CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

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THIS LETTER SENT VIA EMAIL

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CALIFORNIA'S RESPONSE TO CMS' REQUEST FOR PROGRAM INTEGRITY ACTION PLAN

Dear Mr. Brillman and Ms. Brandt,

Thank you for your January 27, 2026, letter[1] outlining the Centers for Medicare & Medicaid Services' (CMS) request for detailed information regarding Medi-Cal program integrity. California values our partnership with CMS in ensuring Medicaid programs operate with accountability, transparency, in compliance with federal requirements, and consistent with federal approvals. We share a strong commitment to protecting taxpayer resources and maintaining public confidence in Medi-Cal.

The California Department of Health Care Services (DHCS), in partnership with the federal government, other state agencies, counties, and program partners, administers Medi-Cal, providing vital health services, including physical health, mental health,

[1] DHCS, *CMS Letter,* https://www.dhcs.ca.gov/Program-Integrity/Documents/CA-Medicaid-Letter-Final.pdf, January 2026.

substance use disorder treatment, pharmacy, dental, and long-term care, to more than 14 million Californians. DHCS oversees more than $200 billion annually in combined state and federal funds.

DHCS prioritizes the integrity of the Medi-Cal program through strong protocols to prevent and vigorously combat fraud, waste, and abuse (FWA). To protect Medi-Cal, DHCS uses strong oversight, audits, fraud detection, investigations, payment suspensions, cost recovery, provider terminations, and partnerships with law enforcement to support civil and criminal prosecution of bad actors, holding those who violate program rules fully accountable. Most providers and members follow the rules, but preventing FWA and ensuring that Medi-Cal is the payer of last resort is critical so every dollar goes where it should.

DHCS combines advanced data analytics, proactive monitoring, and coordinated enforcement strategies with strong partnerships across managed care plans (MCP), counties, and state and federal law enforcement. These efforts reflect our commitment to accountability, transparency, prudent stewardship of taxpayers' dollars, and safeguarding access to health services for millions of Californians. California also advances program integrity by prioritizing cost-effective care models, such as home- and community-based services (HCBS), that reduce reliance on costly institutional placements while improving outcomes for Medi-Cal members.

DHCS employs a multi-pronged approach to program integrity, including:

- **Provider enrollment:** Comprehensive screening and monitoring of Medi-Cal providers, including license verification, ownership and control disclosures, site visits and criminal background checks for high-risk providers, monthly monitoring, enrollment freezes, and revalidation to prevent bad actors from taking advantage of the program.

- **Audits and investigations:** Multi-disciplinary teams of auditors, sworn investigators, data scientists, and clinicians in field offices throughout the state conduct compliance audits and fraud investigations to detect and address improper payments and fraudulent activity. DHCS' Audits & Investigations (A&I) program serves as the designated Medicaid Program Integrity Unit (PIU).

- **Third-party liability and recovery:** DHCS ensures Medi-Cal is the payer of last resort by recovering costs from liable third parties, identifying and recovering

from other health coverage, avoiding unnecessary expenditures, and recouping overpayments through settlements and claims offsets.

- **Eligibility and enrollment:** Rigorous oversight of county eligibility determinations, including system validations, periodic residency checks, and targeted reviews of case files to ensure only eligible individuals receive benefits.

In partnership with CMS, other state agencies, counties, MCPs, and providers, DHCS will continue to strengthen oversight, enhance fraud prevention strategies, and uphold the highest standards of accountability and transparency. Together, we can preserve public trust, safeguard taxpayer resources, and ensure Medi-Cal remains a reliable source of health care for millions of Californians.

IN-HOME SUPPORTIVE SERVICES AND HOME AND COMMUNITY-BASED SERVICES

DHCS understands that CMS is raising concerns about the expenditure growth in In-Home Supportive Services (IHSS); however, this growth is not indicative of program integrity risk. Instead, it is the predictable and intended result of decades-long federal and state rebalancing policy, which CMS designed, approved, and promoted. Growth in IHSS is not evidence of weak oversight; it is evidence that California has successfully implemented the federal mandate to shift Long-Term Services and Supports (LTSS) away from institutional care and toward HCBS. See CMS *Olmstead* Update #4 (State Medicaid Director Letter (SMDL) #01-006) (See Attachment No. 0.02), published on January 10, 2001, indicating the letter was issued to "provide guidance and support to States in their efforts to enable individuals with disabilities to live in the most integrated setting appropriate to their needs, consistent with the Americans with Disabilities Act (ADA)." Similarly, in SMDL #19-001 (See Attachment 0.03), published on March 22, 2019, reaffirmed that "Promoting community integration for older adults and people with disabilities remains a high priority for CMS." CMS' own website[2] recognizes the fiscal efficiency of HCBS, listing a benefit as "Cost effectiveness: usually less than half the cost of residential care." The principle that HCBS is substantially less costly to taxpayers than institutional care underpins California's approach.

[2] CMS, *HCBS,* https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services, July 2025.

IHSS Growth Reflects California's Deliberate Compliance with Federal Rebalancing Policy

CMS highlights the increase in IHSS expenditures from $8.2 billion in state fiscal year (SFY) 2015-16 to an estimated $28.5 billion in SFY 2025-26 as a cause for concern, suggesting this figure signals excess or abuse. In reality, it reflects the expansion of access to services that CMS itself has encouraged states to pursue for decades. See SMDL #01-006 and SMDL #19-001 (recognizing the importance of providing community-integrated services to individuals with disabilities). President Trump's administration emphasized this priority again in 2020 in its "Toolkit to Accelerate State Efforts to Rebalance Long-term Care Systems and Enhance Home and Community-Based Services for Eligible Medicaid Beneficiaries" published on November 2, 2020.[3] The Trump Administration recognized that "many elderly individuals and their families should have access to a more robust set of home and community-based care options. That's exactly the opportunity President Trump is delivering with this toolkit." The Toolkit also recognized that "rebalancing LTSS from institutional care toward HCBS reflects beneficiary preferences to receive LTSS in home and community-based settings" and that by 2013 a majority of LTSS expenditures were directed toward HCBS, rather than institutionalized care.

As a fundamental HCBS benefit, IHSS provides personal care and related services to nearly 800,000 aged, blind, and disabled Medi-Cal beneficiaries in their own homes.[4] These services allow individuals to avoid unnecessary institutionalization, directly advancing the requirements of the Supreme Court's decision in *Olmstead v. L.C*. and the federal government's longstanding commitment to community-based care. Aging in one's own home and community is not only the preference of the overwhelming majority of older adults and people with disabilities—it's also the law. And it is substantially less costly to taxpayers than providing care in institutional or congregate settings. Just as preventive care through primary care physicians is more cost-effective than emergency care, home-based care delivers better outcomes at a lower cost.

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[3] CMS, *CMS Releases Toolkit to Accelerate State Efforts to Rebalance Long-term Care Systems and Enhance Home and Community-Based Services for Eligible Medicaid Beneficiaries,* https://www.cms.gov/newsroom/press-releases/cms-releases-toolkit-accelerate-state-efforts-rebalance-long-term-care-systems-and-enhance-home-and, November 2020.

[4] DHCS, *Medi-Cal Long-Term Services and Supports Dashboard*, https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx, 2023.

The growth is the direct and foreseeable result of expanding eligibility, increasing utilization consistent with demographic change, and substituting home-based care for institutional placement—outcomes that CMS has repeatedly endorsed and promoted through federal approvals of California's IHSS and HCBS programs[5], because they deliver care at a fraction of institutional costs.

Moreover, a focus on gross IHSS spending obscures the far more relevant fiscal comparison: the cost of institutional care versus home-and community-based alternatives. In California, the average annual cost of a long-term stay in a skilled nursing facility (SNF) for an individual is approximately $137,000[6], compared with roughly $30,000[7] per year to serve an individual through IHSS. Each successful

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[5] The approval letters for the most current State Plan and Waiver Amendments are linked below:

- IHSS, *CA State Plan Amendments (SPA) 23-005 § 1915(k) Community First Choice and § 1915(j) Self-Direction HCS SPA* , https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-23-0005-Approval.pdf, May 2024
- DHCS, *HCBS for Individuals with Developmental Disabilities, CA SPA 24-0028 § 1915(i) HCBS SPA,* https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0028-Approval.pdf, December 2024
- DHCS*, Home and Community Based Alternatives Waiver, CA § 1915(c) Waiver CA-0139.R.06.07,* https://www.dhcs.ca.gov/services/ltc/Documents/CA-0139R0607-Approval-Letter-2025.pdf, December 2025
- DHCS, *Assisted Living Waiver, CA § 1915(c) Waiver CA-0431.R04.02*, https://www.dhcs.ca.gov/services/ltc/Documents/CA0431-R04-02-Approval-Letter-11-12-2024.pdf, November 2024
- DHCS, *Medi-Cal Waiver Program, CA § 1915(c) Waiver CA-0183.R06.02*, https://www.dhcs.ca.gov/services/ltc/Documents/CA-0183-R06-02-Approval-Letter-11012023.pdf, November 2023
- DHCS, *Multipurpose Senior Services Program, CA § 1915(c) Waiver CA-0141.R07.00*, https://www.dhcs.ca.gov/services/medi-cal/Documents/CA0141R0700-Approval-Letter.pdf, September 2024
- DHCS, *HCBS-DD Waiver, CA § 1915(c) Waiver CA-0336.R05.10*, https://www.dhcs.ca.gov/services/ltc/Documents/CA0336R05-10-Approval-Letter-Dec2024.pdf, December 2024
- DHCS, *Self-Determination Waiver, CA § 1915(c) Waiver CA-1166.R01.00*, https://www.dds.ca.gov/wp-content/uploads/2021/12/SDP_Renewal_Approval_Letter_and_Application_2021.pdf, December 2021

[6] California Health Care Foundation, *Policy at a Glance*, https://www.chcf.org/wp-content/uploads/2025/04/MediCalSeniors_PolicyAtAGlance.pdf, April 2025.

[7] California Legislative Analyst's Office (LAO), *The 2025-2026 Budget for IHSS*, https://lao.ca.gov/Publications/Report/5009#:~:text=Cost%20Per%20Hour%20Continues%20to,hour%20in%20January%201%2C%202025, March 2025.

diversion from institutional care to IHSS avoids approximately $107,000 annually in Medicaid spending—savings shared by California and the federal government alike. This cost differential underscores why IHSS growth represents fiscal prudence, not excess. Viewed through a Medicaid stewardship lens, investment in IHSS is not only consistent with longstanding federal policy—it is fiscally responsible. Higher-cost institutional care is inconsistent with federal HCBS policy, shared federal and state cost-containment goals, and beneficiary preference.

IHSS Has Operated with Continuous Federal Approval and Oversight for 30 Years

IHSS has been part of California's federally approved Medicaid State Plan since 1994, operating statewide under clearly defined eligibility and service parameters. Its evolution has occurred transparently and with ongoing CMS oversight, ensuring these cost-effective strategies remain aligned with federal policy.

Following *Olmstead*, California submitted and implemented a CMS-required plan to strengthen access to HCBS, further positioning IHSS as a primary alternative to institutional care. See Cal. Stats. 2002, ch. 1161 section 96 (enacting former Cal. Health & Safety Code section 101315, superseded 2006), requiring the state's Health and Human Services agency to submit an "Olmstead Plan" in conformity with CMS' six principles. See also California Olmstead Plan (See Attachment No. 0.01). Over time, the State has participated in multiple federally supported initiatives—including Money Follows the Person, expanded 1915(c) waivers, and managed care integration—each aimed at accelerating rebalancing away from institutional care toward home and community-based care.

IHSS spending growth is the intended result of federally encouraged, cost-saving policy choices that reduce institutionalization, improve outcomes, and conserve taxpayer dollars.

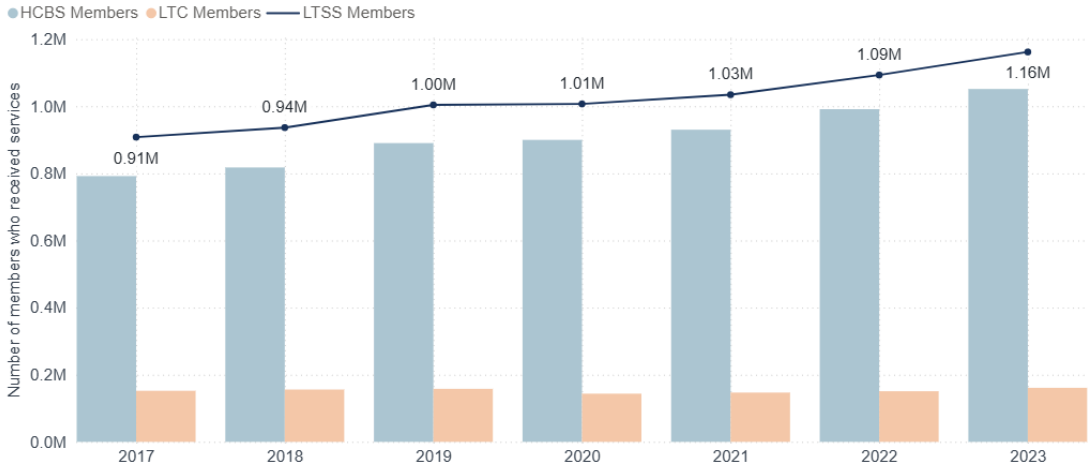
California's Rebalancing Outcomes

IHSS now accounts for roughly 72 percent[8] of LTSS utilization in California, not because of unchecked growth, but because CMS-approved policy frameworks have consistently elevated home-based care as the preferred delivery model. California now spends *just 3 percent* of its Fee-For-Service (FFS) Medicaid long-term care dollars on

[8] DHCS, *Medi-Cal Long-Term Services and Supports Dashboard,* *https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx,* 2023.

skilled nursing facilities, placing it among the top states nationally in rebalancing performance on this measure.[9] Only 13 percent[10] of long-term care users in California were in institutional settings in 2023, well below the national median of 20 percent.[11] These figures represent a reduction in unnecessary institutional utilization, precisely the outcome CMS has historically sought to achieve.

As noted in the table below, while the number of individuals receiving HCBS has increased since 2017, the number of individuals receiving Long Term Care (LTC) services, including SNF services, has remained relatively flat.



