Status of Medi-Cal Fraud Control Initiatives

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California Department of Health Care Services
Audits & Investigations Division

Fiscal Years 2016-17 & 2017-18

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General Overview

The purpose of this report is to highlight the Department of Health Care Services' (DHCS) Fraud Control Initiatives for Fiscal Years (FY) 2016-17 and 2017-18. 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 7 positions reserved for program support. The bill also required DHCS to submit a quarterly report, which continued in subsequent budget acts through 2008.

Effective February 1, 2009, the annual Budget Act requires 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 (AB 1781, Laird, Chapter 268, Statutes of 2008). The annual Budget Act requires the report to include the following:

- Number of positions filled by division.
- Components of the initiative, including number of claims and beneficiary records reviewed, Error Rate Study, and Random Claim Sampling.
- Amount of savings and cost avoidance achieved and estimated.
- Number of providers sanctioned.

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.

More than 17 years have passed since the original positions were approved. Since that time, all 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.

(1) Number of Positions Filled by Division

While every DHCS employee plays a role in maintaining program integrity, the following divisions perform specific duties to address program integrity, including anti-fraud activities:

- Audits & Investigations (A&I)
- Provider Enrollment Division (PED)
- Third Party Liability and Recovery Division (TPLRD)
- California Medicaid Management Information System Operations Division (CA-MMIS)

Table 1 summarizes the total number of authorized positions for each respective division and the total number of positions performing anti-fraud activities as of June 2018. Anti-fraud activities is defined as any duty that is directly and indirectly related to the investigation of credible allegations of fraud. Direct duties involve investigative reviews. Indirect duties include, but are not limited to, data research and analytics, provider screening activities associated with provider enrollment, and post investigation recovery efforts of identified overpayments.

Table 1 – Summary of DHCS Anti-Fraud Positions

Division	Total Positions as of 06/2018	Positions Performing Anti-Fraud Activities	Percentage of Total
Audits & Investigations	781	214	27%
Provider Enrollment	133	77	57%
Third Party Liability and Recovery	190	7	4%
California Medicaid Management Information System Operations	126	2	2%
Total	1,230	300	24%

Audits & Investigations

A&I serves as DHCS' primary anti-fraud division and the designated Medicaid Program Integrity Unit (PIU). In this role, A&I coordinates with all other DHCS divisions in maintaining the integrity of the Medi-Cal program. As of June 2018, A&I's anti-fraud effort consists of 214 positions. Table 2 breaks down the anti-fraud positions by A&I branch or unit.

Table 2 – A&I Anti-Fraud Positions by Branch/Unit/Section

A&I Branch/Unit	Number of Positions	Percentage of Total
Special Investigations Unit	30	14%
Investigations Branch	76	35%
Medical Review Branch	94	44%
Analytics, Policy and Intake Section	14	7%
Total	214	100%

The anti-fraud positions within A&I belong to the distinct sections, units, and branches described below. The remaining A&I staff conduct various financial and compliance audits to verify the accuracy of provider cost reimbursements, assist with provider rate settings, managed care plan contractual compliance, corrective action plans, reimbursement reconciliations, and other programmatic objectives. We consider these non-anti-fraud activities to be an integral component of California's overall Medicaid PIU efforts.

Special Investigations Unit (30 anti-fraud positions)

The Special Investigations Unit (SIU) is comprised of auditors, medical professionals, sworn peace officers, and analytical/research staff. The SIU uses a multi-disciplinary team approach to identify and investigate Medi-Cal fraud, waste, and abuse using sophisticated data analytics to identify potential fraud and to target resources efficiently. The SIU addresses the most complex provider fraud investigations.

Investigations Branch (76 anti-fraud positions)

The Investigations Branch (IB) consists of sworn peace officers with the primary responsibility of investigating recipient fraud. The IB is also the lead investigative body for In-Home Supportive Services (IHSS) in California as authorized by California Welfare and Institutions Code (WIC) section 12305.82. Recipient fraud cases (the bulk of IB's caseload) are referred to local and federal prosecutors for criminal prosecution.

In some circumstances, the skill-sets of IB's sworn peace officers are also leveraged for select provider fraud cases when assistance is needed by other A&I units and branches.

