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# Status of Medi-Cal Fraud Control Initiatives

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Prepared by the  
California Department of Health Care Services  
Audits & Investigations Division

**Fiscal Years 2014-15 and 2015-16**  
**Issued August 2018**

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## **Executive Summary**

The anti-fraud initiatives in this report demonstrate the Department of Health Care Services' (DHCS) continued success in reducing fraud, waste, and abuse in the Medi-Cal program. Through these initiatives, DHCS Audits and Investigations Division (A&I) yielded positive outcomes for Fiscal Years (FY) 2014-2015 and 2015-2016. A&I referred 219 Credible Allegation of Fraud (CAF) cases to the California Department of Justice (DOJ) and achieved a Return on Investment (ROI) of \$202,600,000.

## Introduction

In 2003, the California Legislature enacted legislation which authorized additional resources and staffing to DHCS to combat fraud and waste in the Medi-Cal program. Assembly Bill (AB) 1765 (Committee on Budget, Chapter 157, Statutes of 2003) authorized 161.5 positions, with 154.5 reserved for implementing and expanding DHCS anti-fraud programs and seven positions reserved for program support. It also required DHCS to submit a quarterly legislative report, which continued in subsequent budget acts through 2008.

Effective February 1, 2009, the annual budget act has required DHCS to submit biennial reports in writing on the results of the additional positions and specific anti-fraud activities under the 2003 Medi-Cal Anti-Fraud Initiative to the Legislature. The annual budget bill act requires the report to include the results of the most recently completed error rate study, random claim sampling process, and the number of positions filled by division. In addition, the report includes the amount of savings, cost avoidance achieved, cost avoidance estimated, the number of providers sanctioned, and the number of claims and beneficiary records reviewed. The report is to be submitted to the chairpersons of the committees in each house of the Legislature that consider appropriations and to the chairperson of the Joint Legislative Budget Committee.

As 15 years has passed since the original positions were approved and the positions have been completely integrated into DHCS' overall anti-fraud effort, this report provides the results of the overall DHCS anti-fraud effort instead of providing the effort of just the original 154.5 approved positions.

DHCS continues to make strides in reducing fraud, waste, and abuse in the Medi-Cal program. The anti-fraud initiatives in this report include Random Claim Review, Expansion and Strengthening of the Pre-Check Write, Expansion and Strengthening of the Pre-Enrollment/Enrollment Process, and ongoing anti-fraud achievements. These initiatives continue to play a significant role in the anti-fraud program.

## Anti-Fraud Organizational Structure

A&I serves as DHCS primary anti-fraud division. A&I coordinates with all other DHCS divisions in maintaining the integrity of the Medi-Cal program. A&I's anti-fraud effort consists of 221 staff located in the following division level section and five branches:

### Analytics, Policy, and Intake Section (12 anti-fraud positions)

The Analytics, Policy, and Intake (API) Section is the centralized control unit for Medi-Cal fraud complaints received by DHCS. Once received, an analyst reviews the details of the complaint and determines the next steps to be taken. Analytics staff complete research memos to support existing investigations and case development. Policy staff research programmatic concerns and recommend policy changes to executive management. The section is also responsible for processing the Credible Allegation of

Fraud referrals to the DOJ, as well as compiling A&I's dashboard containing ROI information and audit/case activity.

#### Medical Review Branch (96 anti-fraud positions)

The Medical Review Branch (MRB) is a multi-disciplinary branch which includes clinicians, auditors, analysts, and research specialists. MRB focuses on maintaining program integrity within the Medi-Cal program through reviews, audits, inspections, and surveys of non-institutional and managed care providers. MRB's activities are designed to assure that state and federal dollars spent for goods and services in the Medi-Cal program are used for essential healthcare benefits in compliance with program rules, regulations and laws. MRB's activities and projects are detailed within this Legislative Report.

