

DEPARTMENT OF HEALTH SERVICES

It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities

Audit Highlights . . .

Our review of the Department of Health Services' (Health Services) activities to identify and reduce provider fraud in the California Medical Assistance Program (Medi-Cal) revealed the following:

- Because it has not yet assessed the level of improper payments occurring in the Medi-Cal program and systematically evaluated the effectiveness of its antifraud efforts, Health Services cannot know whether its antifraud efforts are at appropriate levels and focused in the right areas.*
- Health Services has not clearly communicated roles and responsibilities and has not adequately coordinated antifraud activities both within Health Services and with other entities, which has contributed to some unnecessary work or ineffective antifraud efforts.*
- An updated agreement with the California Department of Justice could help Health Services better coordinate investigative efforts related to provider fraud.*

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Departments of Health Services' and Justice's responses as of December 2003

The Joint Legislative Audit Committee (audit committee) asked us to review the Department of Health Services' (Health Services) reimbursement practices and the systems in place for identifying potential cases of fraud in the Medi-Cal program, with the aim of identifying gaps in California's efforts to combat fraud. Many of the concerns we report point to the lack of certain components of a model fraud control strategy to guide the various antifraud efforts for the Medi-Cal program. Specifically, we found:

Finding #1: Health Services lacks some components of a model fraud control strategy.

Although Health Services has received many additional staff positions and has established a variety of antifraud activities to combat Medi-Cal provider fraud, it lacks some components of a comprehensive strategy to guide and coordinate these activities to ensure that they are effective and efficient. Specifically, it has not yet developed an estimate of the overall extent of fraud in the Medi-Cal program. Without such an assessment, Health Services cannot be sure it is targeting the right level of resources to the areas of greatest fraud risk. The Legislature approved Health Services' 2003 budget proposal for an error rate study to assess the extent of improper payments in the Medi-Cal program, and Health Services is just beginning this assessment.

In addition, Health Services has not clearly designated who is responsible for implementing the Medi-Cal fraud control program. A model antifraud strategy involves a clear designation of responsibility for fraud control, which in turn requires someone or a team with authority over the functional components that implement the antifraud program. Although Audits

- ☑ *Because it lacks an individual or team with the responsibility and authority to ensure fraud control issues and recommendations are promptly addressed and implemented, some well-known problems may go uncorrected.*
 - ☑ *Health Services does not obtain sufficient information to identify and control the potential fraud unique to managed care.*
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and Investigations (audits and investigations) is the central coordination point for antifraud activities within Health Services, some antifraud efforts are located in other divisions and bureaus of Health Services or in other state departments over which audits and investigations has no authority. Thus, audits and investigations' designation as the central coordination point within Health Services does not completely fill the need for an individual or team that crosses departmental lines and is charged with the overall responsibility and authority for detecting and preventing Medi-Cal fraud.

Rather than measuring the impact of its efforts by the amount of reduction in fraud, Health Services measures its success by reference to unreliable savings and cost avoidance estimates. A component of a model antifraud strategy requires evaluating the impact of antifraud efforts on fraud both before and after implementation of the effort. However, Health Services measures its efforts by the achievement of goals established during the development of its savings and cost avoidance estimates. Although antifraud efforts offer savings, they also need to be measured against their effect on the overall fraud problem to determine whether the control activities should be adjusted.

Finally, Health Services does not currently have processes to ensure that each claim faces some risk of fraud review. According to Health Services, although its current claims processing system subjects each claim to certain edits and audits, it does not subject each claim to the potential for random selection and in-depth evaluation for the detection of potential fraud. The 2003 budget proposal included establishing a systematic process to randomly select claims for in-depth evaluation and this is one of the components the Legislature approved.

We recommended that Health Services develop a complete strategy to address the Medi-Cal fraud problem and guide its antifraud efforts. This should include adding the currently missing components of a model fraud control strategy, such as an annual assessment of the extent of fraud in the Medi-Cal program, an outline of the roles and responsibilities of and the coordination between Health Services and other entities, and a description of how Health Services will measure the performance of its antifraud efforts and evaluate whether adjustments are needed.

