
Status of Medi-Cal Fraud Control Initiatives



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California Department of Health Care Services
Audits & Investigations Division

Fiscal Years 2010-11 and 2011-12

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Executive Summary

Results in Brief

The anti-fraud initiatives reported in this report demonstrate the Department of Health Care Services' (DHCS) continued success in reducing fraud and abuse in the Medi-Cal program. The anti-fraud initiatives demonstrate a positive Return on Investment (ROI) on the resources used to the dollars saved. For Fiscal Years (FY) 2010-2012 the Audits and Investigations Division (A&I) Medical Review Branch (MRB) achieved a return on investment (ROI) of \$6.98 for every \$1 spent on anti-fraud activities.

Medi-Cal Payment Error Study (MPES)

The MPES 2011 results continue to show that the overwhelming majority of payments, 93.95 percent of total payments made in FFS medical and dental programs, were billed and paid appropriately. In contrast, an estimated 6.05 percent of those payments had some indication that they contained a provider payment error. The 6.05 percent payment error shows a slight increase over the 5.45 percentage rate of the 2009 study, due partly to the growth of the Medi-Cal FFS program.

Random Claims Review (RCR)

The RCR process subjects approximately 15 randomly selected claims submitted by providers to review prior to payment per week. The process places Medi-Cal providers on notice that all claims are at risk for review prior to payment. When a claim is selected for review, providers are required to submit documentation to support the claim prior to payment.

Strengthening the Pre-Enrollment/Enrollment Process

The ability to prevent fraudulent providers from enrolling or re-enrolling in the Medi-Cal program is a key component in the fight against Medi-Cal fraud. All enrollments are subject to thorough review by the DHCS Provider Enrollment Division (PED). During this review period, PED reviewed 38,312 enrollment applications from providers seeking admission to the Medi-Cal program. Of the 38,312 applications submitted, 7,628 applications were denied for not meeting Medi-Cal program requirements.

➤ *The overall ROI for the DHCS anti-fraud initiatives for FY's 2010-2012 was \$6.98.*

➤ *MPES 2011 demonstrated that 93.95 % of FFS Medi-Cal Payments were billed and paid appropriately.*

➤ *DHCS selected 1,520 claims for review prior to payment; 14 percent of the claims were denied payment due to lack of medical justification or because no documentation was submitted.*

➤ *DHCS PED received and processed 38,312 applications from providers applying for admission to the Medi-Cal program. PED denied 7,628 of the applications received.*

Introduction

In 2003, the California Legislature enacted legislation which authorized additional resources and staffing to the Department of Health Services (now Department of Health Care Services) to combat fraud and waste in the Medi-Cal program. Assembly Bill 1765 (Oropeza, Chapter 157, Statutes of 2003) provided an increase of 161.5 positions, of which 154.5 were for implementing and expanding DHCS anti-fraud programs. Seven staff positions were for program support.

The legislation required that DHCS report to the Legislature the results of specific anti-fraud activities which are included in the body of this report as well as the results of the latest Medi-Cal Payment Error Study (MPES). The report is to be submitted to the chairperson of the Committee on Appropriations and to the chairperson of the Joint Legislative Budget Committee. This report covers the fiscal period from July 1, 2010 through June 30, 2012. The Audits and Investigations Division (A&I), Medical Review Branch (MRB) was designated as the lead Branch responsible for developing the report. The MRB is charged with the responsibility of performing federally mandated post-service, post-payment utilization reviews of non-institutional Medi-Cal providers.

DHCS continues to make strides in reducing fraud, waste and abuse in the Medi-Cal program. The success is represented in the anti-fraud return on investment (ROI). The anti-fraud production statistics demonstrate that DHCS is committed to recouping the dollars paid out as a result of improper billing by providers.

The anti-fraud initiatives reported in this report include the Random Claims Reviews, Expansion and Strengthening of the Pre-Check Write, Expansion and Strengthening of the Pre-Enrollment/Enrollment Process, and ongoing anti-fraud achievements. These initiatives are continuing to play a significant role in the anti-fraud program.

Return on Investment (ROI)

The ROI is based on cost recovery, savings, and avoidance activity during the period 7/1/10 – 6/30/12. MRB's program integrity efforts resulted in an average return on investment of \$6.98 in savings and avoidance for every \$1 invested in the effort. The table to the right identifies the ROI for each activity.

