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STATE CONTINUES AGGRESSIVE ANTI-FRAUD MEASURES TO PROTECT THE FISCAL INTEGRITY OF MEDI-CAL

Annual Study Identifies Errors and Potential Fraud Within the Program

SACRAMENTO – Continuing its strong efforts to fight fraud, waste and abuse in the Medi-Cal program, the Department of Health Care Services (DHCS) today released its fourth annual [Medi-Cal Payment Error Study](#) (MPES), the nation's most comprehensive study of payment errors in a state Medicaid program.

The study identified areas in which the Medi-Cal program is at greatest risk for potential errors. It found that 93.44 percent of reimbursements paid to fee-for-service Medi-Cal providers in 2007 were billed appropriately and paid accurately, which represents an improvement from the 92.73 percent accuracy rate of 2006.

"DHCS has a strong, proactive monitoring program to alert us of efforts to defraud the Medi-Cal program," said DHCS Director David Maxwell-Jolly. "The MPES targets areas at greatest risk of provider payment errors, helping to focus our anti-fraud efforts where they are needed most."

Determined to reduce fraud even further, the Governor's revised 2009-2010 budget includes \$3.4 million for a new Medi-Cal anti-fraud initiative. It will more aggressively target fraud in adult day health care (ADHC) centers, pharmacies, physicians, transportation services and durable medical equipment transactions. Savings would increase significantly after startup in 2009-10, rising from \$47.9 million to approximately \$87 million in future years.

"Promoting program integrity is a vital element of every policy decision, and ensuring the fiscal integrity of the Medi-Cal program during these tough budget times is a key priority," said Maxwell-Jolly. "The Governor has demonstrated his commitment to the importance of taking strong measures to guarantee that our state's safety net programs remain healthy and secure for this and future generations."

The MPES identified overall errors and the subset that are potentially fraudulent. Over the past three years, the overall MPES error rate has shown a steady decline. The MPES 2007 rate is almost 10 percent less than the rate for MPES 2006, which itself was 13 percent lower than the MPES 2005 error rate.

Of the total claims reviewed, 2.53 percent, or \$405 million, were found to have characteristics of potential fraud. This is lower than the 2.75 percent found in the 2006 study, which represented \$445 million in payments. California's MPES is the only study conducted by a state or federal entity that includes this estimate of potential fraud.

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The most frequent MPES error category was “lack of medical necessity,” which accounted for 27 percent of the total number of MPES 2007 errors. Approximately 77 percent of these medically unnecessary errors were potentially fraudulent. Other error categories included insufficient provider documentation, which means that the documentation presented by a provider did not support the services claimed, coding errors and policy violations.

Physicians accounted for 57 percent of total errors, while pharmacy services accounted for 31 percent. ADHC centers were the third largest contributors to the overall error rate, and most ADHC errors were for a lack of medical necessity, meaning some beneficiaries were admitted by ADHC providers inappropriately when services were not required. Other groups with identified errors included institutional providers (hospital and long-term care providers), dentists, labs and durable medical equipment suppliers.

“The MPES findings reinforce the need to continuously and systematically identify those areas of the Medi-Cal program that are most vulnerable to fraud, waste and abuse and to use these findings to guide DHCS in its allocation of fraud control resources and its development of innovative anti-fraud strategies and prevention tools,” said Maxwell-Jolly.

DHCS performs investigational and routine field compliance audits to identify provider claim errors, takes appropriate corrective actions and applies appropriate sanctions. DHCS reviews claiming patterns, develops cases and places sanctions on those providers who submit claims with errors or characteristics of fraud. Currently, all errors identified in MPES 2007 are being reviewed to determine if follow-up reviews on audits should be conducted.

“California’s Medi-Cal anti-fraud efforts are the most comprehensive of any state Medicaid program in the nation,” said Maxwell-Jolly. “We will continue working with federal, state and local partners and examining opportunities to use new technologies that will further assist in the identification and detection of fraud, waste and abuse.”

Medi-Cal is California's Medicaid program and provides vital health care services to more than 6.8 million low-income individuals, including families with children, pregnant women, seniors and persons with disabilities, with an annual total budget of nearly \$41 billion.

DHCS will use the MPES 2007 findings to assist in developing the methodology and focus of MPES 2009.

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