Health Services' Action: Pending.

Health Services stated that it is in the process of implementing the model fraud control strategies. It has received federal funding for evaluating and measuring payment accuracy and will develop plans for annual payment accuracy studies that will aid in allocating resources and evaluating fraud deterrence and detection efforts. Health Services also stated that it will document the roles and responsibilities of the various programs participating in antifraud efforts and will work with the Health and Human Services Agency to improve the coordination of antifraud activities with other departments under its authority.

Finding #2: Health Services has not yet conducted routine and systematic measurements of the extent of fraud in the Medi-Cal program.

Health Services has not systematically assessed the amount or nature of improper payments in the Medi-Cal program. Improper payments include any payment to an ineligible beneficiary, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for applicable discounts. Without this information, Health Services does not know whether it is overinvesting or underinvesting in its payment control system, or whether it is allocating resources in the appropriate areas.

The Legislature approved portions of Health Services' May 2003 budget proposal including an error rate study and random sampling of claims. Building upon its authorization to conduct an error rate study, in August 2003 Health Services applied to the federal Centers for Medicare and Medicaid Services to participate in its Payment Accuracy Measurement (PAM) project for fiscal year 2003–04. In its PAM proposal, Health Services stated that it would develop an audit program to accomplish certain objectives, including identifying improper payments, and a questionnaire to confirm that a beneficiary actually received the services claimed by the provider. However, until Health Services completes its audit program and procedures, it is premature to conclude on the adequacy of its approach to verify services with beneficiaries to estimate the level of fraudulent payments.

We recommended that Health Services establish appropriate claim review steps, such as verifying with beneficiaries the actual services rendered, to allow it to estimate the amount of fraud in the Medi-Cal program as part of its PAM study. We also recommended that it ensure the payment accuracy benchmark developed by the PAM model is reassessed by annually monitoring and updating its methodologies for measuring the amount of improper payments in the Medi-Cal program.

Health Services' Action: Pending.

Health Services reported that it will ensure an appropriate claim review step is included to verify with the beneficiary that actual services were rendered. It also plans to reassess monitoring and measurement methodologies annually.

Finding #3: Health Services does not evaluate the effect on the extent of fraud of its antifraud activities and uses unreliable savings estimates.

Health Services does not perform a cost-benefit analysis for each of its antifraud activities, nor does it use reliable savings estimates to justify its requests for additional antifraud positions. According to Health Services, it uses a form of cost-benefit analysis, using estimated savings or cost avoidance as the benefit, to make decisions regarding resource allocations. Health Services indicated that it looks at the costs and savings of its antifraud activities in the aggregate and not by specific activity because not all the fraud positions it received are directly involved in savings and cost avoidance activities. Although it acknowledged that it does not use a formal cost-benefit analysis, Health Services asserts that it performs an intuitive type of assessment.

Health Services computes a savings and cost avoidance chart (savings chart) to estimate the savings it expects to achieve from its antifraud activities in the current and budget year. Health Services also uses the savings chart to quantify the achievements of each of its antifraud activities in the prior year and as a management tool to allocate resources. Health Services used the savings chart it created in November 2002 to support its request for 315 new positions for antifraud activities in its May 2003 budget proposal, of which the Legislature ultimately approved 161.5 positions.

However, Health Services' November 2002 savings chart potentially overstates its estimated savings because of a flaw in the methodology it uses to calculate the savings. Health Services

calculates its savings and cost avoidance estimates for some categories by using the average 12-month paid claims history of providers who have been placed on administrative sanctions. Health Services assumes that 100 percent of the claims it paid during the prior 12-month period to those providers sanctioned in the current year would be savings in the budget year. However, it does not perform any additional analysis to determine what proportion of the sanctioned providers' paid claims was actually improper. We questioned the soundness of Health Services' methodology because even though the improper portion of the claim history would be potential savings, any legitimate claims submitted by the sanctioned provider could continue as a program cost for beneficiaries who would presumably receive health care services from another provider who would bill the program.