Medical Review Branch (94 anti-fraud positions)

The Medical Review Branch (MRB) is a multi-disciplinary branch that includes medical professionals, 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. Areas of focus include data analytics, provider enrollment onsite reviews, billing and utilization reviews of fee-for-service providers, annual managed care plan audits, and preventative fraud measures that include random claim reviews and Individual Provider Claims Analyses Reports (IP-CAR). The IP-CAR serves as a report card for provider peer group performance comparisons.

Analytics, Policy, and Intake Section (14 anti-fraud positions)

The Analytics, Policy, and Intake Section (Intake Unit) is the centralized intake unit for processing Medi-Cal fraud complaints. The Intake Unit is also responsible for analyzing payer data for IHSS providers.

Provider Enrollment Division

PED is responsible for the timely enrollment, re-enrollment and monthly monitoring of medical providers and applicants, who meet all participation standards defined by federal and state statutes as well as regulations.

PED has a total of 133 positions, 77 of which perform anti-fraud activities. Pursuant to WIC section 14043.26, PED must complete an application review for a new physician or new physician group, within 90 days, which comprises the majority of applications processed by PED. Other types of provider applications, such as, psychologist, licensed clinical social worker, licensed midwives, nurse practitioner, physician assistant, podiatrists, etc., must be completed within 180 days.

The ability to identify and reject potentially fraudulent providers from admission into the Medi-Cal program is the first component of any anti-fraud program, and PED has significant safeguards and tools to address program integrity. All applications are closely screened by PED against the federal List of Excluded Individuals/Entities and System for Award Management and the Medicare and Medicaid termination database, which contains debarment and exclusion actions taken by Medicare and other state Medicaid programs. In addition, PED maintains a data repository called “Gatekeeper” that houses information regarding Medi-Cal providers and related individuals that have been flagged as suspect in DHCS audits, investigations, referrals, etc. PED updates this “watch list” monthly and it is utilized by PED and A&I to provide an additional control to prevent suspect providers from trying to enroll or re-enroll in the program.

A&I’s MRB is responsible for conducting all provider enrollment onsite reviews, and A&I’s IB is responsible for assisting PED with fingerprinting and background check requirements for designated high-risk provider types.

Third Party Liability and Recovery Division

TPLRD ensures that the Medi-Cal program complies with state and federal laws and regulations requiring that Medi-Cal be the payer of last resort. TPLRD accomplishes this by recovering Medi-Cal expenses from liable third parties and avoiding Medi-Cal cost by identifying or purchasing alternative health care coverage. TPLRD has a total of 190 positions. Of these 190 positions, 7 positions perform anti-fraud efforts.

California Medicaid Management Information System Operations Division

The CA-MMIS Operations Division operates and maintains the fiscal intermediary (FI), also known as CA-MMIS, processing and paying approximately $19 billion annually to health care providers in the Medi-Cal Fee-For-Service (FFS) program. The Division is responsible for the overall administration, management, oversight, and monitoring of the FI contract and all services provided under the contract. The 2 anti-fraud positions within CA-MMIS are analysts located in the Policy, Fraud and Support Services Unit. The positions have oversight and review of the Fiscal Intermediary's Post Service Pre-Payment Audits (PPM), Procedure Code/Drug Code Limitation restriction, Suspended and Ineligible Provider, and Suspect Provider Case activities within the FI's Provider Review Unit.

(2) Components of the Initiative

During FY 2016-17 and FY 2017-18, DHCS continued to employ components of the original initiative including the Error Rate Study, Pre-Check Write, and Enrollment and Re-Enrollment processes. Although DHCS did not separately track provider claims and beneficiary records for each of the initiatives in the referenced fiscal years, all initiatives involve claims and records review. As the initiatives have evolved to reflect the ever-changing Medi-Cal landscape, and other initiatives have been added to address current fraud trends (e.g., Targeted Investigations, Opioid Crisis), collectively, the anti-fraud activities continue to combat fraud, waste and abuse. These activities are highlighted below.

Error Rate Studies

Historically, DHCS tracked payment errors through the Payment Accuracy Measurement Study (PAM) which was submitted to the Legislature in 2005 as a Medi-Cal Payment Error Study. Due to developments in sampling strategies, the PAM Study transitioned to the Error Rate Study (ERS) to account for differences in claim lines and claim levels. ERS was later replaced by the Payment Error Rate Measurement Study (PERM), which is still conducted today.