California has also assiduously reviewed and documented the drivers of recent IHSS spending growth. Caseload increases reflect California's Medicaid expansion and its aging population. Higher approved service hours correspond to increased acuity and functional need. Rising expenditures also reflect legislatively mandated minimum wage increases, which have helped to recruit and maintain the workforce necessary to meet CMS's and California's longstanding goals of transitioning toward home and community-

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[9] Kaiser Family Foundation, *Distribution of FFS Medicaid Spending on Long Term Care,* https://www.kff.org/medicaid/state-indicator/spending-on-long-term-care/?dataView=1&currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D,%22states%22:%7B%22all%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Nursing%20Facilities%22,%22sort%22:%22asc%22%7D, 2024.

[10] DHCS, *Medi-Cal Long-Term Services and Supports Dashboard*, https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx, 2023.

[11] CMS, *Long Term Services and Supports Users and Expenditures,* https://www.medicaid.gov/medicaid/long-term-services-supports/reports-evaluations, 2023.

based care. The California State Auditor (CSA) has reviewed IHSS and has not identified systemic concerns with expenditure growth. On the contrary, the CSA has recommended expanding enrollment and strengthening the workforce, explicitly recognizing that IHSS avoids significantly more costly institutional care.[12] This program saves taxpayer dollars – and it gives program recipients independence and allows older Californians and Californians with disabilities to stay connected to their communities. California's Master Plan for Aging has set bold goals to support older adults to age in place and in their communities, and this includes HCBS supports, like IHSS.

California takes its responsibility to safeguard Medicaid dollars seriously and remains committed to rigorous program integrity oversight of IHSS. IHSS growth is not inherently problematic since the growth aligns with the positive impact of the program's purpose, federal policy and California's collaborative role in implementing that policy, and caseload, wage, and service intensity increases. Documented fiscal evidence and observable outcomes further support the program's integrity and effectiveness. IHSS spending growth is not a warning sign. It is the measurable result of intentional, federally encouraged policy choices that have reduced institutionalization, improved beneficiary outcomes, and conserved Medicaid resources for both the state and the federal government. Additionally, fraud exposure in the IHSS program is minimized through rigorous eligibility validation processes, including health care certifications and annual assessments, and through robust oversight of provider claims. Administrative safeguards, including electronic timesheets signed by IHSS recipients under penalty of perjury, ensure services are delivered before payment. These measures, combined with continuous monitoring and enforcement, reflect California's commitment to program integrity and fiscal stewardship.

CALIFORNIA'S COMPREHENSIVE PROGRAM INTEGRITY ACTION PLAN – A NATIONALLY-RECOGNIZED PROGRAM INTEGRITY FRAMEWORK

California safeguards taxpayer dollars and operates transparently. DHCS is fully committed to meeting this obligation through a comprehensive program integrity framework. DHCS works closely with MCPs, counties, and external partners, including the State's Medicaid Fraud Control Unit (MFCU) and CMS, to prevent, detect, and combat FWA across all delivery systems. DHCS' program integrity framework is built on

[12] CSA, *IHSS* Program, https://information.auditor.ca.gov/reports/2020-109/summary.html, 2021.

the following pillars:

- **Assess risks**: Advanced data analytics and trend analysis are regularly performed to assess program risks and identify fraud schemes. Predictive modeling and link analysis help uncover fraud networks and root causes of FWA across Medi-Cal, including care delivered through MCPs, and care delivered through the FFS delivery system, such as IHSS.

- **Define expectations**: Clear compliance and performance expectations guide program integrity efforts. These expectations go well beyond hard and soft dollar recoveries to include fraud prevention, deterrence, improved provider behavior, program compliance, and minimizing patient harm. DHCS' PIU uses a defined return on investment (ROI) methodology to measure outcomes and ensure accountability. Resource allocation is driven by ongoing risk assessments, and roles and responsibilities within A&I are well-defined to support a holistic approach to program integrity.

- **Prevention**: DHCS' PIU coordinates with DHCS' provider enrollment division to prevent fraud through a comprehensive, analytics-based approach to screening and eliminating problem providers. Activities include enhanced pre-screening, provider education, and early investigation of suspect providers to minimize damage. On-site reviews and administrative and criminal background checks, including fingerprinting, are conducted for designated high-risk providers and additional providers as indicated. These efforts demonstrate DHCS' commitment to early fraud detection and prevention, including actions beyond pre-payment activities to identify and dismantle fraud networks before they proliferate.

- **Effective A&I**: California is one of only two states where the Medicaid agency employs armed, sworn peace officers with the legal authority to execute search warrants. Multidisciplinary teams, including auditors, sworn investigators, clinicians, and data scientists, conduct coordinated "top to bottom" reviews of providers warranting audit or investigation. Strong partnerships with internal units and external entities such as the MFCU, local district attorneys, and routine deconfliction and collaboration with federal law enforcement and criminal investigative bodies such as the United States (U.S.) Department of Justice (DOJ), Federal Bureau of Investigation (FBI), and the U.S. Department of Health and Human Services Office of the Inspector General (OIG) are critical to success. Providing high-quality credible allegation of fraud (CAF) referrals to the MFCU to support civil and criminal prosecution is a key deliverable of this work.

- With respect to managed care and IHSS program integrity, DHCS' PIU works collaboratively with managed care Special Investigation Units (SIU) and the California Department of Social Services (CDSS), respectively, to address FWA. DHCS' PIU meets regularly with MCP SIUs to discuss open and ongoing investigations, data sharing opportunities, cross-training opportunities, investigation best practices and emerging fraud trends. DHCS' PIU also serves as the designated investigative entity responsible for IHSS fraud investigations pursuant to Cal. Welf. & Inst Code § 12305.82 and as noted in CDSS' IHSS Uniform Statewide Protocols published in 2013.[13]

- **Strong enforcement**: A three-pronged approach—administrative, civil and criminal—is used to take actions against violators and fraudsters. Sanctions and utilization controls are critical to stemming losses and changing bad provider behavior. Strong collaboration with the MFCU, the California DOJ, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), based on CMS' best practices, strengthens enforcement efforts and supports accountability for all parties involved.

- **Knowledge transfer and preservation**: DHCS dedicates resources to document and preserve anti-fraud techniques and strategies for future program integrity personnel, ensuring the long-term success and viability of DHCS' PIU and Medi-Cal program integrity.

- **Continuous improvement**: DHCS continually enhances its efficiency and effectiveness in combating FWA through staff training, adoption of emerging technologies, and continuous infrastructure improvements that support program integrity efforts.

- **Longstanding collaboration with CMS and national partners**: DHCS prides itself on being recognized by CMS as a program integrity leader that has consistently implemented program integrity best practices. Historically, DHCS has been an active leader in CMS' Center for Program Integrity (CPI) and

[13] CDSS, *IHSS Uniform Statewide Protocols*, https://www.cdss.ca.gov/agedblinddisabled/res/IHSSUniformStatewideProtocols-ProgramIntegrityActMAR2013(bookmarked).pdf, 2013.

initiatives. For example:

- CMS has consistently invited DHCS staff to serve as faculty at CMS' Medicaid Integrity Institute (MII) symposiums and CMS-convened program integrity training courses. CMS has requested DHCS to present at MII events to showcase DHCS' audit and investigative expertise, advance data analytics, performance metrics and return-on-investment calculation methodology, annual MCP audits, strategic 340B drug discount program audits, and other program integrity work.

- DHCS' PIU leadership has served on various MII working groups to assist CPI with various objectives, such as CPI's annual MII education curriculum development and national performance metric and ROI methodology development.

- The current DHCS A&I Deputy Director served two terms on the executive board of the Health Care Fraud Prevention Partnership (HFPP), a CMS-convened public-private partnership that helps detect and prevent health care fraud through data and information sharing across federal government, state government, law enforcement, private health insurance plans, and health care anti-fraud associations.

- DHCS worked collaboratively with CMS CPI and the HFPP on its "Opioids White Paper" project. DHCS was also invited by the FBI and OIG to participate in the Federal Opioid Initiative. DHCS investigators, clinicians and analysts worked with both FBI and OIG agents on targeted cases. DHCS research scientists worked with federal research scientists to identify targets and areas where opioid abuse was prevalent within the State of California (SOC).

- DHCS has worked side-by-side with CMS CPI contractors to support CPI's long-standing program integrity efforts and initiatives. Examples include support for, and partnership with, the Zone Program Integrity Contractor (ZPIC) that addressed data-matching for dual eligibles, Medicaid Integrity Contractor (MIC) including both the Education and Audit MIC, and the current Universal Program Integrity Contractor (UPIC). Hospice audits and investigations in particular have been jointly conducted by DHCS and the UPIC (audit MIC in years past) in a collaborative manner for over 15 years. This long-standing collaborative relationship

between DHCS and CMS CPI demonstrates our shared objectives and commitment to combat FWA in the Medi-Cal program.

- DHCS' comprehensive investigative strategies to identify fraud networks, involving collusion among multiple provider types to exploit targeted members, have been highlighted and presented at the MII and National Association of Medicaid Program Integrity (NAMPI) conferences.

DHCS welcomes the continued partnership with the federal government and national leadership to combat FWA.

RESPONSE TO CMS' REQUEST

In response to CMS' request, DHCS provides the following information, demonstrating our commitment to program integrity and addressing each of the specified areas: Fraud, Waste, Abuse, and Improper Payments—Program-Level Oversight; Eligibility Determination and Immigration Status Controls; Provider Screening, Enrollment, and Validation; Program Integrity Infrastructure and Accountability; and IHSS.

Fraud, Waste, Abuse, and Improper Payments — Program-Level Oversight

1. Does DHCS establish threshold dollar targets for managed care plan fraud recoveries? If so, on what basis are the thresholds determined, do the dollar thresholds vary by plan size or other characteristics, and what targets has DHCS established for plan recoveries?

DHCS does not limit dollar targets for MCP fraud recoveries. 42 Code of Federal Regulations (C.F.R.) § 438.608(a)(7) requires MCPs to promptly refer any potential FWA to the State Medicaid PIU or any potential fraud directly to the MFCU, and DHCS enforces this requirement, but the federal regulations do not mandate fraud recovery targets. DHCS enforces MCPs' compliance with FWA requirements through contractual obligations outlined in the Medi-Cal Managed Care Boilerplate Contract and All Plan Letters (APLs), which, among other things, require MCPs to:

- Maintain a Program Integrity and Compliance Program, including a Fraud Prevention Program.

- Report suspected FWA cases to DHCS within ten business days of identification.

- Conduct investigations of all suspected FWA activities.
- Submit completed FWA investigation reports to A&I.
- Submit quarterly status reports to DHCS on all FWA investigative activities ten working days after the close of every calendar quarter (MCP Boilerplate Exhibit A, Attachment III, Subsection 1.3.2.D.3) (See Attachment No. 1.01).

This approach aligns with CMS guidance in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Program Integrity Toolkit[14] emphasizing detection, reporting, and corrective action without mention of any threshold dollar targets.

2. Does DHCS receive cases referred to the state by plans, and, if so, how many cases were referred to the state by plans, by year, over the past 5 years? What were the resolutions of those cases?

Yes, DHCS receives cases referred to the state by plans. DHCS receives on average 1,700 complaints/referrals each month from various sources such as the general public, counties, internal data mining/analytics, audits that lead to indicators of potential fraud, and from the MCPs. Every complaint/referral received by DHCS is reviewed and evaluated based on the egregiousness of the suspected fraud, complaint source (e.g., anonymous complaint versus a referral from a trusted government agency), timeframe of suspect fraudulent activity, materiality of fraudulent claims paid, suspected patient harm, complainant credibility and sufficiency of the evidence provided to determine which complaints should be assigned for investigation. Further investigative resources are allocated based on priority criteria, including cases that are deemed to be the most egregious in terms of dollar impact, scope, fraud scheme involved, and patient harm.

In accordance with 42 C.F.R. § 438.608, including but not limited to 42 C.F.R. § 438.608(a)(2), (7), and as set forth in executed MCP contracts, MCPs must refer, investigate, and report all FWA activities that the MCP identifies to A&I. MCPs must file a preliminary report with A&I detailing any suspected FWA identified by or

[14] CMS, *Medicaid and CHIP Managed Care Program Integrity Toolkit*, https://www.medicaid.gov/medicaid/program-integrity/download/managed-care-overpay-rec-toolkit.pdf, January 2025.

reported to the MCP, its subcontractors, its downstream subcontractors, and/or its network providers within ten working days of the MCP's discovery or notice of such FWA. Subsequent to the filing of the preliminary report, the MCP must promptly conduct a complete investigation of all reported or suspected FWA activities. Within ten working days of completing its FWA investigation, the MCP must submit a completed investigation report to DHCS' PIU. DHCS is providing a report identifying all 10,792 MCP referrals it received over the past five calendar years (2021–2025). The report includes the MCP names and resolutions (See Attachment No. 2.01).

3. Does DHCS refer instances of suspected fraud to the state's MFCU, and if so, how many matters were referred to the MFCU by the state, by year, for the past 5 years? How many such referrals did the MFCU accept, and how many did it reject? What were the resolutions of those matters?

Fraud detection and supporting civil and criminal prosecution are top priorities for DHCS. DHCS actively and routinely refers instances of suspected fraud to the MFCU pursuant to 42 C.F.R. § 455.15 and Cal. Welf. & Inst. Code § 14107.11.

DHCS provides the public at large with a variety of ways to report suspected Medi-Cal fraud, including through its website[15] and Medi-Cal Fraud Hotline. DHCS receives fraud complaints from a variety of sources, including, but not limited to, the public, MCPs, and other government agencies. On average, DHCS receives 1,700 complaints every month, all of which are reviewed and evaluated to determine appropriate action. If A&I determines that an investigation is warranted, the case is ranked based on fraud risk, placed in a queue, and assigned out based on priority criteria. All investigations that are pursued are done so thoroughly to substantiate the fraud allegations. If A&I determines that sufficient evidence exists to warrant a fraud referral, a CAF referral is sent to the MFCU for further investigation and prosecution, consistent with federal requirements.