We recommended that Health Services perform cost-benefit analyses that measure the effect its antifraud activities have on reducing fraud. Additionally, it should continuously monitor the performance of these activities to ensure that they remain cost-effective.

Health Services' Action: Pending.

Health Services stated that through the use of enhanced data analysis software and relationships with its various contractors, it will develop a standard cost-benefit analysis methodology for each antifraud proposal.

Finding #4: The provider enrollment process continues to need improvement.

Health Services' Provider Enrollment Branch (enrollment branch) screens applications to ensure that the providers it enrolls are eligible to participate in the Medi-Cal program. This includes ensuring that all Medi-Cal providers have completed applications, disclosure statements, and agreements on file, to help it determine whether providers have any related financial and ownership interests that may give them the incentive to commit fraud or were previously convicted of health care fraud. It also must suspend those Medi-Cal providers whose licenses and certifications are not current or active. Although these activities are important first lines of defense in preventing fraudulent providers from participating in the Medi-Cal program, the enrollment branch is not fully performing either of these activities.

In our May 2002 report, *Department of Health Services: It Needs to Significantly Improve Its Management of the Medi-Cal Provider Enrollment Process*, Report 2001-129, we made a number of recommendations to improve the provider enrollment process. However, the enrollment branch has not fully implemented many of these recommendations. For example, we recommended that the enrollment branch use its Provider Enrollment Tracking System to ensure that it sends notifications to applicants at proper intervals. However, the enrollment branch still does not track whether it sends the required notifications to applicants, nor does it notify a provider when an application is sent to audits and investigations for secondary review.

New legislation that took effect on January 1, 2004, increases the importance of sending these notifications. If the enrollment branch does not notify applicants within 180 days of receiving their applications that their application has been denied, is incomplete, or that a secondary review is being conducted, it must grant the applicant provisional provider status for up to 12 months. Moreover, this new legislation requires these notifications for applications be received before May 1, 2003. As of September 29, 2003, the enrollment branch had 1,058 applications still open that it received before May 1, 2003. If the enrollment branch did not notify these applicants of its decision on or before January 1, 2004, it must grant them provisional provider status regardless of any ongoing review.

It is noteworthy that when the enrollment branch refers applications to audits and investigations for secondary review, the processing time typically extends well beyond 180 days. Because audits and investigations currently has about a six-month backlog, the first thing an analyst does when performing a preliminary desk review is contact the applicant to verify the current address and continued interest in applying to the program. The analyst also redoes some of the screening previously performed by the enrollment branch, such as checking to confirm that the applicant's license is valid, resulting in inefficiencies and further extending the time applicants are left waiting.

Health Services is unable to ensure that all provider applications are processed consistently and in conformity with federal and state program requirements. The enrollment branch reviews applications for certain provider types, such as physicians, pharmacies, clinical labs, suppliers of durable medical equipment, and nonemergency medical transportation. The enrollment

branch checks a variety of sources to confirm licensure, verify the information provided on the application, confirm that the applicant has not been placed on the Medicare list of excluded providers, and refers many applications to audits and investigations for further review. However, other divisions within Health Services and other departments responsible for reviewing certain types of provider applications and recommending provider enrollment do not conduct a similar review. Since different units and departments screen providers against different criteria, Health Services may be allowing ineligible individuals to participate as providers in the Medi-Cal program.

Health Services' procedures are not always effective to ensure that enrolled providers remain eligible to participate in the Medi-Cal program. Our review of 30 enrolled Medi-Cal providers that Health Services paid in fiscal year 2002–03 disclosed two with canceled licenses. Even though state law requires providers whose license, certificate, or approval has been revoked or is pending revocation to be automatically suspended from the Medi-Cal program effective on the same date the license was revoked or lost, as of August 2003, the provider numbers for both of these providers were being used to continue billing and receiving payment from the Medi-Cal program every month since the cancellations occurred. Our review of the 30 selected providers also found that, despite the fraud prevention capabilities these required disclosures and agreements provide, the enrollment branch did not always have the agreements and disclosures required by state and federal regulations. Two of the 30 provider files we reviewed did not contain disclosure statements, and Health Services could not locate agreements for 24 of these providers. The disclosure statements provide relevant information to ensure that the provider has not been convicted of a crime related to health care fraud, and that the provider does not have an incentive to commit fraud based on the financial and ownership interests disclosed. The provider agreements give Health Services a certification that the provider will abide by federal and state laws and regulations, will disclose all financial and ownership interests and criminal background, will agree to a background check and unannounced visit, and will agree not to commit fraud or abuse.