Additionally, MRB publishes the Medi-Cal Payment Error Study (MPES). The MPES report measures overpayments in Fee-for-Service (FFS) Medi-Cal and estimates the percentage of fraudulent billing. The most recently published MPES was issued in FY 2013 and can be found at [http://www.dhcs.ca.gov/individuals/Pages/AI\\_MRB.aspx](http://www.dhcs.ca.gov/individuals/Pages/AI_MRB.aspx).

#### Special Investigations Unit (23 anti-fraud positions)

The Special Investigations Unit (SIU) is a multi-disciplinary unit which includes auditors, clinicians, analysts, and investigators. SIU identifies and investigates Medi-Cal fraud, waste, and abuse. SIU is responsible for identifying providers suspected of networking across program types to coordinate Medi-Cal fraud. Additionally, SIU identifies statistical outliers in provider communities. SIU uses sophisticated data analysis to identify providers whose billing patterns and practices have the highest potential to defraud Medi-Cal. SIU's risk-based approach to audits is an efficient use of resources, effectively removing fraudulent providers, recovering material Medi-Cal funds, and changing behaviors in the provider community. In addition, SIU refers providers to outside agencies to pursue all avenues of enforcement and deterrence.

#### Investigations Branch (90 anti-fraud positions)

The Investigations Branch (IB) consists of sworn peace officers who work closely with county staff to investigate allegations of fraud. In addition to working with internal partners, the branch works with other state, local and federal allied agencies by way of joint operations and task force assignments. Investigators work across branches to identify loss, fraud trends, and collection efforts. IB has assigned investigators to SIU, the Health Authority Law Enforcement Task Force, Ventura County Interagency Pharmaceutical Crimes Unit Task Force, the Drug Enforcement Administration Diversion Task Force, and Eurasian Organized Crime Task Force. By utilizing internal and external partners, IB has extended its reach during investigative, financial recovery, and prosecution efforts.

### Financial Audits Branch (no anti-fraud positions)

The Financial Audits Branch (FAB) ensures, through financial audits, that payments made to providers of Medi-Cal or other State or federally funded health care programs are valid, reasonable, and in accordance with laws, regulations, and program intent. While the branch does not specifically work on anti-fraud efforts, branch staff often identify potential fraud during their regular financial audits. Branch staff send this information to the API for possible investigation.

### Internal Audits (no anti-fraud positions)

Internal Audits (IA) is an independent organization housed within A&I that is charged with department-wide program internal audit responsibilities.

## **Return on Investment (ROI)**

During FY 2014-15 and 2015-16, A&I continued to achieve significant positive results related to its anti-fraud initiatives. A&I's overall ROI during FY 2014-2015 and 2015-2016 was \$594.3 million. Of this amount, \$202.6 million was directly related to anti-fraud efforts, savings of \$2.60 for every \$1 spent. The other \$391.7 million of ROI was the result of FAB's financial audits.

The table below displays A&I's anti-fraud ROI by category and fiscal year.

	<b>FY 2014-15</b>	<b>FY 2015-16</b>	<b>Total</b>
Recoveries	\$21,300,000	\$24,800,000	\$46,100,000
Cost Savings (Change in Billing Behavior)	\$47,700,000	\$30,600,000	\$78,300,000
Cost Avoidance (Denied Enrollment)	\$32,000,000	\$46,200,000	\$78,200,000
<b>Total</b>	<b>\$101,000,000</b>	<b>\$101,600,000</b>	<b>\$202,600,000</b>

Recoveries reflect actual dollars collected as reported by Third Party Liability Division.

Cost Savings reflect the calculated total dollars saved due to administrative sanctions placed on Medi-Cal providers, thus reducing their future reimbursements.

Cost Avoidance reflect calculated total dollars avoided as a result of denying an applicant from entering the Medi-Cal program, thus reducing any potential future reimbursement to zero.

The table below demonstrates the actions taken and the average savings per action.