Payment Error Rate Measurement Study

The PERM is a federally mandated review of Medicaid, Children's Health Insurance Program (CHIP), Managed Care Capitation and FFS payments, as well as eligibility determinations. The Centers for Medicare & Medicaid Services (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 3 years on a 17-state-per-year rotational basis. The most recent PERM results were issued in November 2019, which covered FY 2017-18 and 2018-19. CMS does not publish state specific results. A summary of aggregate PERM results can be found on page 117 of the CMS Financial Report:

https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2019.pdf

Medi-Cal Payment Error Study

Additionally, A&I publishes the Medi-Cal Payment Error Study (MPES). The MPES report measures overpayments in FFS Medi-Cal and estimates the percentage of fraudulent billing. The most recently published MPES was conducted in 2013 and issued in 2015. Of the total payments in the Medi-Cal FFS medical and dental programs, an estimated 7.96% had some indication that they contained a provider payment error. Findings revealed that 1.61% were for claims that disclosed some characteristics of potential fraud. The largest payment error category was documentation errors (47.1%), followed by policy errors (24.8%), coding errors (7.9%), and errors linked to Pharmacy prescriptions (8.4%). Given MPES workload and program risk, DHCS is reevaluating its measurement approach given the program shift from FFS to Managed Care.

Random Claim Review

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. A&I randomly selects claims for review prior to payment approval. The Random Claim Review (RCR) is a real-time look into services and trends in Medi-Cal billing. To increase detection, staff are cross trained to ensure familiarity with all claim types. A&I, in collaboration with CA-MMIS, developed a systematic process for randomly selecting claims for review. When a claim is selected, providers are required to submit documentation to support the claim prior to payment approval. Any claim that is not supported is denied. A&I continues to improve the process by focusing on claims with the highest potential of error. In addition to preventing improper claims from being paid, the 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.

During FY 2016-17 and 2017-18, due to competing workload, the RCR was suspended, and, subsequently no claims were reviewed under this process. In FY 2019-20, the RCR was reestablished. Outcomes of this initiative will be addressed in future reports.

Pre-Check Write

A&I uses auditing and investigative procedures to monitor provider practices and billing. Working with CA-MMIS, A&I 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, A&I staff conduct onsite Field Audit Reviews (FAR) of identified suspicious providers. As a result of the FAR process, A&I can place an administrative sanction on a provider, conduct an Audit for Recovery, or contact the State Controller to stop payment on a check.

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. 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 contains questionable information or presents a potential risk for fraud, it is referred to A&I. A&I performs a more detailed investigation, including an onsite review, and then makes a recommendation to PED to approve or deny enrollment.

During FY 2016-17 and 2017-18, DHCS reviewed 54,978 provider applications and denied 6,890 of the applications received. Table 3 highlights the number of applications submitted and denied for each respective fiscal year.

Table 3 – Summary of Applications Submitted and Denied

Provider Applications	FY 2016-17	FY 2017-18	Total
Submitted	28,269	26,709	54,978
Denied	4,092	2,798	6,890
Total	32,361	29,507	61,868

Post-Enrollment Monitoring

Post enrollment, PED conducts monthly monitoring of all enrolled providers. Under provisions of the 2010 Patient Protection and Affordable Care Act (ACA), providers are required to be monitored monthly to make certain they continue to meet state and federal standards of participation. The monthly monitoring of enrolled providers verifies that these providers have not subsequently been excluded from Medicare or another state Medicaid program since their last approved enrollment. All enrolled providers are screened through the Provider Application and Validation for Enrollment (PAVE) system against: inclusion on the federal List of Excluded Individuals/Entities, System for Award Management and the Medicare and Medicaid termination database, which contains debarment and exclusion actions taken by Medicare and other state Medicaid programs as part of the monthly monitoring process. If a provider is identified as having been excluded from participation from Medicaid, they are terminated from the Medi-Cal program.