Our May 2002 audit recommended that the enrollment branch consider reenrolling all provider types. Reenrollment would improve the enrollment branch's ability to ensure that all providers have current licenses, disclosure statements, and agreements on file. Although the enrollment branch has begun

reenrolling certain provider types it has identified as high risk, it has not developed a strategy to reenroll all providers and does not have a process to periodically check the licensure of existing providers with state professional boards. Additionally, it has not completed an analysis to determine what resources it would need to reenroll all providers.

To improve the processing of provider applications, we recommended that Health Services complete its plan and related policies and procedures to process all applications or send appropriate notifications within 180 days, complete the workload analysis we recommended in our May 2002 audit report to assess the staffing needed to accommodate its application processing workload, and improve its coordination of efforts between the enrollment branch and audits and investigations to ensure that applications, as well as any appropriate notices, are processed within the timelines specified in laws and regulations.

To ensure that all provider applications are processed consistently within its divisions and branches and within other state departments, we recommended that Health Services ensure that all individual providers are subjected to the same screening process, regardless of which division within Health Services is responsible for initially processing the application. In addition, we recommended that Health Services work through the California Health and Human Services Agency to reach similar agreements with the other state departments approving Medi-Cal providers for participation in the program.

To ensure that all providers enrolled in the Medi-Cal program continue to be eligible to participate, we recommended that Health Services develop a plan for reenrolling all providers on a continuing basis; enforce laws permitting the deactivation of providers with canceled licenses or incomplete disclosures; and enforce its legal responsibility to deactivate provider numbers, such as when there is a known change of ownership. Further, we recommended that Health Services establish agreements with state professional licensing boards so that any changes in license status can be communicated to the enrollment branch for prompt updating of the Provider Master File.

Health Services' Action: Pending.

Health Services stated it has taken some steps to improve the processing of provider applications and has created a workgroup to establish a complete work plan for processing applications as required by the new legislation. It will also evaluate the internal workload study on application processing and finalize the analysis. With the addition of new staff to enhance antifraud efforts, Health Services noted that provider enrollment and audits and investigations began to develop closer working relationships, and cited various actions taken to improve communication and coordination. In addition, its programs will participate and coordinate internally, as well as with other departments, programs, and entities that perform similar enrollment functions with the aim of using consistent enrollment processing procedures. Finally, Health Services indicates that it is developing a plan to reenroll all providers, will improve its procedures to ensure that provider numbers are properly deactivated, and is working with professional licensing boards to obtain provider permit and licensing information that is timely and readily useable.

Finding #5: The pre-checkwrite process could achieve more effective results.

Health Services has a review process it calls pre-checkwrite that identifies and selects certain suspicious provider claims for further review from the weekly batch of claims approved for payment. Although the pre-checkwrite process appears effective in identifying suspicious providers, Health Services does not review all of the providers flagged as suspicious. Moreover, Health Services does not delay the payments associated with suspect provider claims pending completion of the field office review.

We reviewed 10 weekly pre-checkwrites, which identified a total of 88 providers with suspicious claims from which Health Services selected 47 for further review. At the time of our audit, 42 provider reviews had been completed, and 31, or 74 percent, of these had resulted in an administrative sanction and referral to the Investigations Branch (investigations branch) or to law enforcement agencies. According to Health Services, limited staffing precludes it from reviewing all suspicious providers. Health Services states that it must perform additional analysis to develop sufficient evidence and a basis for placing sanctions, including withholding a payment or placing utilization controls on providers.