<b>Actions Taken</b>	<b>Actions Imposed FY 2014-15</b>	<b>Total Savings FY 2014-15</b>	<b>Actions Imposed FY 2015-16</b>	<b>Total Savings FY 2015-16</b>
Temporary Suspensions & Payment Suspensions	149	\$8,924,355	84	\$6,176,184
Procedure Code Drug Limits	6	\$176,046	1	\$29,341
Prior Authorizations	0	\$0	1	\$24,299
Civil Money Penalties (1st, 2nd, 3rd warning notices)	38	\$884,982	49	\$1,182,174
<b>Total</b>	<b>193</b>	<b>\$9,985,383</b>	<b>135</b>	<b>\$7,411,998</b>

Temporary Suspension & Payment Suspension – A Temporary Suspension may be placed on a provider if a provider is under investigation by the Department or any state, local, or federal government law enforcement agency for fraud and abuse. A provider under a Temporary Suspension may not participate in the Medi-Cal Program. A Payment Suspension may be imposed on a provider upon receipt of credible evidence of fraud by a provider. When providers are placed on a payment suspension, they may continue to bill the Medi-Cal program for services provided. The reimbursement they claim is withheld and placed in a special holding account, pending the outcome of further investigation.

Procedure Code Drug Limits - when a provider is identified as over-utilizing certain codes and services, the provider may be placed on a billing limitation of specific procedure codes. This is imposed for a period of 18 months.

Prior Authorizations – when a provider is identified as having rendered unnecessary services, the provider may be placed under Prior Authorizations. Prior Authorization requires the provider to seek approval prior to rendering services. This is imposed for a period of two years.

Civil Money Penalties (CMP) is used for instances of improper claims, unnecessary services, or false information on claims. A CMP is implemented to warn providers about specific deficiencies in their program operation and is designed to urge providers to correct those deficiencies.

## **Key Accomplishments**

### **Expansion and Strengthening of the Pre-Check Write**

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

### **Random Claims Review (RCR)**

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

### **July 1, 2014 – June 30, 2016**

- A total of 2,283 claims representing 1,416 unique provider numbers have been reviewed.
- A total of 1,951 claims or 85 percent were determined to be valid.
- A total of 332 claims or 15 percent were determined to be improper.

### **Denied Claims Percentages**

The reasons claims were deemed improper for payment include:

- No documentation received (57 percent)
- Inadequate documentation to support the claim (11 percent)
- Documentation does not support service/product billed (6 percent)
- Documentation does not support level/quantity billed (5 percent)
- Service not performed (5 percent)
- Beneficiary is not provider's patient (3 percent)
- Provider billed in error (3 percent)
- Miscellaneous/ Other (10 percent)

MRB completes an analysis of all RCRs that result in a negative outcome. This analysis resulted in 10 providers undergoing a review by MRB. These reviews resulted in DHCS referring two providers to the DOJ for further investigation and possible prosecution and DHCS issuing six warning letters to providers.

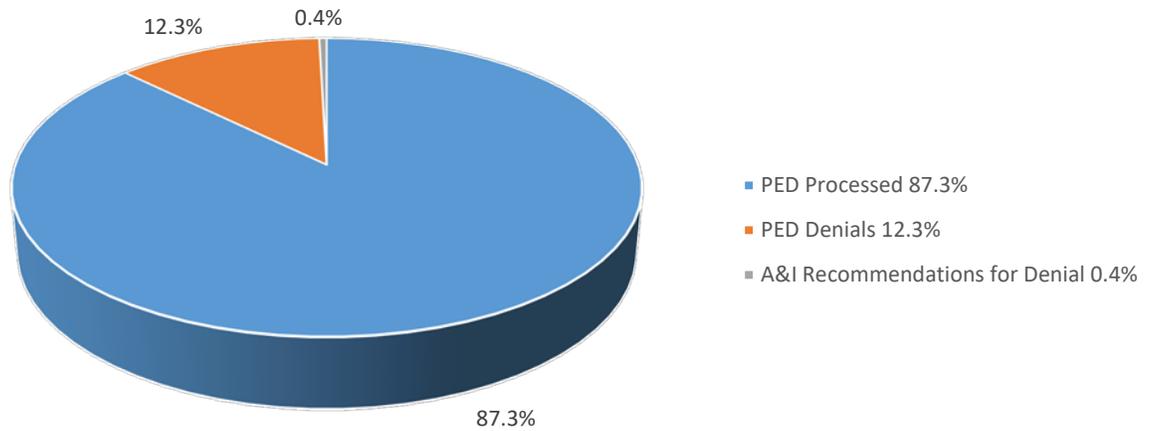
### Strengthening the Enrollment/Pre-Enrollment Process