DHCS completes the annual OIG recertification questionnaire that concerns the MFCU as well as the interaction of DHCS and the MFCU. Within the past five years, the questionnaires (See Attachment No. 3.01) submitted to the OIG by DHCS, contained the total number of referrals sent to the MFCU (408), the number the MFCU accepted (305), and the number the MFCU rejected (9). Note that a single

[15] DHCS, *Do You Suspect Medi-Cal Fraud? Report it.,* https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

referral may include multiple suspects and entities. In addition, DHCS reported during the past five questionnaires the total number of referrals that were pending a decision by the MFCU (93) and the number of referrals that were returned to DHCS for further development (1). The 408 referrals and the subtotal of CAFs accepted and rejected by the MFCU reflect a point-in-time perspective of the CAF statistics reported during each questionnaire review period. Due to the timing of each review period, the statuses of a CAF referral may be updated into a different category after a review period has been reported out (i.e. a pending CAF referral may subsequently become accepted or rejected). Note that the age of an investigation has no bearing on how long it stays active. Ultimately, the strength of the evidence gathered to date determines when a case is resolved.

The table below summarizes the resolution status as of December 2025, of the 408 CAF referrals that DHCS submitted to the MFCU over the past five annual review periods. Note, DHCS works collaboratively with the MFCU but does not have control over their prosecutorial decisions. Each row reflects the current resolution category for those referrals.

Resolution	4/1/20-3/31/21	4/1/21-3/31/22	4/1/22-3/31/23	4/1/23-3/31/24	4/1/24-3/31/25
Active	0	2	2	38	157
Charges Filed	0	2	3	4	25
Adjudicated/Restitution	6	0	0	4	3
Closed	48	7	10	22	5
Declined	52	6	2	7	0
Dismissed	1	0	0	0	1
Dismissed/Restitution	1	0	0	0	0
Total	**108**	**17**	**17**	**75**	**191**

Resolution category definitions:

- **Active:** Referral currently under investigation by MFCU.
- **Charges Files**: Criminal charges have been filed by MFCU.
- **Adjudication/Restitution**: Case has been resolved through court proceedings. Includes court-ordered financial obligation on the convicted defendant.

- **Closed:** Case closed without charges or further action.
- **Declined:** MFCU declined to pursue prosecution after further review of the case.
- **Dismissed:** Case dismissed by the court or prosecutor.
- **Dismissed/Restitution**: Case dismissed by the court or prosecutor following the fulfillment of restitution terms.

It is important to highlight the differences between court-ordered restitution tied to criminal prosecutions (cases of which are noted in the above table) versus recoveries achieved via program integrity activities performed by DHCS. DHCS' A&I annual five-year (SFY 2020-21 through SFY 2024-25) ROI average is $835 million, which equates to a ROI ratio of 8.6 to 1 ($8.6 generated for every $1 spent). See answer to Question 27 regarding program integrity metrics for additional ROI details.

4. What is the per capita rate of recovery by Medicaid managed care plans?

Based on data reported by MCPs for SFY 2024-25, the weighted-average per-capita rate of recovery across all MCPs is approximately $1.24 per member per month.

5. What are the primary areas (topical, going to service type, and, as relevant, to geographical considerations) where fraud has been identified?

The primary areas where fraud has been identified in terms of topical/service type are listed below. Analysis of recent CAF referrals to MFCU and DHCS' open investigations log for SFY 2025-26 (See Attachment Nos. 5.01 and 5.02), which includes complaints and tips from all sources (e.g., internal data analytics results, fraud referrals from MCPs, public complaints received) demonstrates that the following provider types and service categories are most frequently impacted.

Topical/Service Type Areas:

- **Clinical Laboratories:** Clinical labs are implicated in COVID-19 lab test-related fraud, false billing, and services not rendered, with a growing number of CAF referrals. In SFY 2024-25 there was one CAF involving five subjects and to date in SFY 2025-26 there were two CAFs involving eight subjects.
- **Ground Medical Transportation:** Allegations include phantom trips and upcoding. In SFY 2024-25 there were two CAFs involving four subjects.

- **Hospice Providers:** The largest number of CAF referrals sent to the MFCU involve hospice providers, with allegations including billing for services not rendered, medically unnecessary services, and upcoding. In SFY 2024-25, DHCS submitted 36 hospice-related CAF referrals involving 147 subjects to the MFCU, and in SFY 2025-26, 12 CAF referrals involving 42 subjects.

- **IHSS:** IHSS provider referrals involve suspected billing for ineligible services and services not rendered. In SFY 2024-25 and 2025-26, there were 15 and 12 IHSS-related CAF referrals respectively.

- **Pharmacies/Pharmacists:** DHCS has identified fraud related to pharmacy billing, including phantom billing, high-cost/low-value drugs, kickbacks, and medically unnecessary services. In SFY 2024-25 and 2025-26, DHCS referred 14 CAFs to DMFEA. DHCS currently has over 170 pharmacy-related open investigations.

- **Physicians/Physician Groups:** Cases include upcoding, billing for ineligible services, and kickbacks. In SFY 2024-25 there was one CAF involving seven subjects.

Geographical Considerations:

- **Los Angeles County:** The majority of hospice, IHSS, pharmacy, and laboratory fraud cases are concentrated in Los Angeles County, reflecting both that it is our state's most populous county and the size of the provider network and historical patterns of fraud in high-volume urban areas.

- **San Bernardino, Riverside, and San Diego Counties:** These counties also show a significant percentage of open fraud investigations, particularly in IHSS and pharmacy services.

- **Other Urban and High-Volume Counties:** Alameda, Kern, Fresno, and Santa Clara counties are also frequently represented in open fraud investigations.

6. For any areas where fraud has been identified, have these led to monetary recoveries?

Yes, areas where fraud has been identified have resulted in monetary recoveries. These recoveries reflect amounts collected over the past five years, following completed investigations and issuance of provider demand letters. The table below displays total recoveries.

SFY	Recovery Amount
2024-25	$136M
2023-24	$43M
2022-23	$41M
2021-22	$16M
2020-21	$11M

A&I's overall annual five-year (SFY 2020-21 through SFY 2024-25) ROI average of $835 million (ROI ratio of 8.6 to 1. $8.6 generated for every $1 spent) includes the fraud recoveries noted above as well as ROI tied to waste and abuse. See answer to Question 27 regarding program integrity metrics for additional ROI details.

7. Does DHCS evaluate and monitor whether Medicaid managed care plans have any internal controls to identify and recover fraud?

Yes, DHCS continuously evaluates and monitors whether MCPs have internal controls to identify and recover fraud in accordance with C.F.R. Title 42, Chapter IV, Subchapter C, Part 438, Subpart H. This objective is achieved via program oversight and monitoring activities, and annual statutorily mandated medical audits to review contract compliance.

DHCS' comprehensive oversight framework ensures that MCPs maintain proper safeguards in mitigating, identifying, and recovery of fraud.

- Prior to go-live, all MCPs undergo Operational Readiness facilitated by DHCS' managed care program, which is the mandatory assessment process ensuring that MCPs have the necessary infrastructure, staffing, policies, and systems to administer managed care benefits to members. As part of this assessment, DHCS reviews all required MCP deliverables to determine whether MCPs are prepared to deliver services safely and meet program requirements before going live, including internal controls to identify and recover fraud. In cases where deliverables fall short or do not meet requirements, DHCS provides formal notice and allows MCPs to revise

policies and procedures (P&Ps) to demonstrate they have the requisite program integrity processes and capabilities.

- The Boilerplate Contract (See Attachment No. 1.01) has a dedicated section, Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*) (See Attachment No. 7.03), that specifies the requirements for MCPs' Program Integrity and Compliance Program. These requirements include: Compliance Program; Fraud Prevention Program; Provider Screening, Enrolling, and Credentialing/Recredentialing; Contractor's Obligations Regarding Suspended, Excluded, and Ineligible Providers; Disclosures; Treatment of Overpayment Recoveries; and Federal False Claims Act Compliance and Support. These contract provisions are fundamental safeguards that require MCP capacity to identify and recover fraud, in accordance with applicable federal regulations.

- The Boilerplate Contract requires MCPs to obtain written approval from DHCS before changing MCPs deliverables, protocols, policies, and procedures. As a result, DHCS reviews and approves proposed procedural edits/amendments. (MCP Boilerplate Contract, Exhibit E, Subsection 1.1.10 (See Attachment No. 7.04) (*Obtaining DHCS Approval*).

- DHCS, at any time, can add to or clarify contractual requirements via APL[16], which often requires MCPs to bolster or add internal controls. Examples include APL 22-013 (Provider Credentialing/Re-Credentialing and Screening/Enrollment) (See Attachment No. 7.02); and APL 15-026 (Actions Required Following Notice of a CAF) (See Attachment No. 7.01).

- DHCS performs annual medical audits to review contract compliance pursuant to Cal. Welf. & Inst. Code § 14456. DHCS has designated Program Integrity and Compliance Program (MCP Boilerplate Contract, Exhibit A, Attachment III, Section 1.3 (*Program Integrity and Compliance Program*) as a high-risk area, necessitating mandatory review with every annual MCP audit. Audit reports are published publicly.[17]

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[16] DHCS, *All Plan Letters*, https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx, 1998-2026.

[17] DHCS, *Medical Audit Reports and Corrective Action Plans,* https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx, 2021-2025.

- Audit findings trigger a DHCS corrective action plan (CAP) process facilitated by the DHCS managed care program, which necessitates ongoing back-end monitoring and oversight to ensure remediation solutions are sufficient. Failure to satisfactorily implement required corrective actions can result in DHCS imposing monetary sanctions against an MCP.

8. Does DHCS undertake any FWA activities related to the below list of 14 high-risk services that have been the focus in MN, and if so, what activities has the state undertaken?
    - Adult Companion Services
    - Adult Day Services
    - Adult Rehabilitative Mental Health Services
    - Assertive Community Treatment
    - Early Intensive Developmental and Behavioral Intervention
    - Housing Stabilization Services
    - Individual Home Supports
    - Integrated Community Supports
    - Intensive Residential Treatment Services
    - Night Supervision
    - Nonemergency Medical Transportation
    - Peer Recovery Services
    - Personal Care Assistance / Community First Services and Supports
    - Recuperative Care

    DHCS employs a data-informed, risk-based framework to drive program integrity strategy. DHCS targets high-risk service categories and provider types based on advanced data analytics, and as a result has identified priority focus areas that include clinical lab, ground medical transportation, hospice, IHSS, pharmacy, and physician/physician group categories. Based on publicly available information, DHCS understands that Minnesota (MN) identified these 14 high-risk service types through a review of shared ownership, corporate structures, and social networks in that state.

    DHCS has longstanding experience with analyzing shared ownership, control interests, and corporate structures to penetrate complex networks of sophisticated fraud schemes. In fact, CMS and national groups have recognized DHCS as a

national leader in this regard. DHCS' comprehensive investigative strategies to identify fraud networks, involving collusion among multiple provider types to exploit targeted members, have been highlighted and presented at the MII and NAMPI conferences. DHCS routinely evaluates complex corporate structure patterns and social networks to follow the thread and pierce the veil of fraud schemes that span multiple service categories. As a result, the priority focus areas for California are not necessarily the same as those in MN.

A&I has conducted fraud investigations tied to Medi-Cal services programs that appear to correspond to some of MN's high-risk services based on a preliminary review, such as:

- **Community Based Adult Services**
    - **MN Equivalent**: Adult Companion Services, Adult Day Services.
    - **Fraud scheme involved**: Services not provided and services not provided to eligible members.
- **IHSS**
    - **MN Equivalent**: Individual Home Supports, Night Supervision, Personal Care Assistance/Community First Services and Supports.
    - **Fraud schemes involved**: Concurrent billings tied to IHSS and inpatient services (such as skilled nursing, emergency room, and hospital stays) and check splitting involving collusion between IHSS provider and beneficiary/member. Investigations generally involve lower dollar amounts relative to other A&I investigations, with typical suspected fraudulent amounts averaging around $30,000 per investigation.
- **Nonemergency Medical Transportation**
    - **MN Equivalent**: Nonemergency Medical Transportation
    - **Fraud schemes involved**: upcoding, double billing, services not provided, services provided to ineligible members, and kickbacks.

9. Does DHCS validate encounter data to ensure it accurately reflects services delivered and supports program integrity monitoring?

Yes, DHCS validates encounter data through multiple processes to ensure it accurately reflects services delivered and supports program integrity monitoring to detect and prevent FWA. These activities are grounded in federal regulations under 42 C.F.R. Part 438 and related CMS guidance.

Encounter Data Validation

Pursuant to 42 C.F.R. § 438.358(c)(1), DHCS contracts with Health Services Advisory Group, Inc. (HSAG), to conduct encounter data validation (EDV) studies. The EDV studies are designed to meet the periodicity schedule required in 42 C.F.R. § 438.602(e) for an independent audit of the accuracy, truthfulness, and completeness of encounter data submitted by, or on behalf of, each plan.

EDV study reports are publicly available on the DHCS website.[18] The EDV activity for 2025-26 is an Information Systems Review, which is an assessment of DHCS' and the plans' information systems and processes. It will include an evaluation of the plans' processes for collecting, maintaining, and submitting encounter data to DHCS, and evaluate the strengths and limitations of the plans' information systems in promoting and maintaining quality encounter data.

Quality Measures for Encounter Data

Currently, the Quality Measures for Encounter Data Report (QMED) 1.0 initiative complies with 42 C.F.R. § 438.242 requirements to review and validate encounter data using established quality assurance protocols.[19] Effective January 1, 2015, the quality of the MCP encounter data has been measured for completeness, accuracy, reasonability, and timeliness (CART). DHCS grades MCPs as "High-Performing," "Low-Performing" or "Non-Compliant," in terms of encounter data quality, using the methodology described in the QMED document.

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[18] DHCS, *Medi-Cal Managed Care Quality Improvement Reports*, https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEDV.aspx, SFY 2018-19 to SFY 2023-24.

[19] DHCS, *Medi-Cal Managed Care Encounter Data Reporting,* https://www.dhcs.ca.gov/dataandstats/data/Pages/MMCDClmsEncDataRpt.aspx.