Provider Application and Validation for Enrollment (PAVE)

In September 2018, DHCS fully deployed an enrollment portal and associated business process application with electronic provider management activities. During the FY 2016-17 and 2017-18, a list of provider types with the exception of Non-Medical Transportation and Diabetes Prevention Program that were enrolled through PAVE can be found at:

https://www.dhcs.ca.gov/provgovpart/Pages/Provider-Enrollment-Options.aspx

Some of the efficiencies of PAVE are:

- Improves provider experience with application guidance to providers utilizing intuitive questionnaires, in-context tutorials, hover help, digital assistant, and completion status bubbles.
- Assists providers in completing and submitting their applications.
- Reduces the number of incomplete applications submitted by providers.

- Improves application processing times resulting in providers enrolling sooner and improving access to care for Medi-Cal beneficiaries.
- Improves PED's business processes.
- Provides monthly monitoring of all enrolled providers against various exclusionary databases as well as the Social Security Death Master File in compliance with the ACA.
- Electronic management of the revalidation of all providers every five years in compliance with the ACA.

Re-Enrollment Status

Program integrity requirements established by CMS require state Medicaid programs to revalidate provider enrollment at least every five years. PED was required to revalidate all currently enrolled providers by March 2016. The revalidation requirement is similar to DHCS' current re-enrollment process and was tracked through the PAVE system.

The effort to revalidate providers was delayed due to a sharp increase in applications that providers submitted in response to the 21st Century Cures Act. Aided by PAVE's full deployment in September 2018, PED continues its efforts to complete all required revalidations.

Electronic Health Record

The Medi-Cal Promoting Interoperability Program, formerly known as the Electronic Health Record (EHR) Incentive Program, provides 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). A&I conducted a risk assessment and is currently auditing eligible professionals and groups for Meaningful Use (MU) and finishing AIU audits. In FY 2016-17, A&I completed 102 audits (5 of which resulted in the collection of $92,083 for noncompliance). In FY 2017-18, A&I completed 25 audits (12 of which resulted in the collection of $240,834 for noncompliance).

Targeted Investigations

DHCS receives approximately 1,400 complaints per month from multiple sources including, other governmental agencies, Managed Care Plans, and the general public. DHCS utilizes a decision tree to evaluate each complaint, which takes into account the source of the complaint, completeness of the complaint, the timeframe of the suspected fraudulent activity, and the dollar amount of Medi-Cal claims at risk.

The results of the decision tree determine how each complaint is handled. Each complaint results in either an assignment for investigation, the sending of an educational letter to a provider and/or beneficiary or a referral made to another governmental agency.

Table 4 – Summary of Complaints and Cases Opened

Activities	FY 2016-17	FY 2017-18	Total
Complaints	12,870	15,770	28,640
Cases	1,587	2,604	4,191
Total	14,457	18,374	32,831

In addition, A&I utilizes advanced data analytics to gain an understanding of emerging fraud trends and program vulnerabilities, which include providers providing beneficiaries with expensive unnecessary drugs, such as benzodiazepines and Xanax; providers paying kickbacks in exchange for beneficiary access; marketing to attract beneficiaries to a particular provider and location; providers falsifying medical and billing records; and providers creating fake identities of beneficiaries, incorrectly determining eligibility, and soliciting and enrolling clients who have no medical necessity. A&I has also uncovered trends relating to unauthorized and excessive dispensing of drugs, as well as billing for expensive human immunodeficiency virus (HIV) and antipsychotic medications without reasonable evidence of medical necessity.

Opioid Crisis

As the opioid epidemic grows, A&I continues to work diligently through new and existing relationships with various law enforcement agencies and Managed Care Plans. A&I's IB assists Managed Care Plans in restricting opioid access to beneficiaries abusing Medi-Cal benefits through "drug seeking" behavior. Additionally, IB works jointly with federal, state and local agencies on a variety of cases to combat the rising opioid epidemic which include investigations involving Substance Use Disorder (SUD) facilities and providers. This partnership most recently resulted in multiple arrests of physicians, pharmacists and co-conspirators in a joint case entitled, "Operation Hypocritical Oath."

(3) Cost Savings and Cost Avoidance

During FY 2016-17 and 2017-18, DHCS continued to achieve significant positive results related to its anti-fraud initiatives totaling $256 million. A breakdown of each Division's Return on Investment (ROI) is below. Note: PED savings due to enrollment and re-enrollment activities and TPLRD anti-fraud efforts are reflected in A&I's ROI.