Medi-Cal's anti-fraud enrollment process reduces the risk of fraudulent providers from enrolling or continuing enrollment in the Medi-Cal program. The Provider Enrollment Division (PED) thoroughly reviews all applications for enrollment. PED uses a number of confidential risk factors to evaluate the information provided on the applications. If an application contains invalid information, PED may deny the application. If an application lacks adequate justification for denial but is graded as high-risk for fraud, it is referred to MRB. MRB performs a more detailed investigation, including an on-site review, and then makes a recommendation to PED to approve or deny enrollment. PED reviewed 53,804 applications from providers in FY 2014-2015 and 2015-2016 and denied 6,001 of the applications received.

The following data reflects the results of the enrollment process for FY 2014-2015.

- PED received and processed 24,356 Medi-Cal provider enrollment applications. The application types include but are not limited to New Enrollment Applications, Address Change Applications, and Change of Ownership Applications.
- PED denied 3,003 (12 percent) applications.
- PED determined 738 (3 percent) applications warranted further analysis and referred the applications to MRB. MRB recommended 108 (0.4 percent) of the referred applications be denied.

### Enrollment Applications FY 2014-2015



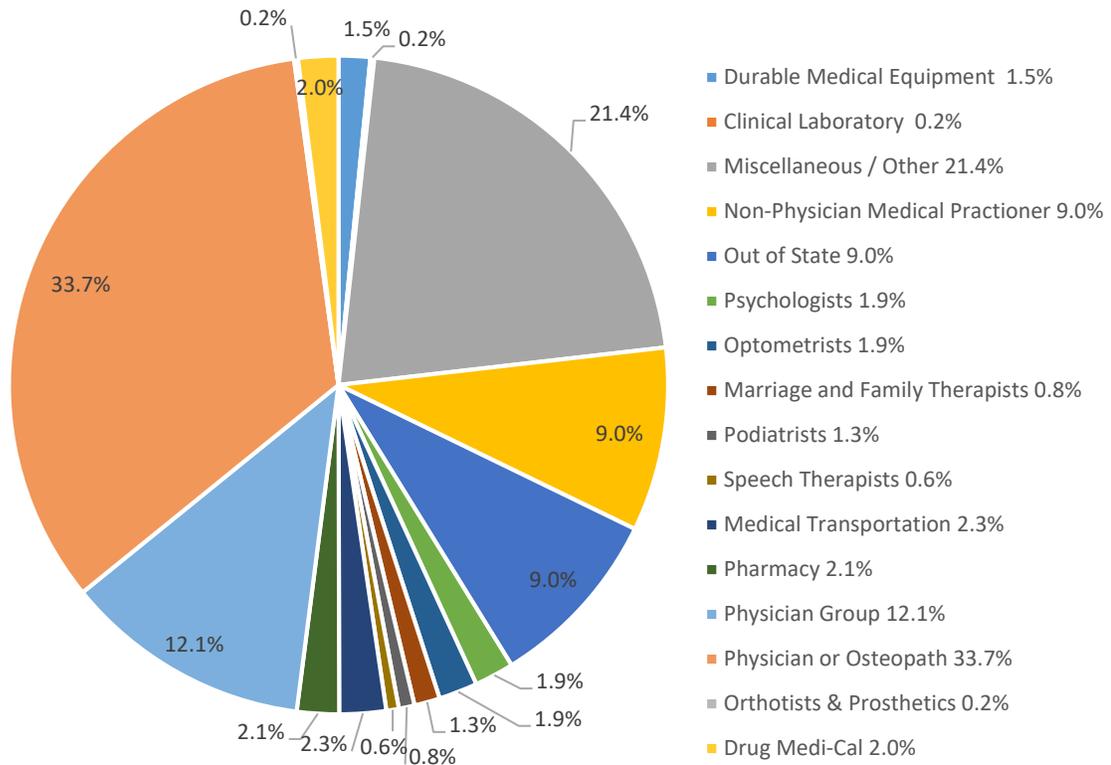
Enrollment Applications	Fiscal Year 2014-2015
PED Processed	87.3 percent
PED Denials	12.3 percent
A&I Recommendations for Denial	0.4 percent