In addition, DHCS is releasing formal guidance for QMED 2.0 which simplifies the plan grading as well as expands the scope of the report. The CART dimensions are increasing to incorporate Uniqueness and Consistency in assessing data quality. The new report also adds new data quality measures to reflect State and federal reporting requirements. Lastly, new measures and updated measures have been developed to align with Transformed Medicaid Statistical Information System (T-MSIS) Outcomes Based Assessment (OBA) targets. Once finalized, the QMED 2.0 guidance will be published along with the supporting APL on the DHCS website.[20]

T-MSIS Data Quality Improvements

DHCS meets with CMS on a monthly basis to review open OBAs to address any concerns identified by CMS. DHCS resolves open OBA issues by performing root cause analysis to determine necessary fixes to report and ensure compliance with the requirements of 42 C.F.R. §§ 438.242, 438.604, and 438.818, which specify requirements for collecting and reporting managed care encounter data in T-MSIS. DHCS partners with CMS to align on priorities and resolve all the open "Critical" and "High" OBAs, with the goal to have no Critical OBA items open and resolving "High" issues to keep the open number to four or fewer to meet CMS' requirements. As noted above, new measures and updated measures for QMED 2.0 have been developed to align with current business priorities, including T-MSIS OBA targets to monitor data quality compliance. Monthly webinars address data quality issues.[21]

Annual Medical Audits for Contract Compliance

Encounter data is leveraged to identify instances that have a high probability for FWA. DHCS responds by investigating anomalies and spikes and compares the services delivered and payments received by the providers against what was reported. Through annual medical audits for contract compliance, pursuant to Cal. Welf. & Inst Code § 14456, MCPs' internal policies, procedures, and controls are reviewed with accompanying test work to ensure they are meeting the requirements outlined in 42 C.F.R. § 438.608.

Financial Audits and Reviews

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[20] DHCS, *All Plan Letters*, https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx, 1998-2026.https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[21] DHCS, *Data Reporting and Monitoring Webinar Series,* https://www.dhcs.ca.gov/dataandstats/Pages/Quality-Webinar-Series.aspx, 2024-2025.

DHCS periodically performs financial audits of MCPs as required by 42 C.F.R. § 438.602(e). The audit process includes reviews of encounter data against supplemental data produced by MCPs for audit and/or rate-setting purposes. In addition, DHCS utilizes encounter data in the development of risk-based managed care capitation rates and in the calculation of certain risk corridors or other retrospective terms of payment. Encounter data completeness and reasonableness, at an aggregate level, is evaluated during these processes and through quarterly "stoplight reports" that assess encounter data volume against supplemental data reported for rate-setting purposes.

Third Party Liability and Recovery

Prior to December 2023, as part of DHCS' third-party liability and recovery activities, as required by 42 United States Code (U.S.C.) § 1396(a)(25)(B) and § 1902(a)(25) of the Social Security Act, DHCS requested encounter data for specific members involved in personal injury actions directly from MCPs. The data received, in addition to the existing data exchange processes, was used to assert recovery rights. This practice has been discontinued, except for very limited circumstances (99.9 percent decrease), because MCP-submitted encounter data quality and completeness has increased to a level where this supplemental process is no longer necessary.

10. All immigration enumerators, if applicable, for every Medicaid beneficiary including: Citizenship / immigration information from Medi-Cal health insurance application; USCIS/Alien Registration number (A-Number); Form I-94, Arrival/Departure Record number; Student and Exchange Visitor Information System (SEVIS) ID number; Card Number/I-797 Receipt number

DHCS requests each applicant's citizenship or qualifying immigration status when applying for coverage and transmits it to CMS on a monthly basis consistent with CMS' Transformed Medicaid Statistical Information System data reporting requirements. Detailed identifiers such as United States Citizenship and Immigration Services (USCIS)/A-Number, Form I-94 number, SEVIS ID, or I-797 Receipt number are used only for eligibility verification purposes, and not retained beyond that purpose, since federal law does not require retention.

Specifically, in accordance with Cal. Welf. & Inst. Code § 14011.2(e)(2)(B), and (C), proof of citizenship or nationality must be retained by the county in the case record. The only federal requirement for retaining an applicant's information is specific to the

types of demographic data listed under 42 U.S.C. § 300kk, but the requirement does not include the applicant's immigration status.

DHCS objects to CMS' request No. 10 insofar as it demands "all immigration enumerators […] for every Medicaid beneficiary," pending more information about the purpose of CMS's request, the relevance to CMS's inquiry of this large quantity of data, as well as details regarding CMS' implementation of the preliminary injunction order in California et al. v. U.S. Dep't of Health and Human Servs., No. 25-cv-05536 (N.D. Cal. Dec. 29, 2025), in which the court has prohibited CMS from sharing information about Medicaid recipients who are lawfully present. California also objects insofar as CMS' request seeks to obtain information that is subject to ongoing litigation brought by other federal agencies. See United States of America v. Baass, Opp'n to Petition to Enforce Subpoena, No. 25-mc-83 (C.D. Cal., Sept. 24, 2025) (opposing enforcement of administrative subpoena demanding "all" Medi-Cal applications as inter alia an improper fishing expedition, overly broad, lacking legitimate investigative purpose, and unduly burdensome).

11. All currently enrolled Medicaid Providers, irrespective of investigation status.

A listing of all enrolled Medicaid providers is published on the California Health and Human Services (CalHHS) Open Data Portal.[22]

12. All Medi-Cal provider enrollment forms from the past 5 years.

Since 2016, DHCS has leveraged the online enrollment system, Provider Application and Validation for Enrollment (PAVE), to streamline and automate the enrollment of Medi-Cal providers. Most provider types enroll through PAVE, which uses a dynamic form that adapts questions based on user input. DHCS included several PAVE forms that reflect the questions for different enrollment types (See Attachment Nos. 12.01-12.35), as well as legacy paper forms (See Attachment Nos. 12.36-12.96) used by certain DHCS programs and departments.

Our strategic goal is to fully automate enrollment for all provider types within the next several years, enhancing efficiency, accuracy, and overall user experience, and further enabling DHCS to conduct robust program integrity activities.

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[22] CalHHS, *Profile of Enrolled Medi-Cal FFS Providers,* https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers, February 2026.

13. Does DHCS and the Medicaid managed care plans with which it is contracted implement payment suspensions due to credible allegations of fraud, and if so, how many payment suspensions were implemented over the last 5 years? How many, if any, good cause exceptions to payment suspensions has the state permitted?

Yes, DHCS and its contracted Medicaid MCPs implement payment suspensions (PS) due to CAF in accordance with 42 C.F.R. §§ 455.23, 438.608(a)(8), and Cal. Welf. & Inst. Code § 14107.11. Upon receipt of a CAF (as defined in Cal. Welf. & Inst. Code § 14107.11(d)) for a provider who is the subject of an investigation under the Medi-Cal program, the provider shall be temporarily placed under a PS (97 imposed over the past five years), unless it is determined that a good cause exception (339 taken in past five years) exists that supports the determination not to impose the PS. The 339 good cause exceptions noted were all requested by the MFCU. MCPs are required to immediately suspend payments to providers when a state or federal agency determines there is a CAF. (MCP Boilerplate Contract, Exhibit A, Attachment III, Subsection 1.3.4.D.).

Historically, the MFCU has frequently requested a law enforcement good cause exception to avoid jeopardizing the MFCU forthcoming investigation. In such cases, DHCS has honored the MFCU's request in order to protect the integrity of MFCU investigations. More recently, as a direct result of DHCS' stronger engagement with the MFCU on this issue, the MFCU has agreed to a more selective approach in its request for law enforcement good cause exceptions in response to DHCS' desire to suspend payments as quickly as possible to minimize financial harm to the Medi-Cal program.

In addition to the PS, pursuant to Cal. Welf. & Inst. Code § 14043.36, if it is discovered that a provider is under investigation by DHCS or any state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension (TS) from the Medi-Cal program, which includes temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. The TS, a more stringent sanction unique to California, differs from a PS in that the TS prohibits the provider from participating in the Medi-Cal program, including prohibition of submitting claims. In practice, DHCS considers the TS a discretionary sanction option to help further provider accountability.

When DHCS imposes a PS due to a CAF, it lists the suspended providers in the Restricted Provider Database (RPD), a permission based DHCS database (accessible to only authorized DHCS and MCP staff) listing a variety of DHCS-imposed provider sanctions. DHCS notifies MCPs of providers placed on the RPD and requires MCPs to take appropriate action based on the imposed provider sanction. In addition to tracking other required databases, MCPs must review the RPD on at least a monthly basis and must take appropriate action against suspended providers, including suspending Medi-Cal payments to providers placed on PS. APL 21-003 (See Attachment No. 13.02), Attachment A; MCP Boilerplate Contract, Exhibit A, Attachment III, Subsection 1.3.4. (See Attachment 7.03) MCPs are required to notify A&I that the suspended provider is no longer receiving payments in connection with the Medi-Cal program.

The PS and good cause exception statistics are reported to CMS-CPI annually in the Medicaid PS State Annual Report (See Attachment No. 13.01). The PS and good cause exception statistics noted above were reported to CMS-CPI in the Medicaid Payment Suspension State Annual Report for the period of October 1, 2020 – September 30, 2021, through October 1, 2024 – September 30, 2025. The October 1, 2024 – September 30, 2025, statistics have been compiled by DHCS (See Attachment 13.03) but have not yet submitted to CMS-CPI. The submission to CMS-CPI is due May 2026.

14. Does DHCS test managed care plan compliance with fraud, waste, and abuse obligations under federal managed care regulations, and if so, how and what findings/results has DHCS obtained?

Yes, DHCS audits MCPs compliance with FWA obligations under federal managed care regulations codified in 42 C.F.R. Part 438, Subpart H such as:

- Provider Screening
- Mandatory compliance program
    - Programs must have written policies, staff training, internal monitoring and corrective action procedures
    - Fraud referrals and prompt reporting requirements
- PS

- Overpayment Recovery

DHCS has designated Program Integrity and FWA systems as high risk in its annual medical audit (Q15 Audit Program Cat 6) (See Attachment No.14.01). As a result, DHCS performs test work for this topic annually for each MCP audited.

As part of DHCS' ongoing oversight, DHCS has identified several areas of FWA non-compliance by MCPs including, but not limited to the following:

- Payments to Ineligible Providers, instances were identified where the MCP paid claims submitted by providers who were not eligible to render services. Specifically, these providers were either deceased or listed on the DHCS RPD. (CalOptima 2025 Preliminary Finding).

- Failure to Notify DHCS of Overpayments due to potential FWA. (Kern 2025 Preliminary).

- Failure to Notify DHCS of Provider Removal of a suspended, excluded, or ineligible provider from its network (Kern 2025 Preliminary).

- Non-Compliance with Reporting Requirements, failing to provide the DHCS FWA reports containing the status of all preliminary, active, and completed investigations (Santa Clara 2025, Contra Costa Health Plan 2025) (See Attachment Nos.14.02,14.03).

- Incomplete FWA investigation, FWA investigations were not reported within required timeframes, resulting in delays in resolution and reporting to DHCS (Contra Costa Health Plan 2025).

- Did not have P&Ps that included required criteria for selecting a Compliance Officer and a job description outlining the responsibilities and authority of the position (San Francisco Health Plan) (See Attachment No.14.05).

- Did not notify the PIU within ten working days of removing a suspended, excluded, or terminated provider from the provider network (L.A. Care 2024) (See Attachment No. 14.04).

DHCS has historically not had many repeat findings in the FWA space. The specific findings above triggered immediate CAP dialogue with each respective MCP, where ongoing technical support as well as monitoring of each CAP work towards CAP resolution. The audits in the upcoming SFY will determine whether their approved CAPs have resulted in changed behavior at an operational level. Failure to satisfactorily implement required corrective actions can result in DHCS imposing monetary sanctions against an MCP.

Eligibility Determination and Immigration Status Controls

15. What controls are in place to ensure county eligibility determinations are accurate at initial enrollment and renewal?

Pursuant to 42 C.F.R. § 435.912, California has developed structured controls in the form of county performance standards for determining, renewing and redetermining eligibility in an efficient and timely manner across a pool of applicants or members. DHCS uses a structured set of controls to ensure accuracy in county eligibility determinations, which includes issuing formal policy letters[23] (All County Welfare Director Letters and Medi-Cal Eligibility Division Informational Letters) that define procedures based on state and federal requirements. These policies guide program administration and serve as the foundation for system functionality. DHCS provides statewide training to county eligibility workers on all policy changes to ensure consistent implementation across counties. From a system perspective, DHCS and counties receive system alerts when eligibility issues occur. These alerts have defined timelines for resolution to maintain program integrity.

To align with federal regulations, California has state statute (Cal. Welf. & Inst. Code § 14154) that outlines county eligibility performance standards in three areas for timeliness and accuracy: 1) applications (initial enrollment), 2) redeterminations, and 3) monitoring of Medi-Cal Eligibility Data System (MEDS) alerts.

16. Does DHCS audit county eligibility determinations, and if so, how, and what error rates are observed?

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[23] DHCS, *Medi-Cal Eligibility,* https://www.dhcs.ca.gov/Program-Integrity/Pages/PI-Medi-Cal-Eligibility.aspx.

Pursuant to 42 C.F.R. § 435.912, California has developed structured controls in the form of county performance standards (See Attachment Nos. 16.01 and 16.02) for determining, renewing and redetermining eligibility in an efficient and timely manner across a pool of applicants or members DHCS conducts oversight reviews of counties to ensure compliance, with every county being reviewed every two years. These reviews assess a set of performance measures related to timeliness and accuracy of eligibility determinations for renewals and applications. A sample of cases from each county is fully checked to confirm all required documents are on file and county actions were performed in compliance with all state and federal requirements before eligibility is finalized or renewed. These reviews do not have an associated error rate but do detect error trends and isolate areas in policy that may need clarification. In 2023, California as a Cycle 2 state, had a lower eligibility Payment Error Rate Measurement rate than the national average.

DHCS also participates in biennial Medi-Cal Eligibility Quality Control Pilots, and reviews county determinations in accordance with the Department's CMS-approved pilot planning document.

17. What DHCS processes exist to prevent or detect misclassification errors related to immigration status that may impact the eligibility for and availability of federal matching funds, and how does DHCS correct any such errors?

For Medi-Cal members with an unsatisfactory immigration status (UIS) for purposes of Medicaid eligibility, federal financial participation (FFP) is only claimed for emergency and pregnancy-related services.

Policy

DHCS issues formal policy letters that define immigration status eligibility and classification based on state and federal requirements. These policies guide program administration and serve as the foundation for system functionality. DHCS provides statewide training on all policy changes to ensure consistent implementation across counties.

System Processes

Medi-Cal claims for services rendered to members are adjudicated by DHCS and processed using multiple automated systems. The systems adjudicate claim

payments and verify the appropriate amount of federal funding claimed. DHCS updates and stores immigration status information daily to ensure the appropriate FFP is claimed for the claim date of service. Automated validations prevent incorrect FFP claiming by blocking actions when required data is missing, conflicting, or fails critical checks. Individuals with an unknown or unverified immigration status are treated as having UIS and FFP is only claimed for the emergency and pregnancy-related services.

