California State Auditor

FACT SHEET

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The California State Auditor released the following report today:

California Department of Health Care Services

Its Failure to Properly Administer the Drug Medi-Cal Treatment Program Created Opportunities for Fraud

BACKGROUND

The State provides health care services to the aged, disabled, and indigent through the California Medical Assistance Program, known as Medi-Cal. Eligible individuals can receive substance abuse services, including outpatient drug-free treatment services (outpatient drug-free services), through the Drug Medi-Cal Treatment Program (program) when physicians determine they are medically necessary. Effective July 1, 2012, state law transferred to the California Department of Health Care Services (Health Care Services), from the California Department of Alcohol and Drug Programs (ADP), the responsibility of administering the program. ADP and Health Care Services certified providers and negotiated contracts with each county or directly with those providers to ensure access to program services.

KEY FINDINGS

During our review of the program and a selection of counties responsible for administering it, we noted the following:

- Between July 1, 2008 and December 31, 2013, the State approved nearly $1 million to potentially ineligible providers, the majority of which Health Care Services believes it recovered through a subsequent cost-settlement process.
- Our analysis of four years of statewide billing data identified $93.7 million in payments that Health Care Services and ADP authorized for more than 2.6 million outpatient drug-free services that are potentially indicative of fraudulent activity.
- Neither Health Care Services nor ADP had adequate controls to identify payments made to ineligible providers and deceased beneficiaries when they approved the payments—the State authorized payments totaling more than $10,000 related to purportedly deceased beneficiaries.
- We found that 10 providers could not locate the patient records or provide adequate documentation to justify the reimbursement claims for roughly 22 percent of the services we reviewed in three counties.
- Both Health Care Services and ADP certified providers did not disclose required background information—only one of the 30 provider applicants we selected for testing made complete disclosures yet the departments certified all 30.
  - ✓ Both departments did not perform database searches as required to screen provider applicants for 22 of the 25 applicant files that we reviewed.
  - ✓ Neither department consistently complied with the program's certification processes before certifying provider applicants.
  - ✓ To eliminate a backlog of provider applications, ADP performed a less stringent review of the applications for a five-month period and thus, increased the risk of fraud and abuse in the program.
- Health Care Services is in the process of implementing recommendations from its 2013 internal review that highlighted numerous weaknesses and inefficiencies in administering the program and in coordinating with counties. Until it fully implements these recommendations, it cannot ensure that it addresses fraud in the program and effectively mitigates the State's financial and legal risks.

KEY RECOMMENDATIONS

We made numerous recommendations to Health Care Services including that it:

- Ensure providers are reimbursed only for valid services and that it coordinates with counties to recover inappropriate payments and that it develops and implements new procedures for routinely identifying and initiating recovery efforts for payments it authorizes to decertified providers and to deceased beneficiaries.
- Prevent certifying ineligible providers by instructing staff to identify inadequate program applications by comparing them to disclosure statements, conducting required database searches, and designating risk levels for applicants.
- Ensure that it appropriately and consistently reviews provider applications by following its procedures to screen provider applicants' eligibility and retain documentation to support its certification decisions.
- Strengthen coordination between the State and the counties to address gaps in their collective monitoring efforts and improve coordination between its divisions and branches to ensure it addresses fraud allegations timely.

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