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Department of Health Care Services



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DATE: December 30, 2015

ALL PLAN LETTER 15-026

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ACTIONS REQUIRED FOLLOWING NOTICE OF A CREDIBLE ALLEGATION OF FRAUD

PURPOSE:

This All Plan Letter (APL) provides guidance to Medi-Cal managed care health plans (MCPs) on actions they must take upon receipt of information that the Department of Health Care Services (DHCS) has determined that a credible allegation of fraud exists against a provider that is part of the MCP network.

BACKGROUND:

The MCP contract, under Exhibit E, Attachment 2, "Program Terms and Conditions," "Fraud and Abuse Reporting," describes the MCP fraud and abuse reporting requirements, the elements of a mandatory compliance plan to guard against fraud and abuse, and additional MCP requirements.¹

Title 42, Code of Federal Regulations (CFR), Section (§) 455.2 provides the definition: "A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including, but not limited to, the following:

- (1) Fraud hotline complaints.
- (2) Claims data mining.
- (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis."

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS's guidance, including APLs.

¹ The MCP boilerplate contracts are available at:
<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>.

POLICY:

When DHCS notifies the MCP that a credible allegation of fraud has been found against a provider relating to provision of Fee-For-Service Medi-Cal services and that provider is also part of the MCP network, an MCP must take one or more of the following four actions and submit all supporting documentation to the MCQMD@dhcs.ca.gov inbox:

1. Terminate the provider from its network;
2. Temporarily suspend the provider from its network pending resolution of the fraud allegation;
3. Temporarily suspend payment to the provider pending resolution of the fraud allegation; and/or
4. Conduct additional monitoring including audits of the provider's claims history and future claims submissions for appropriate billing.

The MCP must notify DHCS as to which of the above four actions it takes. No action will be required that would interfere with state or federal criminal investigations. If the MCP elects Option 4 referenced above, the MCP must take the following steps and submit all documentation to the MCQMD@dhcs.ca.gov inbox:

1. Immediately implement enhanced monitoring as follows:
 - Monitor relevant claims, claim lines, and encounter data and complete the initial review within 30 calendar days;
 - Provide weekly updates to DHCS until a determination is made as to whether or not an on-site visit is necessary; and
 - Make an initial determination as to whether an on-site visit is necessary after completing the initial review of relevant claims/encounter data. The MCP must consult with DHCS on the need for an on-site review within 10 business days of completing the initial review. The MCP must seek DHCS approval if the initial determination concludes an on-site visit is not warranted.
2. If the MCP's initial determination identifies a potential incident(s) of fraud, waste, or abuse, or otherwise validates DHCS's credible allegation of fraud finding, the MCP must:
 - Commence an audit for the subject provider or subcontractor within 10 business days of validating the credible allegation of fraud, waste, or abuse, or within 10 days of validating DHCS's credible allegation of fraud. The audit must be conducted earlier if the MCP identifies activity that warrants immediate action;

- Provide DHCS with a copy of the final audit report and findings within 45 days;
- Provide DHCS with a copy of the corrective action plan it has imposed on the Medi-Cal provider, which will include specific milestones and timelines for completion;
- Provide DHCS with bi-weekly updates related to the corrective action plan;
- Audit the provider or subcontractor again within six months of closing the corrective action plan to confirm amelioration of the findings;
- Terminate the provider from the MCP's network should there be repeat findings that are significant in nature. The MCP must seek approval from DHCS in situations where the provider is not to be terminated from the MCP's network; and
- Provide DHCS with an outline of oversight activity the MCP will conduct to ensure there is no further fraud, waste, or abuse.

If you have any questions regarding this APL, contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
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