Through combined reviews, PED and MRB denied 3,111 of the 24,356 applications (13 percent), including 10 denials resulting in a three-year debarment. The majority of applications denied were from physicians, with lower denials for Durable Medical Equipment (DME), clinical laboratories, medical transportation, Drug Medi-Cal, and pharmacy providers. Proportionate to the number of applications received, physician denials were the highest. Failure to correct application deficiencies and improprieties found during on-site reviews by MRB resulted in several denials. Improprieties range from not meeting Medi-Cal established place of business requirements to an ownership structure not being disclosed thoroughly or accurately.

Provider Type	Total Denied
Clinical Laboratory	6
Drug Medi-Cal	61
Durable Medical Equipment	48
Marriage and Family Therapists	39
Medical Transportation	71
Miscellaneous / Other	671
Non-Physician Medical Practitioners	280
Optometrists	59

Orthotists & Prosthetics	6
Out of State	279
Pharmacy	64
Physician Group	376
Physician or Osteopath	1,048
Podiatrists	24
Psychologists	60
Speech Therapists	19
<b>Total</b>	<b>3,111</b>

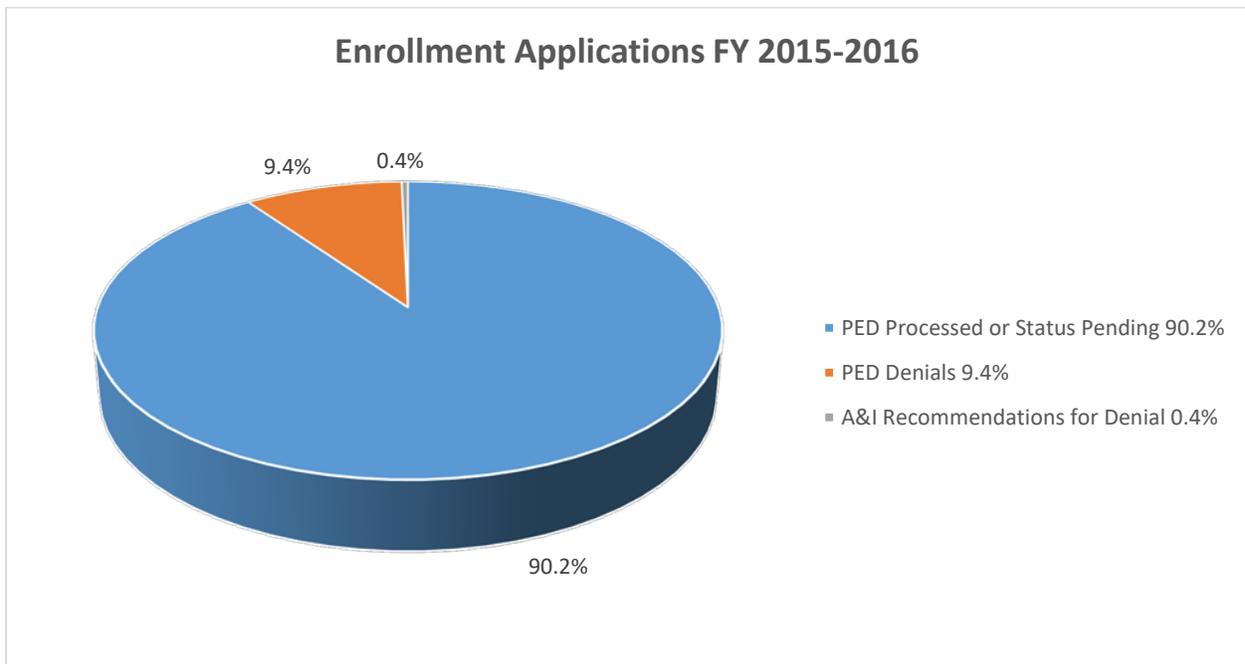
### Total Denied FY 2014-2015



Total Denied	Fiscal Year 2014-2015
Durable Medical Equipment	1.5 percent
Clinical Laboratory	0.2 percent
Miscellaneous / Other	21.4 percent
Non-Physician Medical Practitioners	9.0 percent
Out of State	9.0 percent
Psychologists	1.9 percent
Optometrists	1.9 percent
Marriage and Family Therapists	0.8 percent
Podiatrists	1.3 percent
Speech Therapists	0.6 percent
Medical Transportation	2.3 percent
Orthotists and Prosthetics	0.2 percent
Pharmacy	2.1 percent
Physician Group	12.1 percent
Physician or Osteopath	33.7 percent
Drug Medi-Cal	2.0 percent

The following data reflects the results of the enrollment process for FY 2015-2016.

- PED received and processed 29,448 Medi-Cal provider enrollment applications. The application types included, but were not limited to, New Enrollment applications, Address Change applications, and Change of Ownership applications.
- PED denied 2,780 (9 percent) applications.
- PED determined 851 (3 percent) of applications warranted further analysis and referred the application to MRB. MRB recommended 110 (0.4 percent) of the referred applications be denied.