Return on Investment		
<i>Anti-Fraud Activity</i>	<i>ROI</i>	<i>Ratio</i>
Audits for Recovery	\$17.63	1.00 : 17.63
Field Audit Review	\$6.74	1.00 : 6.74
Pre-Enrollment	\$6.73	1.00 : 6.73
Overall ROI	\$6.98	1.00 : 6.98

Overall ROI is less than ROI for individual anti-fraud activities because it incorporates additional cost categories in the calculation.

The table to the right shows the cost recoveries, cost savings, and cost avoidance.

MRB Return on Investment			
<i>Cost Recoveries</i>	<i>Cost Savings</i>	<i>Cost Avoidance</i>	<i>Demands</i>
\$62,682,565	\$127,604,362	\$35,512,959	\$49,393,708

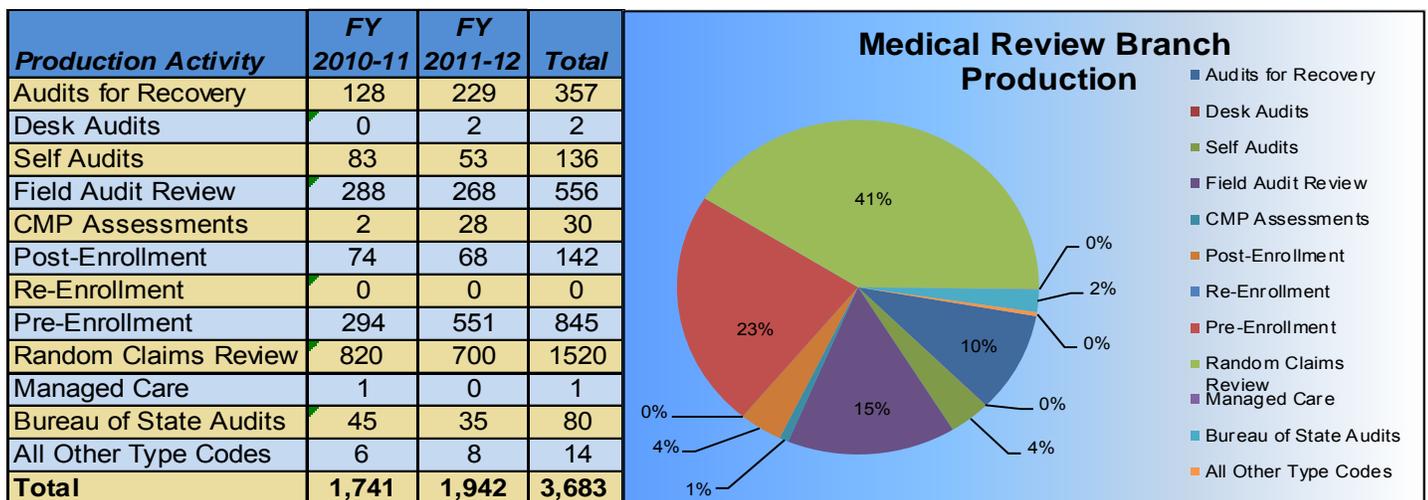
Anti-Fraud Savings

During this reporting period, DHCS continued to achieve significant savings as a result of its anti-fraud initiatives. The table below demonstrates the savings per each action. During this reporting period of fiscal year (FY) 2010-2011 and FY 2011-2012, the total savings for both fiscal years totaled \$173,626,625.

Actions:	Savings per Action:
Audit for Recovery	\$54,575
Withhold of Payment	\$59,642
Temporary Suspension	\$59,642
Procedural Code Limitation	\$26,865
Civil Money Penalty (CMP)	\$19,226
Denied Enrollment	\$89,974

Production Activity

Below is a breakdown of the production activity detailed by activity type.



Below is a breakdown of the actions imposed as a result of MRB's production activity.

Actions Taken	Actions Imposed FY 2010-11	Actions Imposed FY 2011-12	Total
Withholds & Temporary Suspensions	159	86	245
Issued Demands	167	271	438
Post Service Prepayment Audit	132	80	212
Procedure Code Drug Limits	151	103	254
Civil Money Penalty (1st, 2nd, 3rd)	211	262	473

Key Accomplishments

- MRB recoveries during the reporting period totaled \$62,682,565.
- MRB issued 438 Demand Letters during the reporting period totaling \$49,393,708.