However, when Health Services does not promptly complete its reviews and suspend payment of suspicious provider claims until it completes its on-site review, its pre-checkwrite process loses its potential effectiveness as a preventive fraud control measure. Health Services could use existing laws to suspend payments for claims that its risk assessment process identifies as potentially fraudulent or abusive and release them once a pre-checkwrite review verifies the legitimacy of the claim. Although laws generally require prompt payment, they make an exception for claims suspected of fraud or abuse and for claims that require additional evidence to establish their validity.

We recommended that Health Services consider expanding the number of suspicious providers it subjects to this process, prioritize field office reviews to focus on those claims or providers with the highest risk of abuse and fraud, and use the clean claim laws to suspend payments for suspicious claims undergoing field office review until it determines the legitimacy of the claim.

Health Services' Action: Pending.

Health Services stated that it received additional staffing in fiscal year 2003–04 to expand the number and timeliness of pre-checkwrite reviews. It also indicated it will work with its legal office to maximize the pre-checkwrite activities and develop criteria to suspend specific claims and hold checks until the review is complete.

Finding #6: Health Services and the California Department of Justice have yet to fully coordinate their investigative efforts.

Although Health Services is responsible for performing a preliminary investigation and referring all cases of suspected provider fraud to the California Department of Justice (Justice) for full investigation and prosecution, it does not refer cases as required. Moreover, Health Services and Justice have been slow in updating their agreement even though the agreement is required by federal regulations and could be structured to clarify and coordinate their roles and responsibilities and, thus, help prevent many of the communication and coordination problems we noted with the current investigations and referral processes.

Our comparison of fiscal year 2002–03 referrals of suspected provider fraud cases from Health Services' case-tracking system database to similar records from Justice's case-tracking system

database revealed that 63 (41 percent) of the 152 Health Services case referrals to Justice were late, incomplete, or never received. According to Justice, it did not include 60 of the 63 referrals in its database because they were incomplete when Justice received them or it received them close to the date of indictment by an assistant U.S. Attorney for the Eastern District of California (U.S. Attorney). For the remaining three cases, although Health Services asserts that it referred them to Justice, Health Services could not provide documentation that clearly demonstrates its referral of them. Our review of 14 investigation cases corroborated that Health Services' investigations branch referred cases to Justice late; Health Services referred 12 an average of nearly five months after the date it had evidence of suspected fraud.

Although Health Services acknowledged that referring cases to Justice after indictment by the U.S. Attorney is no longer its practice, according to the investigations branch, it investigates and refers cases to the U.S. Attorney because the U.S. Attorney indicts suspected providers and settles cases quickly. Justice, on the other hand, typically focuses on developing cases for trial to pursue sentences that it believes reflect the seriousness of the defendant's conduct. Although both approaches have merit, depending on the particular case, Health Services and Justice have not come to an agreement on when each approach is appropriate and who should make that determination.

Additionally, according to Health Services' investigations branch chief, because neither federal nor state laws provide a clear definition of what constitutes suspected fraud, the investigations branch can refer cases to Justice at varying points in the process, including before, during, or after it has met the reliable evidence standard. Admittedly, the law does not clearly define what constitutes suspected fraud, but Health Services and Justice should reach an agreement on what standard must be met to assist both agencies in coordinating their respective provider fraud investigation and prosecution efforts.

The agreement between Health Services and Justice that is required by federal regulations could help alleviate many of the current problems about when Health Services should refer cases to Justice. Over the last several years, Health Services and Justice have intermittently discussed an update of the existing 1988 agreement. However, these two entities have yet to complete negotiations for an update of this agreement or to define and coordinate their respective roles and responsibilities for investigating and prosecuting suspected cases of Medi-Cal provider fraud.

We recommended that Health Services promptly refer all cases of suspected provider fraud to Justice as required by law and that both Health Services and Justice complete their negotiations for a current agreement. The agreement should clearly communicate each agency's respective roles and responsibilities to coordinate their efforts, provide definitions of what a preliminary investigation entails and when a case of suspected provider fraud would be considered ready for referral to Justice.

To ensure that Health Services and Justice promptly complete their negotiations for a current agreement, we recommended that the Legislature consider requiring both agencies to report the status of the required agreement during budget hearings.