Systematic Alien Verification for Entitlements

For individuals who attest to an immigration status that is eligible for federally funded full scope Medicaid, DHCS completes an automated USCIS Systematic Alien Verification for Entitlements (SAVE) electronic verification process. If the SAVE verification response does not match the attested immigration status, the record is updated to reflect the SAVE verification response. If the SAVE verified immigration status is not eligible for federally funded full scope Medicaid, FFP is claimed for emergency and pregnancy services only.

Monitoring and Alerts

DHCS and counties receive system alerts when a possible immigration status related error occurs. These alerts have defined timelines for resolution to maintain program integrity.

Error Correction

If there is an immigration status error, the original claim is backed out and resubmitted based on the correct immigration status information for the claim date of service. DHCS uses information from CMS containing immigration status to ensure buy-in payments are only made for eligible individuals.

Additionally, in 2020, California self-identified and disclosed to CMS inadvertent unallowable claims for FFP relating to individuals covered under a state-only program. Since then, California has worked extensively in partnership with CMS to ensure appropriate claiming through updates to our systems and processes.

18. Given known data limitations, what steps is DHCS taking to improve its ability to track Medi-Cal utilization and costs by eligibility category, including populations with unsatisfactory or unverified immigration status?

As noted above, in 2020, California self-identified and disclosed to CMS inadvertent unallowable claims for FFP relating to individuals covered under a state-only program. Since then, California has worked extensively in partnership with CMS to ensure appropriate claiming through updates to our systems and processes. This partnership has included CMS and DHCS conducting deep-dive reviews of claims systems, business rules, programming, cost allocation, and managed care rate certification. Throughout this collaboration, DHCS has undertaken extensive steps to improve DHCS' ability to track Medi-Cal utilization and costs, including populations with unsatisfactory or unverified immigration status.

For example, at CMS' direction, starting as of July 2019 for most rate certifications, and as of January 2023 for all rate certifications, DHCS developed, certified, and implemented distinct Medi-Cal managed care capitation rates for members with satisfactory and unsatisfactory (or unverified) immigration statuses. Medi-Cal managed care capitation rates for members with unsatisfactory immigration status have been further segmented into rates for federally eligible emergency and pregnancy-related services and rates for all other (state-only funded) services.

In addition, as part of DHCS' ongoing collaboration with CMS, DHCS has made improvements to the dental FFS and managed care systems, the specialty behavioral health system, the managed care capitation payment system, the FFS claims system, HCBS claiming processes, targeted case management claiming processes, pharmacy claiming methodology, drug rebate invoicing, cost allocation methodology, and administrative claiming processes. DHCS continues to partner closely with CMS through the supplemental quarterly review process initiated in April 2025 to improve Medi-Cal utilization and cost tracking.

DHCS has implemented enhanced estimation processes through the budget development process to better capture expenditures for these populations, integrated UIS-related costs into budget planning and transparency efforts and initiated cross-division collaboration to refine methodologies and improve data accuracy. The budget process includes review of caseload trends that assists with review of sudden changes in populations. Additionally, DHCS is advancing program integrity initiatives and exploring system enhancements to strengthen the linkage

between eligibility data and utilization reporting, ensuring more comprehensive tracking for internal planning and fiscal accountability.

Provider Screening, Enrollment, and Validation

19. What criteria does DHCS use to determine the risk level (limited, moderate, high) that applies to Medi-Cal providers?

DHCS uses the criteria articulated in applicable federal authority, particularly 42 C.F.R. §§ 424.518,455.450, and the guidelines in the CMS Medicaid Provider Enrollment Compendium (MPEC)[24] (refer to Section 1.3D & 1.5.4) to determine provider risk levels (limited, moderate, or high) and screen accordingly. Additionally, pursuant to Cal. Welf. & Inst. Code § 14043.38, DHCS has exercised its authority to designate certain provider types as high-risk for specified periods, which enables the Department to be nimble and respond quickly to identified patterns of FWA.

20. Does DHCS conduct off-cycle revalidations, and if so, in what circumstances?

Pursuant to Cal. Code Regs. Tit. 22, § 51000.55, Requirements for Continued Enrollment, DHCS periodically identifies specific provider categories that will be subject to continued enrollment processing. This authority can be used when there are program integrity concerns in a specific geographic area or with a specific provider category. Continued enrollment requires written notice to providers and their submission of a completed application package within established timeframes.

21. What criteria does DHCS use to determine whether and when to impose a payment suspension?

DHCS imposes provider PS in accordance with the following federal and state laws and regulations:

- The state imposes temporary PS against a provider when a CAF has been established.
    - 42 C.F.R. § 455.23(a) “The state Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is

[24] CMS, *MPEC,* https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf, November 2025.

a CAF for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part."

- Cal. Welf. & Inst. Code § 14107.11 "Upon receipt of a CAF as defined in subdivision (d) and for which an investigation is pending under the Medi-Cal program against a provider as defined in Section 14043.1, or the commencement of a suspension under Section 14123, the provider shall be temporarily placed under PS, unless it is determined there is a good cause exception … not to suspend the payments or to suspend them only in part …"

- Medi-Cal MCPs are required to mirror the state's payment suspension actions via a comparable payment suspension or optional contract termination.

  - 42 C.F.R. § 438.608(a)(8) "Provision for the [Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs) suspension of payments to a network provider for which the State determines there is a CAF in accordance with section 455.23 of this chapter."

  - APL 21-003 (See Attachment No. 21.01) clarifies the obligations of Medi-Cal MCPs when terminating or initiating terminations of contractual relationships between MCPs, Network Providers, and Subcontractors. This APL also establishes MCPs' obligations to check exclusionary databases and terminate contracts with Network Providers and Subcontractors who have been suspended or excluded from participation in the Medi-Cal/Medicare programs. MCPs are not obligated to terminate contracts with Network Providers and Subcontractors placed under a PS. MCPs may continue the contractual relationship; however, MCPs may not pay the Network Provider/Subcontractor until the suspension is lifted.

- Additionally, providers are subject to, and DHCS imposes temporary suspensions, which is a more stringent sanction unique to California, against providers under a law enforcement fraud investigation.

- Cal. Welf. & Inst. Code § 14043.36 (a), "If it is discovered that a provider is under investigation by the department or any state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program."

- The TS differs from a PS.

  - While under a PS, a provider is still eligible to participate in the Medi-Cal program and submit claims. However, payment tied to the submitted claims are temporarily withheld until which time the investigation is closed, and PS has been lifted.

  - While under a TS, the provider is prohibited from participation in the Medi-Cal program and prohibited from submitting claims.

22. In what circumstances does DHCS terminate a provider's enrollment?

DHCS continuously monitors Medi-Cal providers' enrollment to ensure compliance with federal and State laws. California has adopted a broader and more stringent legal framework for terminating a Medi-Cal provider's enrollment than what is currently required under federal law.

The federal authority provides the following grounds for suspension and termination under 42 C.F.R. § 455.416:

- Failure to submit timely and accurate information and cooperate with any screening methods required under this subpart. 42 C.F.R. § 455.416(a).

- Criminal convictions relating to an owner's involvement with Medicare, Medicaid, or CHIP within the last 10 years. 42 C.F.R. § 455.416(b).

- Provider or any owner is terminated under Medicare or any other state Medicaid or CHIP program and listed in the termination database. 42 C.F.R. § 455.416(c).

- Failure to submit timely and accurate information required for enrollment. 42 C.F.R. § 455.416(d).

- Failure to properly and timely submit fingerprints. 42 C.F.R. § 455.416(e).

- Failure to permit access to provider locations for site visits. 42 C.F.R. § 455.416(f).

- Falsification of information on an application. 42 C.F.R. § 455.416(g)(1).

- Unable to verify the identity of any provider applicant. 42 C.F.R. § 455.416(g)(2).

DHCS suspends and terminates providers consistent with these federal regulations.

In addition, California's legal authority for terminating or suspending a Medi-Cal provider goes beyond the requirements in 42 C.F.R. § 455.416. Recognizing the importance of maintaining strict standards of participation to protect the integrity of the Medi-Cal program, California has implemented a robust statutory and regulatory framework for terminating a provider's enrollment from the Medi-Cal program, both temporarily and permanently.

DHCS' suspension and termination grounds under state authority include:

- **California Welfare & Institutions Code**

    - Failure to disclose required information or disclosure of false information. Cal. Welf. & Inst. Code § 14043.2(a).

    - Termination of provisional provider status or preferred provisional provider status. Cal. Welf. & Inst. Code § 14043.27(c).

    - Failure to remediate discrepancies identified during enrollment or review. Cal. Welf. & Inst. Code § 14043.7(c)(1).

    - Failure to comply with supervisory requirements. Cal. Welf. & Inst. Code § 14043.47(d).

- Provider under investigation for fraud or abuse. Cal. Welf. & Inst. Code § 14043.36(a).

- Provider or any owner is excluded or suspended from Medi-Cal or any other state health care program. Cal. Welf. & Inst. Code § 14043.36(b).

- Failure to maintain licensure or certification required for the provider type. Cal. Welf. & Inst. Code § 14043.6.

- Returned mail or inability to contact the provider at the enrollment address. Cal. Welf. & Inst. Code § 14043.62.

- Inactivity, such as no claims submitted for 12 consecutive months. Cal. Welf. & Inst. Code § 14043.62.

- Submission of claims by suspended, excluded, or otherwise ineligible provider. Cal. Welf. & Inst. Code § 14043.61(a).

- Violation of Medi-Cal rules, regulations, or laws. Cal. Welf. & Inst. Code § 14123(a).

- Suspension from participation in the Medicare or Medicaid programs. Cal. Welf. & Inst. Code § 14123(b).

- Temporary suspension to protect public welfare or Medi-Cal program interests. Cal. Welf. & Inst. Code § 14123(c).

- Dental services below the standard of acceptable quality. Cal. Welf. & Inst. Code § 14123(f).

- Failure to comply with the requests for information or records. Cal. Welf. & Inst. Code § 14124.2(b)(1).

- **Title 22 California Code of Regulations**

  - Failure to obtain or maintain necessary licenses and permits. Cal. Code Regs. Tit. 22 § 51000.30(e).

  - Failure to have an established place of business. Cal. Code Regs.

Tit. 22 § 51000.60(b).

- Deactivation of a Provider Number or Location. Cal. Code Regs. Tit. 22 § 51000.53(a).

- Basic requirement for program participation. Cal. Code Regs. Tit. 22 § 51200 (b) and (c).

23. Does DHCS identify and monitor related entities, common ownership, or shared management across multiple enrolled providers, and if so, how?

Yes, DHCS identifies and monitors related entities, common ownership, and shared management when such information is disclosed by the provider through the PAVE portal at the time of initial application, change of ownership, change of address, report of additional location, continued enrollment, and revalidation. DHCS relies on provider self-disclosure through PAVE, consistent with federal requirements, and coordinates with CMS as necessary to assess risk and ensure compliance with Medicaid integrity standards.

This process is governed by federal regulations that establish both the definitions of disclosable affiliations and the mechanisms for reporting and oversight:

- 42 C.F.R. § 455.101 – Provides definitions for *disclosable affiliations* (including ownership interests) and disclosable events.

- 42 C.F.R. § 455.107(d) – Requires providers to report affiliation information to the state.

- 42 C.F.R. § 455.107(f) – Directs the State to consult with CMS to determine whether any disclosed affiliation presents an undue risk of FWA.

Additional related federal requirements include:

- 42 C.F.R. § 455.104 – Specifies required disclosures of ownership and control interests to Medicaid.

- 42 C.F.R. § 455.105 – Requires disclosure of certain business transactions.

- 42 C.F.R. § 455.106 – Mandates disclosure of information related to criminal convictions for new and renewing providers.

Over the past 10 years, DHCS' ability to more quickly and effectively identify clusters of potential fraud involving related entities, common ownership, and/or shared management across multiple enrolled providers has increased significantly, due in part to the availability of enhanced technology and our multi-disciplinary approach to addressing the most sensitive and high-risk areas of the program. For example, our increased use of provider link analysis when running algorithms plus our expanded efforts to compile intelligence via the use of other disparate data sources beyond paid claims, including open source data, has allowed DHCS to better "connect the dots" and reveal potential collusion among various provider types, locations and programs that are taking advantage of targeted clusters of members. The identified fraud networks oftentimes involve marketers and kickbacks being shared among those involved. Furthermore, DHCS PIU's multi-disciplinary approach to evaluating fraud schemes has allowed DHCS to more effectively see the bigger picture. This multi-disciplinary approach involves collaboration among the PIU's various staff disciplines (i.e., auditors, sworn investigators, clinical staff, data researchers) to evaluate fraud scenarios from various vantage points. Auditors evaluate financial data in order to "follow the money." Our sworn peace officers gather vital investigative evidence via provider and member interviews and the execution of search warrants. Clinical staff review patient records to evaluate services rendered for medical necessity. Data researchers and scientists work intimately with all disciplines involved to extract data to support our investigative teams' suspicions and conclusions. This multidisciplinary investigative strategy is effective in identifying related entities, common ownership, and shared management across multiple enrolled providers, and serves as a basis for developing comprehensive CAF referrals that the MFCU can rely on to pursue further investigation and prosecution of those individuals defrauding the Medi-Cal program for personal gain.

24. What tools, including reviews, audits, and other mechanisms, are used to ensure proper provider screening, enrollment, and revalidation (and to detect improper provider screening, enrollment, and revalidation) across locations or programs?

DHCS uses a variety of tools to ensure proper provider screening, enrollment, and revalidation across locations or programs consistent with applicable federal requirements, including the PAVE online provider portal, systematic state and federal database checks, and onsite reviews and audits.

PAVE enables DHCS to process provider applications and maintain compliance with federal and State program integrity mandates by supporting electronic enrollment, validation, revalidation, and ongoing monitoring in accordance with the Patient Protection and Affordable Care Act and related federal requirements in 42 C.F.R., Chapter IV, Subchapter C, Part 455, Subpart E. This process includes, but is not limited to: screening against multiple databases, including Medi-Cal Suspended and Ineligible Provider List, the OIG Exclusion List, System for Award Management (SAM), Social Security Administration (SSA) Death Master File, and review terminations published on the Data Exchange System (DEX); reviewing disclosures; reporting adverse provider actions; reviewing national provider identifiers; verifying licenses; conducting background checks and site visits, as needed; reviewing ownership and control interests; and checking other applicable federal databases.