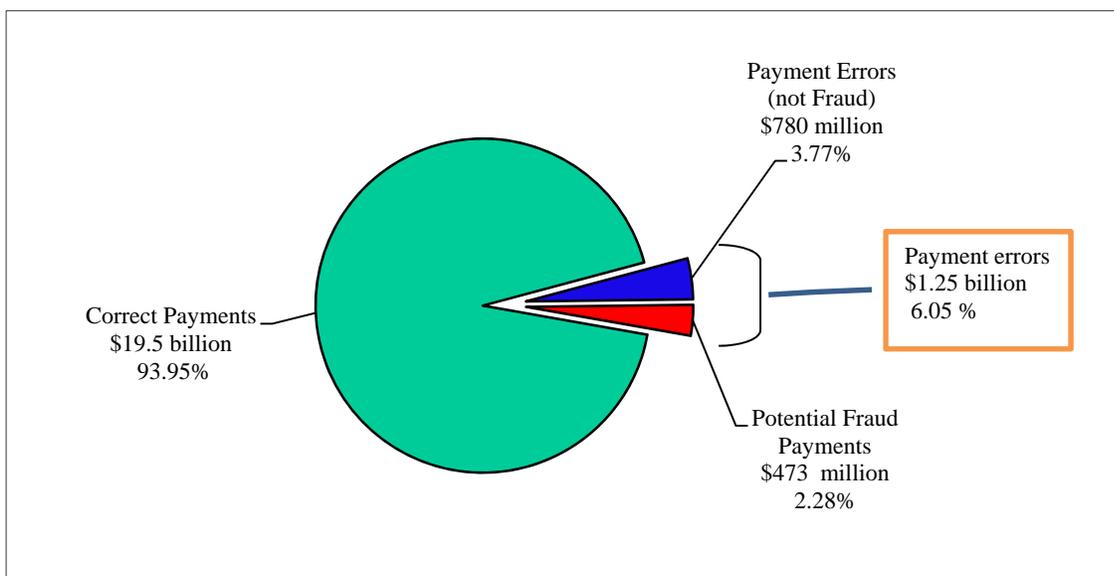
Medi-Cal Payment Error Study (MPES)

DHCS places significant priority on combatting fraud, waste and abuse in the Medi-Cal program. The MPES is a systematic study of the program's accuracy in paying claims submitted by providers. The MPES assists DHCS in determining where the Medi-Cal program is at greatest risk in payment errors. The study also provides an estimate of potential dollar loss to the program, including potential loss due to fraud, waste, and abuse.

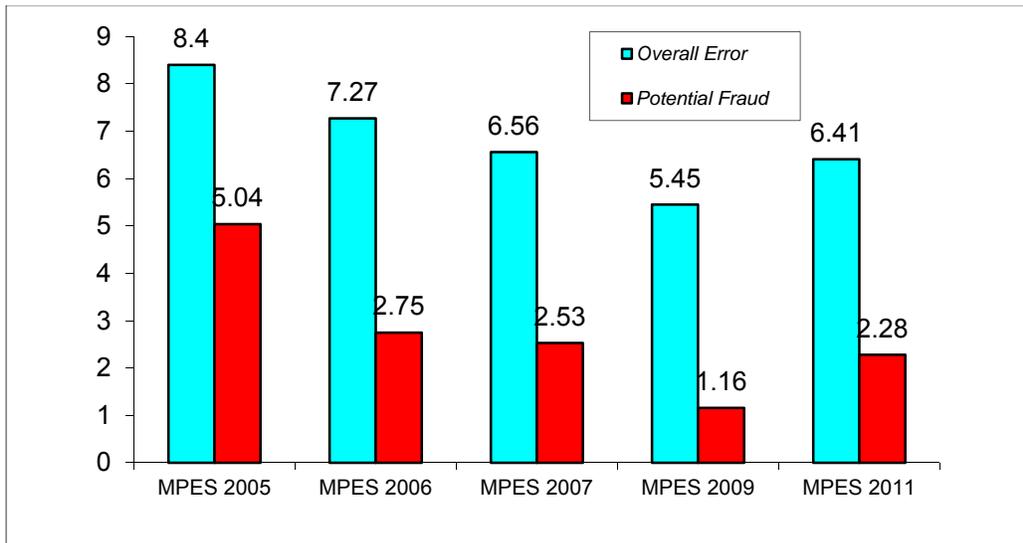
The MPES 2011 findings show that the overwhelming majority of payments, 93.95 percent of total payments made in FFS medical and dental programs, were billed and paid appropriately. In contrast, an estimated 6.05 percent of those payments had some indication that they contained a provider payment error. The 6.05 percent payment error shows a slight increase over the 5.45 percentage rate of the 2009 study.