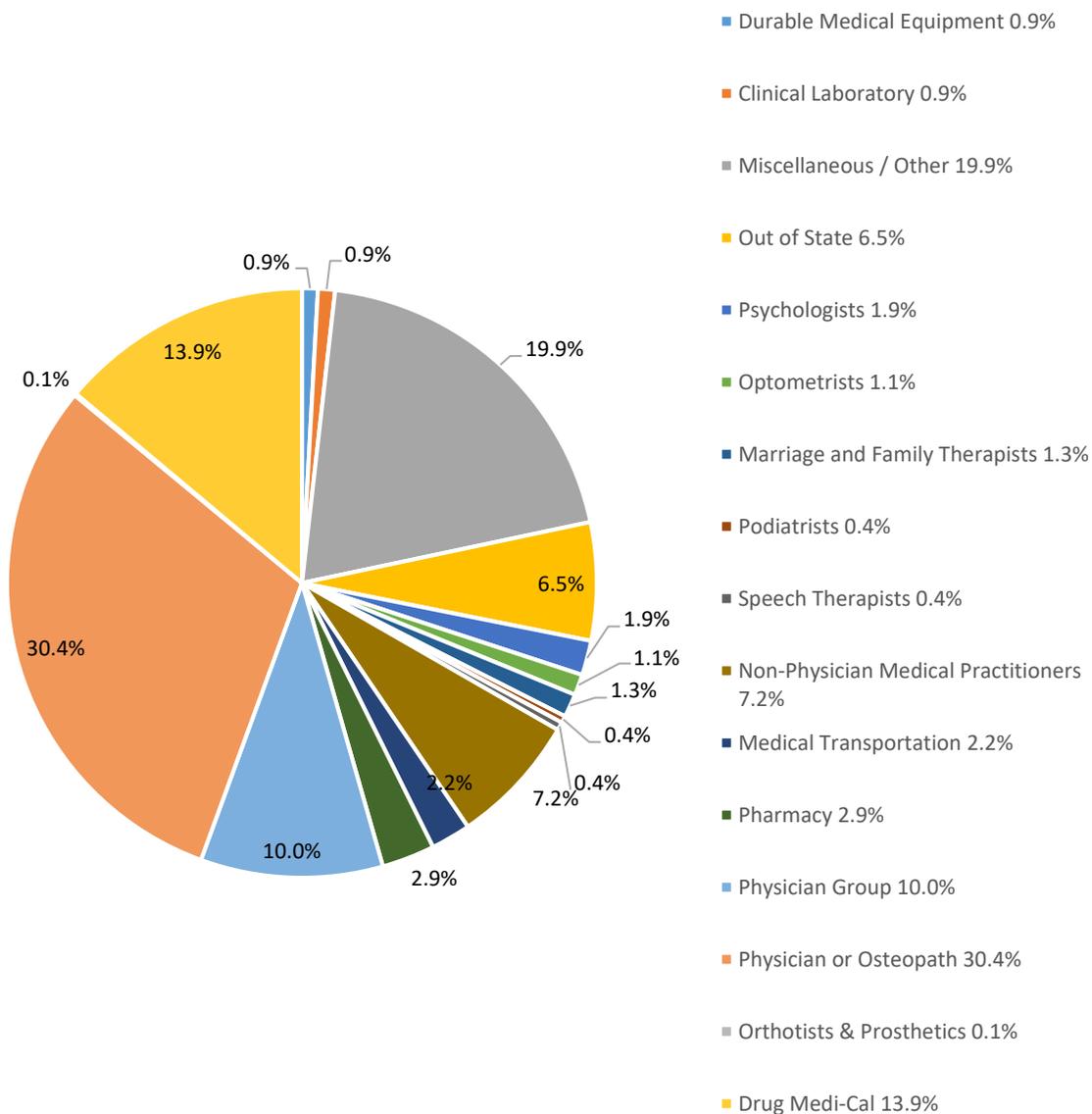


<b>Enrollment Applications</b>	<b>Fiscal Year 2015-2016</b>
PED Processed	90.2 percent
PED Denials	9.4 percent
A&I Recommendations for Denial	0.4 percent

Through combined reviews, PED and MRB denied 2,890 (10 percent) applications, including 26 denials resulting in a three-year debarment. As in the previous fiscal year, the majority of the applications denied were from physicians. There were fewer denials for DME, medical transportation, and pharmacy providers, for the same reasons.

<b>Provider Type</b>	<b>Total Denied</b>
Clinical Laboratory	27
Drug Medi-Cal	402
Durable Medical Equipment	25
Marriage and Family Therapists	37
Medical Transportation	63
Miscellaneous / Other	575
Non-Physician Medical Practitioners	208
Optometrists	33
Orthotists & Prosthetists	3
Out of State	187
Pharmacy	82
Physician Group	289
Physician or Osteopath	880
Podiatrists	11
Psychologists	55
Speech Therapists	13
<b>Total</b>	<b>2,890</b>

### Total Denied FY 2015-2016



<b>Total Denied</b>	<b>Fiscal Year 2015-2016</b>
Durable Medical Equipment	0.9 percent
Clinical Laboratory	0.9 percent
Miscellaneous / Other	19.9 percent
Non-Physician Medical Practitioners	7.2 percent
Out of State	6.5 percent
Psychologists	1.9 percent
Optometrists	1.1 percent
Marriage and Family Therapists	1.3 percent
Podiatrists	0.4 percent
Speech Therapists	0.4 percent
Medical Transportation	2.2 percent
Pharmacy	2.9 percent
Physician Group	10.0 percent
Physician or Osteopath	30.4 percent
Drug Medi-Cal	13.9 percent
Orthotists & Prosthetics	0.1 percent