Health Services' Action: Pending.

Health Services stated that a draft agreement would be finalized soon. It further indicated that it clarified the need to make timely referrals to Justice in its policy and procedures.

Justice Action: Pending.

Justice stated that both agencies are working quickly and in good faith to establish an agreement that will serve to strengthen the working partnership between the two agencies.

Legislative Action: Unknown.

We are unaware of any legislative action implementing this recommendation.

Finding #7: A more effective feedback process could strengthen Health Services' antifraud efforts.

Although audits and investigations is responsible for coordinating the various antifraud activities within Health Services, its line of authority does not extend beyond audits and investigations. What is lacking is an individual or team with the responsibility and corresponding authority to ensure that worthwhile antifraud recommendations are tracked, followed up, and implemented. Such an individual or team would provide Health Services' management with information about the status of the various projects and measures that are under way, to ensure that antifraud proposals, including those involving external entities, are addressed promptly.

Without an individual or team with the responsibility and corresponding authority to follow up and act on recommendations for strengthening its antifraud efforts, some antifraud coordination issues or detected fraud control vulnerabilities may continue to go uncorrected. For example, although Health Services' provider enrollment process is the first line of defense to prevent abusive providers from entering the Medi-Cal program, the provider enrollment process continues to need improvement. Similarly, another unresolved fraud control coordination issue is the lack of an updated agreement between Health Services and Justice related to the investigation and referral of suspected provider fraud cases. Although laws make each of these state agencies responsible for certain aspects of investigating and prosecuting cases of suspected provider fraud, the current case referral practices result in a fragmented rather than a cohesive and coordinated antifraud effort. Both agencies indicate that they have made some efforts to update their 1988 agreement, but they have yet to complete negotiations for a current agreement that spells out each agency's respective roles and responsibilities.

We recommended that Health Services consider working through the California Health and Human Services Agency to establish and maintain an antifraud clearinghouse with staff dedicated to documenting and tracking information about current statewide fraud issues, proposed solutions, and ongoing projects, including assigning an individual or team with the responsibility and corresponding authority to follow up and promptly act on recommendations to strengthen Medi-Cal fraud control weaknesses.

Health Services' Action: Pending.

Health Services recognizes the contribution a clearinghouse can potentially make and will work with the California Health and Human Services Agency to more fully explore this recommendation and different approaches for its implementation.

Finding #8: Health Services needs to give proper attention to potential fraud unique to managed care.

In addition to its fee-for-service program, Health Services also provides Medi-Cal services through a managed care system. Under this system, the State pays managed care plans monthly fees, called capitation payments, to provide beneficiaries with health care services. Although fraud perpetrated by providers and beneficiaries, similar to what occurs under the fee-for-service

system, can also occur, another type of fraud unique to managed care involves the unwarranted delay in, reduction in, or denial of care to beneficiaries by a managed care plan.

Because of incomplete survey results and its concerns about the reliability of encounter data, which are records of services provided, Health Services does not have sufficient information to identify managed care contractors that do not promptly provide needed health care. In addition, Health Services does not require its managed care plans to estimate the level of improper payments within their provider networks to assure they are appropriately controlling their fraud problems and not significantly affecting the calculation of future capitated rates.

We recommended that Health Services work with its external quality review organization to determine what additional measures are needed to obtain individual scores for managed care plans in the areas of getting needed care and getting that care promptly, complete its assessment on how it can use encounter data from the managed care plans to monitor plan performance and identify areas where it should conduct more focused studies to investigate potential plan deficiencies, and consider requiring each managed care plan to estimate the level of improper payments within its Medi-Cal expenditure data.

Health Services' Action: Pending.

Health Services stated that its new contracted vendor should be able to gather data to address the inadequacies found in the surveys. It is also assessing how it can use managed care plan data to help target areas for focused monitoring. Health Services will consult internally and with outside entities on the feasibility of implementing through appropriate contract language the requirement that managed care plans estimate the level of improper payments within their Medi-Cal expenditure data.