The 1,168 claims sampled for MPES 2011 represent the eight major provider types and were distributed as follows: 421 Physician Services, 383 Pharmacy claims, 91 Other Services claims, 73 Lab claims, 50 ADHC claims, 50 Dental claims, 50 DME claims, and 50 Inpatient Services claims. These sampled claims were paid during the period of April 1, 2011 through June 30, 2011.

The chart below illustrates the 2011 MPES findings:



The chart below illustrates the continuous improvement in error rates since the first MPES was initiated in 2005.



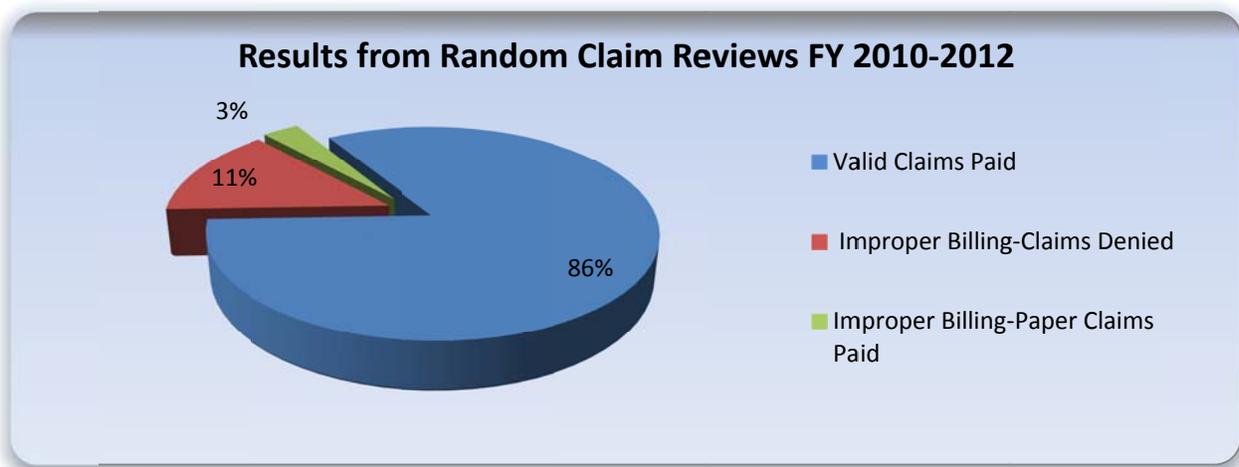
Random Claims Review

A key element in an effective anti-fraud control strategy is the awareness by providers that every claim submitted for payment has some risk of review prior to payment. DHCS randomly selects approximately 15 claims per week for review prior to payment. The random claim review is a real time look into services and trends in Medi-Cal billing. A&I, in cooperation with the fiscal intermediary, developed a systematic process for randomly selecting the claims. When a claim is selected, providers are required to submit documentation to support the claim prior to payment approval. Any claim that is not supported is denied. A&I continues to improve the process by focusing on claims with the highest potential of error. In addition to preventing improper claims from being paid, the reviewed results are also used to further enhance the case detection and development process. The billing patterns of the selected providers are tracked over time to determine if there is any deterrence factor associated with random claims review. The providers who have had negative outcomes through random claim review are evaluated and a full scope field review may be conducted.

July 1, 2010 – June 30, 2012

- A total of 1,440 claims representing 1,079 unique provider numbers have been reviewed.
- A total of 1,234 claims or 86 percent were determined to be valid.
- A total of 206 claims or 14 percent were determined to be improper.
- Of the 206 claims, 160 claims or 72 percent have been denied for payment and the remaining 28 percent were paid due to being paper claims.

In order to maintain compliance with section 5001(f) (2) of the American Recovery and Reinvestment Act, paper claims are paid prior to review and are not subject to the one-week review hold; therefore DHCS loses the ability to deny these claims. After paper claims are paid they are still reviewed for potential improper billing and fraud despite our inability to initially deny them. If DHCS determines the claim was improperly paid or fraudulent, the providers will be notified of the overpayment and given the opportunity to substantiate the claim in question. If proper documentation cannot be provided, DHCS would issue a demand letter and attempt to recover the overpayment. Paper claims constitute approximately 10 percent of the claims received in our sample each week.



