Worker Fraud in the Family Care Program

What is Medicaid fraud?

Fraud* is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or others. It includes any act that constitutes fraud under applicable Federal or State law.
*42 CFR § 433.304 and 42 CFR § 455.2

Ways Workers Have Committed Fraud in the Family Care Program

- Billed for hours although services were not rendered
- Submitted timesheets while the worker or Family Care member was hospitalized, in a nursing home, in a rehabilitation facility, deceased, or incarcerated
- Submitted time sheets to a personal care agency and the Family Care program for the same time period; workers cannot get paid twice for the same work
- Forged the member's or guardian's signature on a time sheet
- Altered the time sheet after it has been signed by the member or guardian
- Submitted false personal information to bill under another person's identity to avoid background check requirements
- Engaged in kickback schemes with the members or guardians
- Assisted members in overstating their needs during the Long-Term Care Functional Screen or Personal Care Screening Tool

Reminder: Workers must only submit timesheets for hours that they actually worked.

What is the Office of the Inspector General?

The Office of the Inspector General (OIG) is the part of the Department of Health Services responsible for identifying and addressing fraud, waste, and abuse in Medicaid programs, including Family Care, Program of All-Inclusive Care for the Elderly (PACE), and Family Care Partnership.

How does OIG address fraud?

- OIG collaborates with the Division of Medicaid Services, the managed care organizations (MCOs), and fiscal agents to review allegations.
- When appropriate, OIG sends a credible allegation of fraud referral to the Department of Justice (DOJ) for investigation and potential prosecution. When such referral is made, OIG suspends payments to the worker.
- In some cases, OIG sends a letter requesting that the worker return the overpayment. If the money is not returned, the case may be referred to collections.
- When convicted of fraud, workers can no longer provide services in Family Care, PACE, Partnership, IRIS (Include, Respect, I Self-Direct), Children's Long-Term Supports (CLTS) waiver program, or any Medicaid program.

Referral to the Department of Justice

Federal law (42 CFR § 455.15) requires OIG to report all credible allegations of fraud or abuse to the DOJ Medicaid Fraud Control and Elder Abuse Unit (MFCEAU) for investigation and potential civil or criminal action. OIG also sends "provider notices" to DOJ for Family Care members and workers when fraud is suspected but additional investigation is needed.

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