Table 5 – Summary of Return on Investment (ROI)

Division	ROI FY 2016-17	ROI FY 2017-18	Total
A&I	$80,675,313	$136,762,279	$217,437,592
CA-MMIS	$14,491,779	$24,401,287	$38,893,066
Total	$95,167,092	$161,163,566	$256,330,658

A&I Cost Savings and Cost Avoidance

A&I's overall ROI during FY 2016-17 and 2017-18 was $899 million. Of this amount, $217 million was directly related to anti-fraud efforts detailed below. The other $682 million of ROI was the result of financial audits. The total average ratio for savings in FY 2016-17 and 2017-18 was $2.11 for every $1 spent ($1.50 for FY 2016-17 and $2.72 for FY 2017-18).

Table 6 – Summary of Cost Savings and Cost Avoidance

Category	FY 2016-17	FY 2017-18	Total
Cost Avoidance (Denied Enrollment)[1]	$49,864,530	$100,494,072	$150,358,602
Cost Savings (Change in Billing Behavior)[2]	$23,395,095	$9,226,033	$32,621,128
Recoveries[3]	$7,415,688	$27,042,174	$34,457,862
Total	$80,675,313	$136,762,279	$217,437,592

CA-MMIS Cost Savings

Savings from Suspicious Provider Billing cases identified by the CA-MMIS FI are presented in the table below.

Table 7 – Summary of CA-MMIS Cost Savings

Category	FY 2016-17	FY 2017-18	Total
Savings	$13,174,345	$22,182,988	$35,357,333
Minus 10% fee Paid to Fiscal Intermediary (FI) for cases accepted by A&I	$1,317,434	$2,218,299	$3,535,733
Total	$11,856,911	$19,964,689	$31,821,600

CAF Referrals

The written form or referral evidencing an allegation of fraud is called a Credible Allegation of Fraud (CAF). Under WIC section 14107.11(d), “An allegation of fraud shall be considered credible if it exhibits indicia of reliability as recognized by state or federal courts or by other law sufficient to meet the constitutional prerequisite to a law enforcement search or seizure of comparable business assets.” Allegations supported with evidence may result in suspension of Medicaid payments pending an investigation unless a good cause exception is implemented.

[1] 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.
[2] Cost Savings reflect the calculated total dollars saved due to administrative sanctions placed on Medi-Cal providers, thus reducing their future reimbursements.
[3] Recoveries reflect actual dollars collected as reported by Third Party Liability and Recovery Division.

Table 8 highlights CAFs referred to the Department of Justice during FY 2016-17 and 2017-18.

Table 8 – Summary of Credible Allegation of Fraud Referrals

Provider Type/Case Type	Number of CAF Referrals
Community Based Adult Services	2
Assisted Living	2
Community Clinic	2
Dental	4
Drug Medi-Cal Treatment	1
Durable Medical Equipment	2
Home Health Agency	2
In Home Support Services	120
Local Education Agency	2
Long Term Care Facility	2
Pharmacy	13
Physician/Physicians Group	4
Rural Health Center/Federally Qualified Health Center	6
Total	156

(4) Provider Sanctions

Under WIC section 14304, DHCS may impose administrative sanctions on Medi-Cal providers. During FY 2016-17 and 2017-18, the following actions were taken:

Table 9 – Summary of Provider Sanctions Imposed

Actions Taken	Actions Imposed FY 2016-17	Actions Imposed FY 2017-18	Total
Temporary Suspensions & Payment Suspensions[4]	39	24	63
Civil Money Penalties (1st, 2nd, 3rd warning notices)[5]	35	41	76
Procedure Code Drug Limits[6]	2	0	2
Prior Authorizations[7]	0	0	0
Total	76	65	141

[4] 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.

[5] 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.

[6] Procedure Code Drug Limits (P\DCL) – 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. The P\DCL process originates with a request from A&I. The California Medicaid Management Information System Operations Division verifies the providers information, instructs the Fiscal Intermediary to implement A&I's actions, and publishes any actions taken against that provider on the Medi-Cal website. If appropriate, an Erroneous Payment Correction will be processed to recoup any claims erroneously paid out for suspended codes submitted by the provider during the period of suspension. Additionally, moving forward claims for suspended procedure/drug codes will not be paid out to the provider for the period annotated on the suspension.

[7] 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.