The reasons the claims were deemed improper for payment include:

Reasons Claims Deemed Improper for Payment:	Claims	Percent
Lack of response from the Provider	87	42%
Insufficient documentation to support claim	43	21%
Documentation does not support claim level/quantity billed	41	20%
Claims billed in error	4	2%
Beneficiary did not receive the service	4	2%
Service provided was different from service billed	8	4%
Less serious miscellaneous improper claims	19	9%

DHCS currently has 20 different reasons for why a claim cannot be verified. Of those DHCS merged a few into the categories above. These categories represented are usually the more serious, material or significant reasons claims are deemed improper for payment. The rest of the reasons are less serious and have a very small representation. A&I completes an analysis of all random claim reviews that result in a negative outcome. This resulted in 44 providers with significant errors being referred for further review.

Expansion and Strengthening of the Pre-Check Write (Field Audit Review)

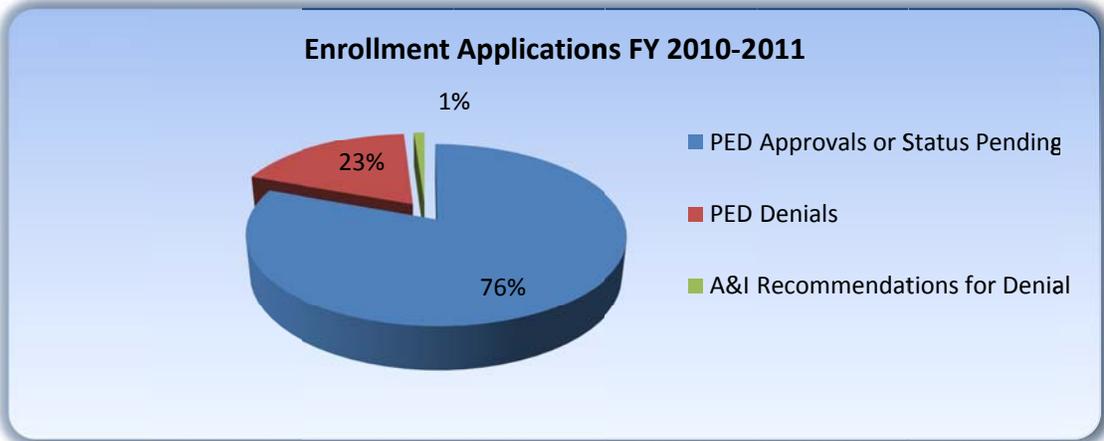
A&I is using auditing and investigative procedures to monitor the practices and billing activity of providers. Working with the fiscal intermediary, A&I is monitoring abnormal changes in payments made to providers, such as large payment increases from previous weeks. This monitoring assists in detecting fraudulent schemes, and suspicious providers. By information gained through the billing activity, A&I staff conduct on-site Field Audit Reviews (FAR) or an Audit for Recovery (AFR) of the identified suspicious providers. As a result of the FAR/AFR, MRB can place an administrative sanction, or contact the State Controller to stop the payment on a check.

Strengthening the Enrollment/Pre-Enrollment Process

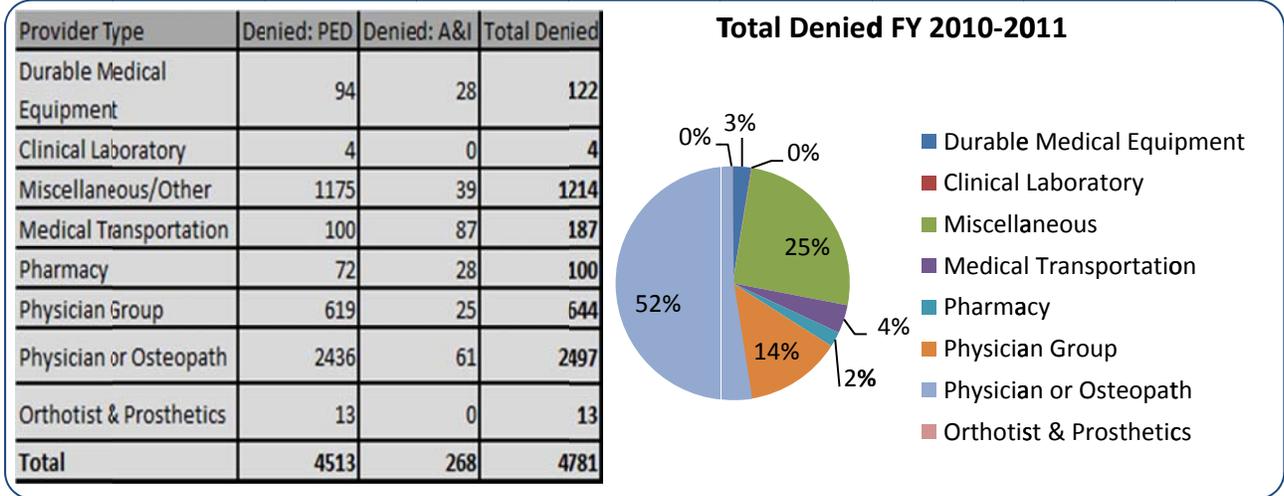
A major component in the Medi-Cal anti-fraud program is the capability to prevent fraudulent providers from enrolling or continuing enrollment in the Medi-Cal program. The enrollment process assists in preventing fraudulent providers from enrolling in Medi-Cal as well as remaining a part of the program. All applications for enrollment undergo a thorough review by PED. A number of confidential risk factors are used to evaluate the information provided on the applications. If information on an application is determined by PED to be invalid, an application can be denied. If an application lacks adequate justification for denial, but is graded as high-risk for fraud, it is referred to A&I. A&I performs a more detailed investigation including an on-site review, and then makes a recommendation to PED to approve or deny enrollment.

