeking to investigate their own fraud complaints must establish a MOU with DHCS by contacting the Chief of Investigations using the current contact information at:
http://www.dhcs.ca.gov/individuals/Pages/AI_IB_Locations.aspx.

- Counties that do not establish an MOU *must* refer all fraud complaints deemed viable to DHCS unless it appears unlikely that the total overpayment will exceed \$500.

- Counties may investigate complaints of suspected fraud with respect to an overpayment of \$500 or less, or refer them to DHCS.
- Fraud referrals to DHCS must be made to DHCS Investigations Branch, Policy and Analysis Unit. The preferred method of referral is email at:

IB.PAU.INTAKE@dhcs.ca.gov. Counties are reminded that personally identifying information must be password protected when emailing.

- The mailing address for paper documents is:

Department of Health Care Services
Audits and Investigations
Investigations Branch – HQ
1500 Capitol Ave.
Suite 72.422
P.O. Box 997413
Sacramento, CA 95899-7413
MS 2200

- Complaints deemed not appropriate for investigation (insufficient indication of fraud) that still reveal an overpayment must be evaluated by county staff to determine the most appropriate method of administrative overpayment recovery.
- Counties must track fraud complaints and report to CDSS quarterly using the Fraud Data Reporting Form (SOC 2245) available at: <http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC2245.pdf>. CDSS will validate the county fraud data, compile, analyze, and include it in the annual report to counties.

If you have questions or comments regarding this ACL or the protocols, please contact Mr. Ernie Ruoff, Manager of the Quality Assurance & Improvement Bureau's Program Integrity Unit at (916) 651-3494 or via email at: ihss-pi@dss.ca.gov.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

c: CWDA