As part of this process and consistent with California's CMS-approved Medicaid State Plan, DHCS complies with federal provider screening requirements under Section 5005 of the 21st Century Cures Act; applicable provisions of the Social Security Act; 42 C.F.R. § 438.602; and 42 C.F.R., Chapter IV, Subchapter C, Part 455, Subparts B and E. DHCS conducts comprehensive screening through multiple federal and state databases, including the Medi-Cal Suspended and Ineligible Provider List, the OIG Exclusion List, SAM, and SSA Death Master File; verifies licenses and national provider identifiers; reviews disclosures and ownership interests; performs background checks; and reports adverse provider actions. Site visits are conducted as needed to confirm compliance.

A&I further strengthens oversight by performing onsite visits for all moderate providers, and onsite visits, criminal background checks, and fingerprints for high-risk providers, in accordance with 42 C.F.R. §§ 455.450, 455.432, and 455.434. Upon completion of these reviews, A&I transmits its findings internally, and an enrollment decision is made. In addition, when conducting post-service, post-payment audits, A&I regularly audits providers' compliance with Medi-Cal program standards of participation and seeks overpayment recovery in connection with negative audit findings.

25. Does DHCS verify that managed care plans conduct required provider credentialing, screening, and ongoing monitoring, and if so, how?

Yes, DHCS verifies that MCPs conduct required provider credentialing, screening, and ongoing monitoring through a variety of processes, including provider

application review, conducting onsite verifications and audits, and performing accreditation checks.

DHCS uses PAVE to process provider applications. Almost all MCPs network providers are enrolled through PAVE. As described above, as part of the provider enrollment process and in accordance with California's Medicaid State Plan, DHCS ensures compliance with federal provider enrollment, credentialing/recredentialing, and screening requirements, including Section 5005 of the 21st Century Cures Act; Section 1902(d)(6) and 1902(kk) of the Social Security Act; 42 C.F.R. § 438.602(b); and 42 C.F.R. part 455, subparts B and E. This process includes, but is not limited to:

- Screening against multiple databases, including Medi-Cal Suspended and Ineligible Provider List, the OIG Exclusion List, SAM, SSA Death Master File, and others.
- Reviewing disclosures.
- Reporting adverse provider actions.
- Reviewing national provider identifiers.
- Verifying licenses.
- Conducting background checks and site visits, as needed.
- Reviewing ownership interests.
- Checking other applicable federal databases.

DHCS exercises oversight of MCPs by conducting annual medical audits for contract compliance and reviewing MCPs' P&Ps concerning provider credentialing, screening, and enrollment. For example, DHCS audits involve testing a sample of claims paid within an audit period to confirm payments were not disbursed to ineligible providers. MCP monthly provider screening reports are also tested to ensure ongoing monitoring of provider eligibility status and to confirm screening is performed against the required databases.

DHCS also collaborates with the CSA to ensure compliance with federal provider enrollment, credentialing/recredentialing, and screening during state audits. The audits may include verifying licenses, reviewing disclosures, screening against OIG's exclusion list, and reviewing payments made for providers enrolled through PAVE and through MCPs. There were no deficiencies found concerning provider eligibility in the most recent audit of SFY 2023-24.[25]

DHCS verifies that all MCPs hold National Committee for Quality Assurance (NCQA) accredited status. To obtain this status, NCQA verifies that the MCPs' providers are properly credentialed after a comprehensive review and assessment of the MCPs' P&Ps on recredentialing every three years since the date of the MCPs' last accreditation. DHCS reviews the accreditations promptly on a rolling basis.

DHCS requires all MCPs to comply with federal provider enrollment, screening, and credentialing/recredentialing requirements. DHCS incorporates federal enrollment and screening requirements through multiple avenues, including sending out guidance letters such as APL, requiring compliance in MCP contracts, and including provisions in Medi-Cal Network Provider Agreements. DHCS requires all MCPs to comply with federal provider enrollment, screening, and credentialing/recredentialing requirements.

Program Integrity Infrastructure and Accountability

26. Are program integrity responsibilities divided among DHCS, counties, managed care plans, and other state agencies, and if so, how?

While DHCS' A&I division is the designated PIU for the Medi-Cal program, California considers program integrity a responsibility of all entities with a role in administering Medi-Cal. Key Medi-Cal program integrity partners include, but are not limited to, the following:

- **Counties** – Member eligibility; eligibility fraud referrals to DHCS; IHSS provider enrollment, training, and monitoring; IHSS fraud referrals to DHCS.

- **Medi-Cal MCPs** – Program Integrity and Compliance Program. (MCP Boilerplate Contract, Exhibit A, Attachment III, Section 1.3.).

[25] CSA, *State of California Federal Compliance Audit Report for the Fiscal Year Ended June 30, 2024*, https://www.auditor.ca.gov/wp-content/uploads/2025/12/2024-002-Report.pdf, December 2025.

- **CDSS** – IHSS oversight, administration and program integrity. Works collaboratively with A&I, the designated investigative body for IHSS program.

- **California DOJ, DMFEA** – DMFEA serves as California's designated MFCU.

- **Other Medi-Cal related state entities (e.g., Department of Aging, Department of Developmental Services)** – Directed to send all Medi-Cal fraud referrals to DHCS.

27. What metrics does DHCS use to assess the effectiveness over time of its program integrity initiatives?

DHCS takes a comprehensive approach to program integrity and tracks a host of key metrics to gauge its effectiveness and success on an annual basis across a range of programmatic objectives, including:

- Overpayment recovery / Cost avoidance.

- Criminal or civil prosecution of fraudsters.

- Fraud prevention.

- Establishing deterrents to FWA.

- Changing bad provider behavior.

- Addressing and minimizing patient harm.

- Program and contract compliance.

- Addressing program gaps/loopholes.

Prioritization and focus on these objectives change regularly based upon current FWA concerns and risks both nationally and locally.

A&I has established two categories for performance metrics: recoveries/cost avoidance; and case activity production. The first category captures the PIU's hard and soft dollar recoveries based on a well-defined methodology, which was

previously presented at CMS's MII and distributed to every other state PIU in the country. The annual five-year (SFY 2020-21 through 2024-25) ROI average is $835 million, which equates to an ROI ratio of $8.6 generated for every $1 spent. The PIU operating budget has historically averaged approximately $100 million to $110 million annually.

A&I ROI

State FY 2020/2021 Through FY 2024/2025

	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025
Identified Overpayments*	$322,000,000	$354,000,000	$370,000,000	$322,000,000	$722,000,000
Recoveries*	306,000,000	315,000,000	364,000,000	319,000,000	486,000,000
Cost Changes (Impact on Rates / Cost Reimb)	141,000,000	147,000,000	132,000,000	130,000,000	158,000,000
Cost Savings (Sanctions)	48,000,000	264,000,000	28,000,000	25,000,000	41,000,000
Cost Avoidance (Enrollment)	241,000,000	215,000,000	284,000,000	249,000,000	282,000,000
TOTAL (Excluding Identified Overpayments)	**$736,000,000**	**$941,000,000**	**$808,000,000**	**$723,000,000**	**$967,000,000**

Annual ROI 5-Year Average = $835 million. Ratio 8.6 to 1 ($8.6 generated for every $1 spent).

*Collection of identified overpayments typically span fiscal years. Thus, the variance between identified overpayments and collections will exist in any given year

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The second category of metrics involves tracking production and case activity statistics annually to capture program integrity activities that may not lead to significant sums of hard or soft dollar recoveries directly. However, such activities play an equally critical role to ensure the integrity of the Medi-Cal program. A key example is the work of A&I's sworn fraud investigators. Key work performed by these law enforcement professionals involve early fraud (eligibility) investigations, drug diversion investigations, and the execution of search warrants to support investigations. While this body of critical work may not generate large dollar recoveries, the work performed serves as a critical deterrent to FWA. When our sworn investigators are active and visible in the provider community, the likelihood that bad provider behavior is changed for the better is significantly increased. Furthermore, the benefit of countless lives saved as a result of a successful drug diversion investigation that removed a drug pusher from the community is immeasurable. These audit production and case activity statistics are monitored year over year to identify trends and assess performance.

A&I Audit Production and Case Activity

State FY 2021/2022 Through FY 2024/2025

	2021/2022	2022/2023	2023/2024	2024/2025
Investigations Division				
Encounter Opened	953	1,269	885	800
Encounter Closed	595	838	716	487
Case Opened	410	757	699	450
Case Closed	833	683	1,326	333
Search Warrants / Subpoenas	59	45	33	48
Arrests	4	5	0	0
Criminal Complaints Filed	184	110	386	74
Criminal Complaints Adjudicated	45	43	13	6
Contract & Enrollment Review Division				
Managed Care Audits	24	49	33	39
Other Audits & Reviews (e.g. Behavioral Health and Drug-Medi-Cal)	897	78	75	38
Enrollment On-Sites	647	635	815	938
Financial Review Divisions				
Audit Reports Issued	4,059	4,381	5,595	4,524

* Opened cases typically span fiscal years. Thus, variances between opened versus closed cases will vary greatly in any given year

In regard to CAF referrals to the MFCU for further criminal and/or civil investigation and prosecution, DHCS prioritizes quality over quantity. The bulk of CAF referrals sent to the MFCU annually involve complex networks of fraud where the case often includes multiple subjects and entities colluding with one another to defraud the Medi-Cal program.

Finally, DHCS defines fraud prevention to include investigative activities that seek to identify and eradicate fraud networks as early as possible before such fraud expands and proliferates within the Medi-Cal program.

28. Are trends in error rates, recoveries, and enforcement outcomes evaluated and reported to CMS and the public, and if so, how?

Enforcement statistics and outcomes are reported to OIG annually in response to the OIG's annual State Program Integrity/Surveillance and Utilization Review Subsystem Unit Questionnaire for MFCU Recertification. PS and fraud referral statistics are also reported to CMS annually. Overpayment recoveries, cost

avoidance, cost savings, and production-related statistics are compiled annually; however, such statistics are neither publicly reported nor federally required to be.

29. How does DHCS prioritize its program integrity objectives and determine personnel/resource tasking?

DHCS prioritizes its program integrity objectives and determines its allocation of personnel resources based on identified FWA risks, emerging trends within the program, and other program integrity obligations such as statutorily mandated annual financial audits (4,000+ audits issued annually). A&I also meets regularly with MCP SIU staff and MFCU staff to share intelligence and to discuss ongoing investigations for purposes of prioritizing investigative activities, coordinating intelligence and emerging trend analysis, and strengthening opportunities for collaboration.

Over 1,700 fraud complaints and referrals are received monthly from all sources (e.g., the public, local, state and federal partners, internal DHCS program partners) which are diligently vetted and ranked based on various criteria. These criteria include, but are not limited to, the egregiousness of the suspected fraud, complaint source (e.g., anonymous complaint versus a referral from a trusted government agency), timeframe of suspect fraudulent activity, materiality of fraudulent claims paid, suspected patient harm, complainant credibility and sufficiency of the evidence provided. Ranked cases are maintained in a queue and assigned out for investigation. Ensuring the highest and best use of existing resources and the allocation of personnel resources to those areas within the program that warrant their attention is the top priority. If FWA risks shift and priorities change, DHCS adjusts its focus and pivots as needed to ensure a timely and effective response to issues as they arise.

The number of authorized positions within A&I represents approximately 15 percent of all total authorized positions within DHCS. The number of authorized positions within DHCS' provider enrollment division represents approximately three percent of total positions. The total number of authorized positions within DHCS' third-party liability and recovery division represents 4 percent of total positions. Collectively, over 20 percent of DHCS personnel are exclusively dedicated to program integrity.

IHSS – Program-Specific Oversight

30. Over the past decade, IHSS spending has grown dramatically from approximately $8.2 billion in 2015–2016 to approximately $28.5 billion in 2025–2026. What factors are driving this significant increase in program costs?

The IHSS program provides domestic and personal care services to children and adults with disabilities and older adults so they can remain safely in their own homes and communities and avoid institutionalization. (See Cal. Welf. & Inst. Code §§ 12300 et seq.) consistent with California's policy emphasis on HCBS (see Cal. Welf. & Inst. Code §§ 12300 et seq). California's approach aligns with federal requirements and incentives, including ADA Title II and the *Olmstead* decision, which require services in the most integrated setting appropriate (ADA Title II; *Olmstead v. L.C.*, 527 U.S. 581 (1999)).

Medi-Cal reimburses SNFs on a per diem basis using facility-specific or class median rates, rather than individualized hourly authorizations. IHSS, by contrast, is structured as a person-centered, hourly benefit designed to maintain individuals in their homes. Recipients served under IHSS generally meet an institutional level of care, meaning that without IHSS or comparable HCBS, many would likely require placement in a SNF. According to CMS, HCBS usually cost less than half of what residential care does, making HCBS a cost-effective alternative to institutional care.

There are three main factors that have driven significant increases in IHSS program costs over the past decade. These include increases to the IHSS caseload, increases to the statewide average IHSS cost per hour, and increases to the average number of IHSS hours per case. A significant driver of increased program costs is increased IHSS wages, with the average IHSS county wage almost doubling between 2014 through 2025.[26] Wage increases are a tool to recruit and retain qualified workers in a field experiencing a provider shortage. Another driver of increased program costs is caseload growth, with the number of IHSS recipients almost doubling between 2015-16 through 2025-26. It is anticipated that the IHSS caseload will continue to grow at an accelerated rate due to an aging populace and the need for services, consistent with CSA recommendations on expanding IHSS enrollment and with California's Master Plan for Aging.

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[26] LAO, *The 2025-2026 Budget for IHSS*, https://lao.ca.gov/Publications/Report/5009#:~:text=Cost%20Per%20Hour%20Continues%20to,hour%20in%20January%201%2C%202025, March 2025.

31. Do CDSS and DHCS coordinate oversight of IHSS, including eligibility, provider enrollment, payment, and federal claiming, and if so, how?

CDSS and DHCS maintain interagency agreements for the purpose of administering several Medi-Cal programs in which IHSS is covered, including the IHSS Personal Care Services Program, Community First Choice Option, and the IHSS Plus Option. CDSS and DHCS collaborate closely on program oversight, policy direction, and federal claiming. (See Cal. Welf. & Inst. Code § 12305.7). DHCS collaborates with CDSS on the development of SPA, and regulations and procedures for the IHSS program. DHCS also provides policy guidance as needed.