The data below reflect the results of the enrollment process for FY 2010-2011.

- PED received and processed a total of 19,961 Medi-Cal provider enrollment applications. The application types range from New Enrollment Applications, Address Change Applications to Change of Ownership Applications.
- PED denied 4,513 (23%) applications.
- PED determined 933 (5%) applications warranted further analysis and referred the applications to A&I.
- A&I recommended 268 (1%) applications be denied and the remaining 665 applications be approved.



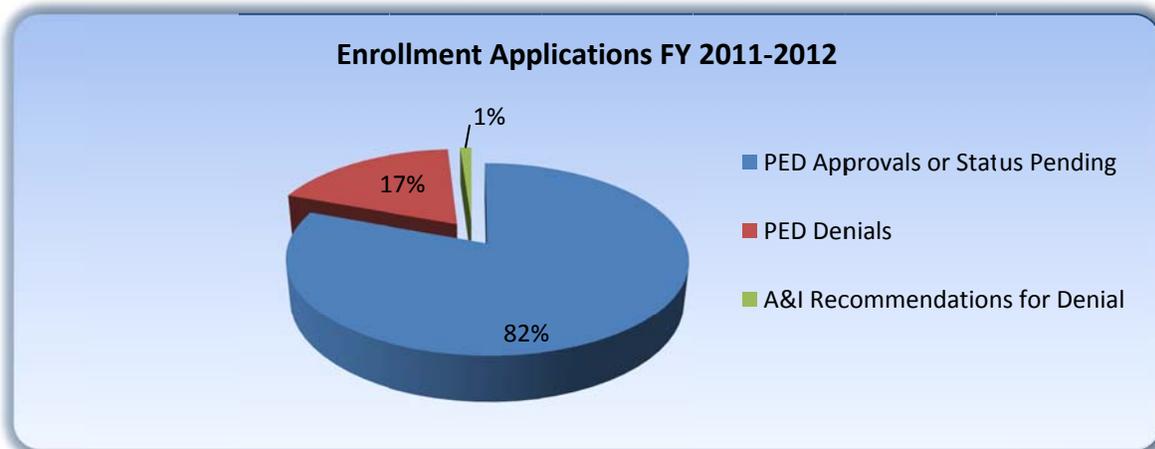
A total of 4,781 (24%) applications were denied through the combined reviews of PED and A&I. The majority of the applications denied were from physicians, with lower denials for DME, medical transportation, and pharmacy providers for two reasons: (1) the majority of the applications submitted are from physicians, and (2) there are moratoria in place on DME applications in Los Angeles, Orange, Riverside and San Bernardino Counties and for non-chain pharmacies in Los Angeles County, thus the submission rate for these providers is lower. The denials were due to a variety of reasons ranging from failure to correct application deficiencies to improprieties found during an on-site review by A&I. Improprieties range from not meeting Medi-Cal established place of business requirements to ownership structure not being disclosed thoroughly or accurately.



The data below reflects the results of the enrollment process for FY 2011-2012.