### Re-Enrollment Status

Seven-hundred and twelve providers were selected to undergo re-enrollment for FY 2014-2015 and 2015-2016. New program integrity requirements established by the Centers for Medicare & Medicaid Services (CMS) under the Patient Protection and Affordable Care Act (PPACA) require state Medicaid programs to re-validate provider enrollment at least every five years. PED was required to re-validate all currently enrolled providers by March 2016. The re-validation requirement is similar to DHCS' current re-enrollment process. DHCS launched a web-based provider enrollment system, Provider Application and Validation for Enrollment (PAVE), in November 2016. By utilizing PAVE, DHCS will complete the revalidation of providers enrolled prior to March 25, 2011 who have not otherwise satisfied revalidation requirements. Based on the rollout of PAVE and a robust revalidation effort on behalf of DHCS, it is anticipated that the revalidation process will be complete in the spring of 2019.

### Payment Error Rate Measurement Study (PERM)

PERM is a federally mandated review of Medicaid and Children's Health Insurance Program (CHIP) managed care capitation and FFS payments, as well as eligibility determinations. CMS administers this review pursuant to the Improper Payments Information Act of 2002 (amended in 2012 by the Improper Payments Elimination and Recovery Act or IPERA) with the goal of measuring improper payments and calculating error rates.

CMS calculates improper payments by reviewing all 50 states every three years on a 17-state-per-year rotational basis. The most recently published PERM was issued in November 2017, which covered FY 2014-2016 and can be found at <https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf>.

## Medi-Cal Managed Care Plan (MCP) Audits

MRB continues to fulfill its statutorily-mandated responsibility to conduct an annual medical audit of each contracting Medi-Cal MCP for contract compliance. MRB has fully implemented the annual medical audits of each MCP. During FY 2014-2015, MRB initiated 23 audits and completed 11. In FY 2015-2016, MRB initiated 24 audits and completed 18. The audits are evolving in scope and nature to reflect the new requirements under the PPACA. MRB submits the audit reports to the auditee and Managed Care Quality and Monitoring Division (MCQMD). MCQMD works with the plan to develop a corrective action plan as necessary. The audit planning, analysis of plan documents, onsite reviews, report writing, and quality review procedures require a minimum of four months to complete. Medical Audit Reports and Corrective Action Plans may be found at <http://www.dhcs.ca.gov/services/Pages/MedRevAuditsCAP.aspx>.

These annual audits focus on six categories:

- Utilization Management
- Continuity of Care
- Availability and Accessibility
- Member's Rights
- Quality Management
- Administrative and Organizational Capacity

### Electronic Health Record (EHR)

The EHR Incentive Program provides EHR incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. DHCS is required to conduct audits of hospitals and professionals who receive EHR incentive payments as a result of the American Recovery and Reinvestment Act of 2011. The Office of Health Information Technology conducts pre-payment reviews for Adopt Implement and Upgrade (AIU). MRB conducted a risk assessment and is currently auditing eligible professionals and groups for AIU. In FY 2014-2015 and 2015-2016, 424 audits were initiated and 227 audits were completed. In addition, 13 AFRs were issued, totaling \$1,724,803 in recoveries.

### SIU Targeted Investigations

In FY 2014-2015 and 2015-2016, SIU visited seven provider types, totaling 43 individual providers.

- 15 providers were placed on Temporary Suspension, preventing millions of dollars in fraudulent claims, as \$29.5 million was billed by these providers in FY 2013-2014.
- 11 Demand Letters were issued, totaling approximately \$5.7 million.
- 14 CAF cases were referred to DOJ.

Furthermore, SIU's review of Federally Qualified Health Centers for FY 2014-2015 and 2015-2016 determined providers failed to report approximately \$1.3 million of Medi-Cal Managed Care payments. Recovery of the overpayments will be recovered by A&I's Financial Audits Branch through reconciliations.

### IB Investigations

During FY 2014-2015 and 2015-2016, IB opened 12,393 cases and closed 12,047 cases. Key accomplishments include:

- 120 arrests made
- 142 search warrants/subpoenas served
- 18 providers placed on temporary suspension
- 204 CAFs referred to DOJ