IHSS program eligibility rules and provider enrollment requirements are established in state statute. The vast majority of IHSS providers are considered employees of the IHSS recipient they work for and payments to providers must meet the requirements of labor, tax, and other employment laws as set forth in federal and state statute and regulations. Payments to providers are managed through the Case Management, Information and Payrolling System (CMIPS), the system of record for the IHSS program. The system uses business rules to ensure both the IHSS recipient and provider are eligible and that payments made to a provider are correct and do not exceed a recipient's authorized hours. Provider payment data is reported to DHCS for federal claiming. (See Cal. Welf. & Inst. Code § 12302.2 (IHSS provider enrollment and recipient as employer), Cal. Welf. & Inst. Code § 12317 (CMIPS system authority), and see also 42 U.S.C. § 1396n(j) (self-directed services under Medicaid)).

To support program integrity efforts, DHCS provides technical assistance and performs regular quality assurance reviews in collaboration with CDSS. DHCS and CDSS meet and confer on a regular basis to discuss ongoing program integrity activities, validate that county Quality Assurance/Quality Improvements (QA/QI) plans are in place, and ensure that P&Ps address system improvements. Additionally, DHCS reviews compilations of county QA/QI activities, which are submitted to CDSS on quarterly report forms documenting results of counties' desk reviews, home visits, case resolutions, fraud prevention and detection, over/under payments, critical incidents, targeted reviews, and quality improvement efforts. This includes DHCS review and evaluation of CDSS staff remediation efforts during and after county monitoring reviews. DHCS reviews error rate studies which estimate the extent of payment and service authorization error and potential fraud in the provision of services. The findings are used to prioritize and direct state and county fraud detection and quality improvement efforts, and to support the development of CAF

referrals to the MFCU. (See Cal. Welf. & Inst. Code § 12305.7 (QA requirements, including error rate studies) and Cal. Welf. & Inst. Code § 12305.71 (fraud detection and data match authority)).

CDSS invoices DHCS for the federal share of Medicaid claims as DHCS is the State's Medicaid Agency under Title XIX of the Social Security Act and 42 C.F.R. Part 431. As the State Medicaid Agency, DHCS coordinates with other California departments to claim allowable Medicaid funds from CMS. To comply with federal financial management requirements, DHCS not only claims the federal funds for IHSS services provided but also utilizes the federal Payment Management System to draw down funding requests as well as requests for Medicaid grant funding through CMS each quarter.

32. Does the state determine whether IHSS participants with cognitive impairment are capable of self-directing their own care, and if so, how? Specifically, what criteria or assessment tools are used to evaluate such individuals' ability to make decisions, manage caregivers, and ensure their own safety when cognitive impairment is present?

California allows individuals with cognitive disabilities to have an Authorized Representative to direct their IHSS care. Recipients select their Authorized Representative. However, if the recipient is a minor with a legal guardian or is a conserved adult, the legal guardian or conservator will be named as the Authorized Representative. The Authorized Representative directs care for the recipient and may even sign timesheets if authorized by the recipient to do so. (See Cal. Welf. & Inst. Code § 12300.3, which governs designation and authority of an authorized representative in IHSS).

County staff administering the IHSS program under the State's supervision assess the extent to which individuals' cognitive impairment impacts their functioning in their activities of daily living, including domestic services, laundry, shopping and errands, meal preparation and cleanup, mobility, bathing and grooming, dressing, bowel, bladder and menstrual care, repositioning, eating, and respiration.

The county further assesses the recipient's mental functioning, including memory, orientation, and judgment, to determine if the individual is self-directing. Each of these three areas of mental functioning must be assessed and individually ranked as part of the mental functioning assessment. The three areas of mental functioning are each evaluated on a three-point scale: Ranks 1 (Independent), 2 (Able to perform a

function but needs verbal assistance, such as reminding, guiding, or encouragement), and 5 (Cannot perform the function with or without human assistance). As part of the mental functioning assessment, social workers are trained to ask specific questions and make observations. This process is detailed in the CDSS' Annotated Assessment Criteria[27] which all social workers utilize.

CDSS requires all county social workers to attend the IHSS Training Academy, which includes standardized training on IHSS Assessment and Authorization policy as well as how to assess and address services for individuals with mental/cognitive impairment and/or mental illness. Additionally, the CDSS QA teams conduct monitoring reviews of IHSS assessments for all 58 counties annually to ensure cases are being authorized appropriately and accurately. The QA and/or the IHSS Training and Development Unit will provide technical assistance and focused training for county staff when there is an identified need as part of monitoring activities.

The uniform assessment tool and QA monitoring process are implemented in compliance with federal approval, such as California's Community First Choice Section 1915(k) SPA.

33. What screening level (limited, moderate, high) applies to IHSS providers, and how often are such providers revalidated?

Under federal statute and regulation, the IHSS program is self-directed, meaning that the recipient has the authority to hire, schedule, direct, and discharge providers. 42 U.S.C. § 1396n(j)(5)(A), (k)(1)(A)(iv); 42 C.F.R. §§ 441.450, 441.550. As set forth in State statute, Cal. Welf. & Inst. Code §§ 12302.2 and 12316.1(i), the IHSS recipient is the employer of the IHSS provider for purposes of selecting, replacing, terminating, scheduling, and supervising the provider.

In order for an individual to be paid by the IHSS program for providing authorized services, the applicant provider must be eligible to work in the U.S. and undergo a four-step enrollment process. The enrollment process consists of:

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[27] CDSS, *ACC*, https://www.cdss.ca.gov/Portals/9/IHSS/ITA/IHSS%20Tools/AnnotatedAssessmentCriteria.pdf, November 2020.

- Submission of a signed IHSS Program Provider Enrollment form (SOC 426), as required under Cal. Welf. & Inst. Code § 12305.81(a).

- Attendance at a mandatory provider orientation provided by the county, as required under Cal. Welf. & Inst. Code § 12301.24(a).

- Signing an IHSS Program Provider Enrollment Agreement form (SOC 846) at the conclusion of the provider orientation, as required under Cal. Welf. & Inst. Code § 12305.24(b).

- Submission of fingerprints in order to undergo a criminal background check through the DOJ, as required under Cal. Welf. & Inst. Code § 12305.86. (Individuals who have been convicted of, or incarcerated following a conviction for, certain disqualifying crimes within the previous ten years are not eligible to be enrolled providers).

IHSS providers are not a provider type listed in the Federal Register, Vol. 76, February 2, 2011, and for purposes of the IHSS program, the IHSS recipient is considered the employer of the provider. As such, recipients maintain control over their employees/providers.

Additionally, the services authorized in the IHSS program are personal care and domestic and related care, not medical in nature. Due to the type of services available through the IHSS program, providers are not required to be licensed individuals.

California maintains continuous oversight of IHSS provider eligibility. As provided in State statute and regulations, counties receive notifications of subsequent arrest and/or disposition information from DOJ. Thus, if a county receives a notification of an enrolled provider's subsequent arrest/crime, the county is required to terminate the provider, if the subsequent conviction is a disqualifying crime. If this occurs, the recipient is notified of the conviction and of the provider's ineligibility to be an enrolled IHSS provider and is instructed to choose another provider. (See Cal. Welf. & Inst. Code §§ 12305.81, 12305.86, which govern IHSS provider background checks and disqualification for specified convictions).

34. Are IHSS providers enrolled at the agency level or at the individual service-provider level?

Under the IHSS program, recipients are considered the employer for purposes of hiring, firing, and supervising their provider(s). IHSS recipients may choose to hire an eligible individual to be their Individual Provider (IP) or choose to hire a provider through the Contract Mode if it is available in their county. Contract Mode is a service delivery method currently available in two counties, San Francisco and Contra Costa, where counties contract with outside agencies to employ and manage caregivers. All IHSS providers, whether hired as an IP or through the Contract Mode, are required to complete the IHSS provider enrollment requirements at the county level to be enrolled as an IHSS provider and to receive payment for providing services through the IHSS program. (See Cal. Welf. & Inst. Code §§ 12301.24, 12302.2, which establish IHSS recipients as the employer and require individual provider enrollment).

35. Does CDSS or DHCS identify providers billing across multiple recipients, counties, or programs, and if so, how?

IHSS providers may work for more than one recipient and across different counties, as long as they do not work more than their recipients' monthly authorized hours and comply with other program rules.

CDSS and county staff use CMIPS, the system-of-record for the IHSS program, to manage recipient cases and perform payroll functions. All enrolled IHSS recipients and IHSS providers are identified in CMIPS. The system will not allow a provider to be paid for hours that exceed their IHSS recipient's authorized hours or for periods when the recipient is not eligible.

CMIPS also tracks recipient eligibility and monthly authorized hours, provider eligibility information, and all timesheet and payment activity and history attached to a recipient and their provider(s).

DHCS tracks billing across multiple recipients and/or programs via its data/fraud analytics on an ad hoc basis when such queries will benefit the investigation. (See Cal. Welf. & Inst. Code § 12317, which establishes CMIPS as the IHSS case management and payrolling system with controls to prevent improper payments; Cal. Welf. & Inst. Code § 12305.7, which authorizes QA monitoring and data matching; and DHCS MCP Boilerplate Contract section 4.3.21 / APL 21012, which requires MCPs to coordinate with IHSS agencies to avoid duplicative services.)

Section 4.3.21 provides that MCPs are contractually responsible for maintaining P&Ps for coordinating with the county IHSS agencies to ensure that members do not receive duplicative services through Enhanced Care Management, Community Supports, and other services by, at a minimum, tracking all members receiving IHSS, designating a day-to-day IHSS liaison, and providing outreach to county IHSS agencies serving mutual members.

36. Does the state monitor variability in county functional-need assessments and authorized service hours, and if so, how?

The CDSS QA teams conduct monitoring reviews of IHSS assessments for all 58 counties annually. CDSS QA reviews individual assessments completed by county social workers to ensure cases are being authorized appropriately and accurately. A standard method for case file reviews is utilized by aligning with current IHSS policies and established regulations to ensure that there is consistency with the functional-needs assessments and authorized service hours throughout the counties. Additionally, CDSS requires all county social workers to attend the IHSS Training Academy, which includes Standardized Training on IHSS Assessment and Authorization policy.

CDSS also conducts statewide error-rate studies and automated data matches to identify patterns and discrepancies in service-hour authorizations across counties and provides technical assistance and CAP when variability is detected. Standardized tools such as the Case Review Tool and Home Visit Checklist are used during QA reviews to ensure uniform application of IHSS policy. These efforts, combined with mandatory IHSS Training Academy participation, help minimize variability in functional-need assessments and authorized service hours. (See Cal. Welf. & Inst. Code § 12305.7, which authorizes CDSS quality assurance for IHSS assessments and service hours; Cal. Welf. & Inst. Code § 12300 (as amended by California State Senate Bill (SB) 1104, statutes of 2004), which established the statewide QA requirements; CDSS IHSS QA Program Overview, which details annual county case reviews and standardized assessment tools; and CDSS IHSS Training Academy Overview, which mandates standardized training for consistent assessments and service-hour authorizations).

37. Are assessments periodically audited for accuracy and consistency, and what corrective actions occur when discrepancies are identified?

As a result of the findings from the QA monitoring reviews, counties are required to remediate cases based on any findings. Remediation could require that the county reassess the case, add documentation, or take other case actions as necessary. CDSS QA verifies all remediations are completed correctly to ensure compliance with all IHSS policies and regulations. QA and/or the IHSS Training and Development Unit will also provide technical assistance and focused training for county staff when there is an identified need as part of monitoring activities. (See Cal. Welf. & Inst. Code § 12305.7, which requires error-rate studies and data matches to guide corrective actions; CDSS IHSS QA Program Overview, which describes periodic desk reviews, home visits, and standardized tools; and CDSS IHSS Training Academy Overview, which provides targeted training and technical assistance to address discrepancies).

38. What controls exist to prevent payment for services rendered during periods of ineligibility or incorrect scope assignment?

State law related to IHSS QA was updated in 2004 pursuant to provisions of the QA Initiative (SB) 1104, statutes of 2004. SB 1104 amended the State's Welfare & Institutions Code to add sections 12305.7(a) and (b), and 12305.71(a)(3) concerning data match requirements in the IHSS program statewide. CDSS conducts Error Rate Studies to estimate the extent of any payment and service authorization errors and fraud in the provision of the IHSS program, in accordance with Cal. Welf. & Inst. Code §§ 12305.7,12305.71, and works with counties to correct deficiencies.

Pursuant to Cal. Welf. & Inst. Code §§ 12305.7,12305.71, CDSS monitors county compliance, utilizes data matches to identify any duplicate Medi-Cal payments, examines any errors in the application of program regulations and authorization of services, and works with counties and DHCS to prevent and detect misuse and/or abuse of program funds, as well as maximize recovery of overpayments through a combination of automation and investigations as follows:

CDSS receives an In-Patient Hospitalization Report from DHCS, via CMIPS. This report is used by counties to investigate possible duplication of services to determine if an overpayment has occurred, specifically, in instances when an IHSS provider has claimed service hours when their assigned recipient(s) were hospitalized or in a long-term care facility. If it is found that an IHSS provider claimed hours in error, the county is required to initiate an overpayment. Cases of suspected fraud are referred to DHCS for investigation and potential prosecution. An additional example of controls in place to prevent inappropriate payments include:

- CDSS receives death match information on IHSS recipients and providers from the California Department of Public Health (CDPH) through an automated interface with CMIPS.

    - CMIPS reviews the data to determine if the death is recorded on the person's record. If the death is not recorded, and the person is a recipient, CMIPS generates a task to the county to review and investigate the death and to update the person's case record to reflect the findings. If the person is a provider, an equivalent task is generated for the county for each case to which the provider is assigned. When counties receive these tasks, they are required to investigate and terminate the recipient order once the date of death is confirmed.

CDSS also developed Anti-Fraud Fact Sheets, Recipient Educational materials, Provider Training Materials, and engages in collaborative meetings with DHCS to prevent payment issues and misuse of program funds.