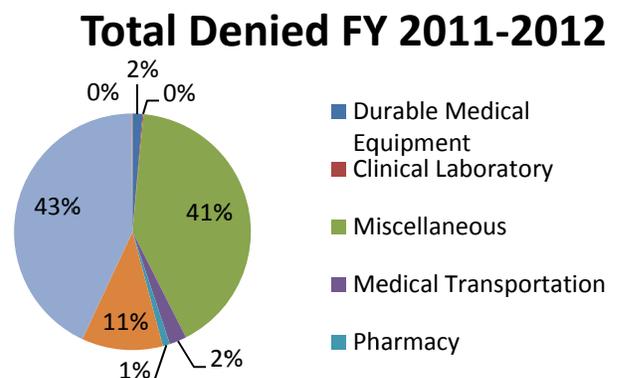
- PED received a total of 18,351 Medi-Cal provider enrollment applications.
- The application types range from new Enrollment Applications, Address Change applications to Change of Ownership Applications.

- PED denied 3,115 (17%) applications.
- PED determined 611 (3%) of the applications warranted further analysis and referred the applications to A&I.
- A&I recommended 165 applications be denied and the remaining 446 applications be approved.



A total of 3,280 (18%) applicants were denied through the combined reviews of PED and A&I. The majority of the applications denied were from physicians, with lower denials for DME, medical transportation, and pharmacy providers for two reasons: (1) the majority of the applications submitted are from physicians, and (2) there are moratoria in place on DME applications in Los Angeles, Orange, Riverside and San Bernardino Counties and for non-chain pharmacies in Los Angeles County, thus the submission rate for these providers is lower. The denials were due to a variety of reasons ranging from failure to correct application deficiencies to improprieties found during an on-site review, conducted by A&I. Improprieties range from not meeting Medi-Cal established place of business requirements to ownership structure not being disclosed thoroughly or accurately.

Provider Type	Denied: PED	Denied: A&I	Total Denied
Durable Medical Equipment	23	22	45
Clinical Laboratory	4	0	4
Miscellaneous	1313	33	1346
Medical Transportation	43	34	77
Pharmacy	21	11	32
Physician Group	331	33	364
Physician or Osteopath	1375	32	1407
Orthotist & Prosthetics	5	0	5
Total	3115	165	3280



Re-Enrollment Status – Fiscal Years 2010-2011 and 2011-2012

There was a significant decline in the amount of providers selected to undergo the re-enrollment process for FY 2010-2011 and FY 2011-2012. The decline is based on the fact that PED has been unable to accept or participate in any new re-enrollment phases due to the high inventory of pre-enrollment applications. The high inventory of pre-enrollment applications was due to the following reasons:

- An increase in vacancies of application processing analyst positions.
- Continued hiring freeze.
- Enactment of AB 1226 (Hayashi, Chapter 693, Statutes of 2007), which reduced the amount of time required to process a physician application from 180 days to 90 days.
- The impact of 18 months of state furlough days.

In order for PED to continue to meet the timeliness standards set forth in law, staff from the Re-Enrollment Unit has been redirected to the processing of pre-enrollment applications.

However, new program integrity requirements were established by CMS under the Patient Protection and Affordable Care Act and one of those requirements (42 CFR 455.414) is that state Medicaid programs must revalidate enrollment of providers at least every 5 years. This includes a requirement that all currently enrolled providers be revalidated by March 2016. The revalidation requirement is similar to our current reenrollment process. PED is developing an online automated application and once the system is operational we will start the process of revalidating providers to meet the new federal requirement.

Payment Error Rate Measurement Study (PERM)

California has completed the FY 2010 PERM review and was assessed an error rate of 1.6 percent. As indicated by the chart below, the California error rate was the second lowest of the seventeen states reviewed. The Centers for Medicare and Medicaid Services developed the PERM study to comply with the Improper Payments Information Act of 2002. The PERM consists of a review of Medicaid (Medi-Cal) FFS claims, managed care payments and eligibility to ensure that claims were paid correctly. All fifty states are reviewed on a three-year rotational basis with seventeen states reviewed yearly. California is a year two state and completed first PERM review in FY 2007 with an error rate of 6.11 percent.

	Fee-for-Service		Eligibility	Combined Rate
National	3.6%	0.5%	4.0%	6.7%
Alabama	1.5%	2.1%	0.8%	2.4%
California	1.7%	0.5%	0.2%	1.6%
Colorado	6.8%	0.0%	1.0%	6.9%
Georgia	4.1%	1.3%	1.5%	4.7%
Kentucky	2.3%	0.4%	0.0%	2.0%
Massachusetts	17.7%	1.0%	0.0%	13.4%
Maryland	1.8%	0.1%	2.0%	3.2%
North Carolina	3.4%	0.0%	8.9%	11.9%
Nebraska	2.2%	0.3%	0.0%	2.1%
New Hampshire	1.5%	n/a	0.0%	1.5%
New Jersey	2.0%	0.0%	1.0%	2.6%
Rhode Island	6.1%	0.4%	11.8%	15.6%
South Carolina	2.6%	0.0%	17.2%	18.8%
Tennessee	1.7%	0.0%	2.8%	3.6%
Utah	4.5%	0.0%	4.5%	8.2%
Vermont	6.8%	0.9%	1.4%	8.0%
West Virginia	4.2%	0.05	30.1%	32.7%

Individual Provider-Claims Analysis Report (IP-CAR)

The IP-CAR project was established with four goals:

- Encourage providers to become more conscientious about billing.
- Give providers peer billing information for self-comparison.
- Encourage providers to bill accurate diagnosis codes.
- Educate providers on the technique of performing a self-audit.

IP-CAR 2010

The first IP-CAR, issued in 2010, supplied primary care providers with information about their billing patterns to compare with that of similar providers. Those who billed a higher percentage of the most expensive office visits were selected to receive reports. The data from the subsequent year revealed a significant drop in the cost per beneficiary for office visits in 2011 compared to the same period of time in 2010. A comparison of the providers who received the IP-CAR with the general provider community revealed divergent trends. Those who did *not* receive the report *increased* their percentage of claims for more expensive office visits; while those who *did* receive a report *decreased* their percentage by a small amount. However, the difference was enough to reduce the overall cost per claim for office visits for the entire population of

providers reviewed. The IP-CAR appears to have changed provider behavior and saved the state an estimated \$2.4 million dollars. In addition, DHCS implemented field audits, utilization controls, sanctions, suspensions, and audits for recovery for a few of the providers identified by this first project.

IP-CAR 2012

The first IP-CAR report for 2012 (IP-CAR-Rx) was sent in June 2012, and focused on pediatric drug prescriptions. Calculations of the number of prescriptions per beneficiary overall, as well as for specific categories, determined who received reports. Providers whose prescriptions were substantially higher than the norm received reports describing their prescribing pattern. Some physicians reported that their national provider identifier numbers had been used erroneously by pharmacists. They were advised to notify the pharmacists to correct the errors. Some providers reported that it was appropriate for their prescribing to rise above the norm due to sub-specialty practices. Others called to discuss their reports and volunteered to be more careful about their prescribing in the future.

Recovery Audit Contractor (RAC)

Section 6411(a) of the Patient Protection and Affordable Care Act requires states to contract and establish a Recovery Audit Contractor (RAC) program to enable the auditing of claims for services made by providers. DHCS has selected Health Management Systems as the RAC for California. The RAC program will act to identify and correct improper payments through the efficient detection and collection of overpayments made to providers. The RAC will receive 12.5 percent of any overpayments and 10 percent of underpayments identified during the audits.

Specific objectives:

- The RAC will identify overpayments and underpayments, and work to recoup overpayments;
- Create processes for entities to appeal adverse determinations made by RACs;
- Coordinate recovery efforts with other governmental entities performing audits, including federal and state law enforcement agencies such as the Federal Bureau of Investigation, Health and Human Services, and the state Medicaid Fraud Control Unit.

Ongoing Activities

- Electronic Health Record Incentive Program – Eligible professionals and groups are registering to the program and the release of incentive funds have started. Prepayment reviews are being conducted by the Office of Health Information Technology; however audit referrals have not been initiated at this time. The audit program is still in the development phase.

- Hospice Share of Cost Self-Audits – MRB identified hospice providers to perform self-audits regarding share of cost. As of June 30, 2012, 132 share of cost regarding self-audits have been completed with overpayments totaling \$7,495,039 with recoveries to date at \$4,714,514.
- Laboratory Reviews –MRB has identified \$7.1 million in overpayments from lab reviews. Sanctions (Temporary Suspension or Payment Withholds) were issued to 17 laboratories and 28 of their affiliates. Quest Diagnostics settled with the DHCS for \$241 million as a result of a civil case prosecuted by the Medi-Cal Fraud Control Unit. The settlement was the largest in the history of California's False Claims Act. The Temporary Suspension or Payment Withholds that were initially placed have been either lifted or stayed, while many of the laboratories continue in settlement talks with the DHCS.