Additionally, to prevent incorrect payments regarding the scope of IHSS services, CDSS adheres to requirements set forth in Cal. Welf. & Inst. Code § 12305.7 and requires all county social workers to attend the IHSS Training Academy, which includes Standardized Training on IHSS Assessment and Authorization policy, in addition to Program Integrity Training. All IHSS recipients are provided with a Notice of Action detailing their IHSS authorized services and hours. Recipients are also required to sign the SOC IHSS Recipient/Employer Responsibility Checklist (SOC 332), attesting that they understand their responsibilities. Prior to approving provider timesheets, recipients must confirm that the services were performed. Recipients also sign all timesheets under penalty of perjury. (See Cal. Welf. & Inst. Code §§ 12305.7,12305.71, which mandate error-rate studies and data matches to prevent improper payments; CDSS IHSS QA Program Overview, which describes CMIPS controls, hospitalization and death match processes, and fraud-prevention activities; and CDSS IHSS Training Academy Overview, which includes program integrity training for county staff).

(See also Cal. Welf. & Inst. Code § 112301.24(a)(5), which requires CDSS IHSS Provider Orientations[28] to include information on the Medi-Cal toll-free telephone

[28] CDSS, *IHSS Provider Orientation*, https://www.cdss.ca.gov/inforesources/ihss/ihss-providers/orientation-process.

fraud hotline and internet website for reporting suspected fraud or abuse in the provision or receipt of supportive services).

39. What are the most common sources of IHSS improper payments identified through audits or reviews?

The most common source of IHSS improper payments identified by both county QA/Program Integrity staff and DHCS are common billing errors, hours billed that were not actually worked, duplicate payments tied to identified overlap of services (e.g., concurrent billings tied to IHSS and inpatient services such as skilled nursing, emergency room, and hospital stays) and check splitting involving collusion between IHSS provider and beneficiary/member. All IHSS recipients must be in the home for the provider to bill for IHSS services. Overpayments tied to common billing errors often stem from providers' misunderstanding of IHSS program regulations/requirements and most often result in county administrative overpayment recovery. If fraud is suspected, IHSS fraud referrals are initiated in accordance with Cal. Welf. & Inst. Code § 12305.82. Additionally, counties must follow the IHSS Fraud Referral Process, as outlined in the CDSS IHSS Uniform Statewide Protocols[29] released via All County Information Notice I-13-13[30] (Implemented All County Letter 13-83). Counties are required to refer potential fraud over $500 to A&I (designated Medicaid PIU) for investigation and report their IHSS anti-fraud efforts to CDSS. (See Cal. Welf. & Inst. Code §§ 12305.7, 12305.71, and 12305.82, which govern error-rate studies, data matches, and fraud referrals; CDSS IHSS QA Program Overview, which details improper payment detection and recovery processes; and All County Letter 13-83 / ACIN I-13-13, which outline statewide IHSS fraud referral protocols).

40. Does the state track recoveries, referrals, and corrective actions specific to IHSS, and if so, how?

Yes, CDSS tracks county-initiated IHSS overpayment recoveries via CMIPS and from county reporting via the IHSS QA/QI Quarterly Activities Reporting Form

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[29] CDSS, *IHSS Uniform Statewide Protocols*, https://www.cdss.ca.gov/agedblinddisabled/res/IHSSUniformStatewideProtocols-ProgramIntegrityActMAR2013(bookmarked).pdf, 2013.

[30] CDSS, *All County Information Notice I-13-13,* https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2013/I-13_13.pdf, 2013.

(SOC 824). County fraud referrals are tracked via CMIPS and from county reporting via the IHSS Fraud Data Reporting Form (SOC 2245). Additionally, county and non-county IHSS fraud referrals are also tracked by DHCS.

IHSS fraud referrals received by DHCS from all sources are tracked in the DHCS case tracking system known as the Tracking, Reporting, Administrative Actions & Case Development System (TRACS). TRACS is used to document these referrals, the resulting investigations, and the disposition of the investigation. The TRACS system does not contain details on overpayment recoveries as that information is contained in the CMIPS system.

In accordance with Cal. Welf. & Inst. Code § 12305.7(f), CDSS's PIU requests, reviews, approves, and tracks county Quality Improvement Action Plans (QIAPs) for non-compliant counties that are not in alignment with IHSS regulations and/or policy. CDSS monitors county non-compliance via data analysis and by requiring counties to submit a QIAP detailing when and how they will achieve compliance. CDSS also requires counties to provide timely QIAP updates and schedules county conference calls, to work closely with counties that require additional assistance. CDSS also provides additional county training, technical assistance, and on-site county guidance as part of monthly QA visits and management of the QIAP process focused on continuous improvement of IHSS program administration. (See Cal. Welf. & Inst. Code §§ 12305.7(f), 12305.82, which authorize tracking of corrective actions and fraud referrals; CDSS IHSS QA Program Overview, which describes SOC 824 and SOC 2245 reporting; and DHCS TRACS system, which tracks IHSS fraud referrals and investigations).

Also, as stated previously, pursuant to Cal. Welf. & Inst. Code §§ 12305.7, 12305.71, CDSS utilizes data matches to identify any duplicate Medi-Cal payments, examines any errors in the application of program regulations and authorization of services, and works with counties and DHCS to prevent and detect misuse and/or abuse of program funds.

41. What enhancements are planned to strengthen program integrity across Medi-Cal delivery systems, particularly in high-volume, process-driven programs such as IHSS?

CDSS continues to work with counties to provide any additional guidance, tools, and processes needed to support and enhance program integrity within the IHSS program. As the population of California ages and the need for home and

community-based services continues to grow, CDSS will continue to automate, standardize, and streamline processes and systems to gain efficiencies, improve access, and enforce program rules. The IHSS program has already implemented electronic timesheets which improved efficiency and allowed for programming that eliminated timesheet errors and made the submittal and approval more transparent. Electronic timesheets provided the foundation for the implementation of Electronic Visit Verification for IHSS in compliance with CMS requirements. Additionally, automated interfaces and data sharing have made identifying potential fraud and collecting overpayments faster and easier. As the program continues to evolve and grow, CDSS and DHCS are committed to continuous improvement that supports program integrity processes and the staff who perform these functions.

In addition, DHCS continues to explore opportunities to expand and bolster its FWA analytics capacity and capabilities to search for claim anomalies and address fraud referrals received by the A&I case intake team from county partners and the general public. Opportunities to expand analytic capabilities continue to be pursued to enhance detection of anomalies in service hours and provider billing patterns that support targeted investigations of high-risk home visits and related cases. DHCS continues to strengthen its inter-agency coordination with CDSS and the counties via expanded and more frequent staff collaboration meetings to share intelligence, discuss the status and details regarding open and ongoing investigations, and to discuss investigative best practices. (See CDSS IHSS Quality Assurance Program Overview, which describes automation, Electronic Visit Verification, and fraud prevention enhancements; DHCS-A&I Program Integrity Plan, which outlines advanced analytics and targeted investigations).

IN CONCLUSION

Thank you for your interest in our shared priority of upholding the integrity of California's Medicaid program, and preventing and combating FWA.

As evidenced by the foregoing information, California operates its Medicaid program in substantial compliance with section 1902(a)(64) of the Social Security Act and 42 C.F.R. Part 455, Subpart A. The state provides sufficient mechanisms to receive reports from beneficiaries and others and compile data concerning alleged instances of FWA relating to the operation of the Medicaid Act. Further, the state implements comprehensive methods for identifying, investigating, and referring suspected Medicaid fraud. These methods include pathways to receive complaints of Medicaid fraud or abuse from any source and methods for identifying any questionable

practices. DHCS' PIU uses this information and related data sources to vigorously pursue robust preliminary and full investigations, and to refer CAFs to the MFCU.

DHCS is committed to continuing the extraordinary decades-long positive collaboration between DHCS and CMS' program integrity leadership, wherein CMS has consistently recognized DHCS as a national leader among State Medicaid Agencies in implementing program integrity best practices.

Sincerely,

Tyler Sadwith

Tyler Sadwith
State Medicaid Director

Enclosure

cc:

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CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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Attachment 1: Listing of Supporting Documents

Response No.	Attachment No.	Document Name
Background Section	0.01	0.01-California Olmstead Plan, 2003
1	1.01	Managed-Care-Boilerplate-Contract
2	2.01	MCP Referrals
3	3.01	State Program Integrity Questionnaire
5	5.01	CAF Referrals
	5.02	Open Investigations
7	7.01	APL15-026
	7.02	APL22-013
	7.03	Exhibit A, Attachment III Program Integrity and Compliance Program Contract
	7.04	Exhibit E, Subsection 1.1.10 Obtaining DHCS Approval
12	12.01	PAVE Medi-Cal - Blood Bank
	12.02	PAVE Medi-Cal (Crossover)
	12.03	PAVE Medi-Cal (Group Allied)
	12.04	PAVE Medi-Cal (ISP Corp Allied)
	12.05	PAVE Medi-Cal (Rendering Allied)
	12.06	PAVE Medi-Cal Ambulatory Surgical Clinic
	12.07	PAVE Medi-Cal Clinical Lab
	12.08	PAVE Medi-Cal Dentist Rendering
	12.09	PAVE Medi-Cal Community Based Organization (CBO)
	12.10	PAVE Medi-Cal Dentist Group
	12.11	PAVE Medi-Cal Diabetes Prevention Program
	12.12	PAVE Medi-Cal Tribal Health Services
	12.13	PAVE Medi-Cal University Dental Provider
	12.14	PAVE Medi-Cal SUDTP
	12.15	PAVE Medi-Cal SUDMD

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Response No.	Attachment No.	Document Name
12	12.16	PAVE Medi-Cal Rendering Physician
	12.17	PAVE Medi-Cal Rendering Doula
	12.18	PAVE Medi-Cal QAS
	12.19	PAVE Medi-Cal Provider Agreement
	12.20	PAVE Medi-Cal Provider Type- Pharmacy
	12.21	PAVE Medi-Cal Portable Imaging Provider
	12.22	PAVE Medi-Cal Out of State Hospital
	12.23	PAVE Medi-Cal ORP enrollment
	12.24	PAVE Medi-Cal Medical Transportation
	12.25	PAVE Medi-Cal Local Health Jurisdiction
	12.26	PAVE Medi-Cal ISP Corp Physician
	12.27	Pave Medi-Cal ISP CORP Doula
	12.28	PAVE Medi-Cal Individual Dentist
	12.29	PAVE Medi-Cal Provider Type- DME
	12.30	PAVE Medi-Cal Group Physician
	12.31	PAVE Medi-Cal Group Entity Doula
	12.32	PAVE Medi-Cal Family PACT (Planning, Access, Care and Treatment)
	12.33	PAVE Medi-Cal Exempt from Licensure County Clinics Not Associated with Hospital
	12.34	PAVE Medi-Cal Exempt from Licensure Clinic
	12.35	PAVE Medi-Cal Drug Medi-Cal Clinic
	12.36	DHCS_6204
	12.37	DHCS 6207 (Medi-Cal Disclosure Statement)
	12.38	DHCS_6209
	12.39	DHCS_6217 (Successor Liability with Joint and Several Liability Agreement)
	12.40	DHCS_6208
	12.41	DHCS 9098
	12.42	DHCS9098_2025
	12.43	ALW Program Provider Application CCA
	12.44	CLHF Program Provider Agreement

Response No.	Attachment No.	Document Name
12	12.45	HCBA Waiver Initial Provider Application CLHF
	12.46	PDHC Provider Agreement
	12.47	PDHC Provider Enrollment Supplemental Disclosure
	12.48	PDHC Initial Provider Application
	12.49	RCFE-ARF-Provider-Initial-Application
	12.50	ALW-Provider-Agreement
	12.51	Residential_Provider_Attestation
	12.52	FPACT Practitioner Participation Agreement DHCS-4470
	12.53	FPACT Provider Agreement DHCS-4469
	12.54	Memorandum of Agreement Application_DHCS7108
	12.55	LEA BOP Provider Participation Agreement (PPA)
	12.56	LEA BOP PPA Exhibit A
	12.57	LEA BOP FY 2025-26 Annual Report
	12.58	2024-27 Tri-Party DUA
	12.59	2024-27 Two-Party DUA
	12.60	DUA 2024-27 Attachment A
	12.61	DUA 2024-27 Attachment B
	12.62	DUA 2024-27 Attachment C
	12.63	DUA 2024-27 Attachment D
	12.64	DUA 2024-27 Attachment E (Part I)
	12.65	DUA 2024-27 Attachment E (Part II)
	12.66	DUA 2024-27 Attachment E (Part III)
	12.67	DUA 2024-27 Attachment F
	12.68	CYBHI-Fee-Schedule-Provider-Participation-Agreement
	12.69	Cohort 6 CYBHI Fee Schedule Program Readiness Application
	12.70	HS 200_Rev.7.2023

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Response No.	Attachment No.	Document Name
12	12.71	HS 215A_Rev.7.2023 (updated Release of Information Statement 2.9.2024)
	12.72	HS 269 Application for Medi-Cal Certification PCC
	12.73	CDPH 611 PCC Affiliate Application
	12.74	HS 328 (Provider Agreement)
	12.75	CMS 1856 Request for Medicare.Medi-Cal Certification Outpatient Physical Therapy
	12.76	CMS-3070G-508 Intermediate Care Facilities
	12.77	DHCS 1051 Civil Rights Compliance Review
	12.78	HCBS1050-09-2025
	12.79	HCBS1060-09-2025
	12.80	MCWP3-09-2025
	12.81	cdph325
	12.82	cdph322
	12.83	CDA ADH 0006 (REV 02-2024)
	12.84	CDA IMS 36 Rev 10 24
	12.85	CDA CBAS 406 (REV 11-2023)
	12.86	HS_309
	12.87	CDA CBAS 4007
	12.88	CDA ADH 0007
	12.89	CDA ADH 1038
	12.90	CDA IMS 33 (REV 11-2023)
	12.91	CDA IMS 35
	12.92	CDA IMS 37
	12.93	CDA 7019i
	12.94	CDA 7019 (REV 11-2023)
	12.95	PSP_ Peach Application_BLANK
	12.96	SOC341A
13	13.01	Medicaid Suspension State Annual Report
	13.02	APL21-003-AttA
	13.03	CAF Payment Suspension Count

Response No.	Attachment No.	Document Name
14	14.01	Audit Program Cat 6 - Plan Organization and Administration
	14.02	Santa Clara Audit Report
	14.03	Contra Costa Audit Report
	14.04	LA Care Audit Report
	14.05	San Francisco Health Plan Audit Report
16	16.01	24-17
	16.02	25-08
21	21.01	APL 21-003