



Audits & Investigations Division

Combating Fraud, Waste & Abuse
in CA's Medicaid Program

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CASA Presentation
January 27, 2015
Sacramento, CA



Agenda

- **Medicare & Medicaid Overview**
- **Audits & Investigations Division Overview**
- **Fraud, Waste & Abuse Defined**
- **Audit & Investigative Approach**
- **Challenges & Opportunities**

Medicare vs. Medicaid

- Medicare and Medi-Cal are both **public health insurance programs** established in 1965 under Title 18 and 19 of the Social Security Act.
- Medicare is administered by the federal government whereas Medi-Cal, California's Medicaid program, is administered by the state.

Medicare vs. Medicaid

Medicare

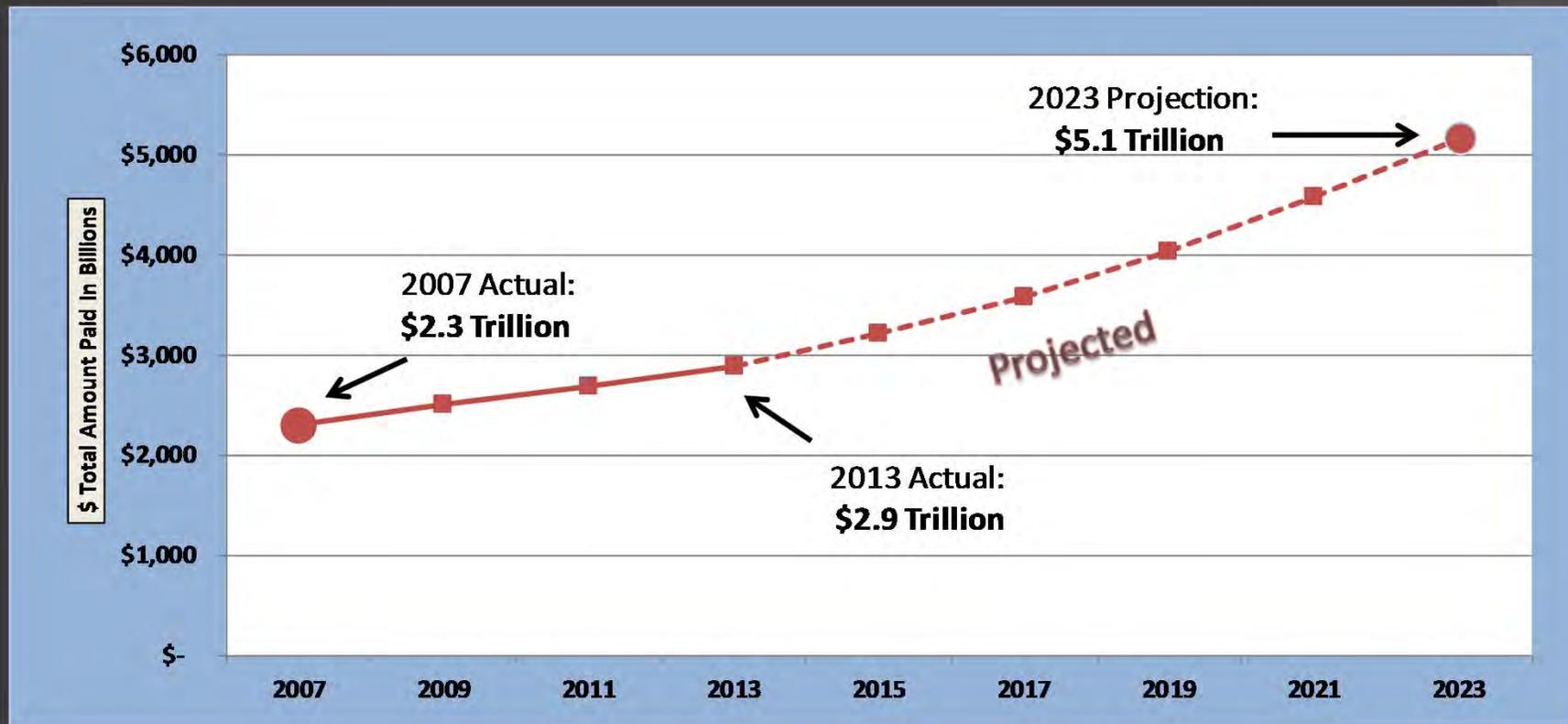
- People 65 and over
- People under 65 with certain disabilities

Medi- Cal

- For low income individuals and families, including People 65 and over
- People who are disabled
- People who are blind
- Pregnant women
- Children under the age of 21
- People who need nursing home care
- People screened for breast or cervical cancer

National Health Expenditure Projections 2013-2023

Health Care Spending is projected to nearly double in the next decade



Source: Centers for Medicare and Medicaid Services

Medicare & Medicaid Expenditures

- Every year Medicare pays over **\$566 billion** for more than 52 million beneficiaries.
- Each year, Medicaid processes 3.9 billion claims, representing more than **\$430 billion** paid annually, for more than 57 million beneficiaries.
- **Every 8 seconds**, someone becomes Medicare eligible.

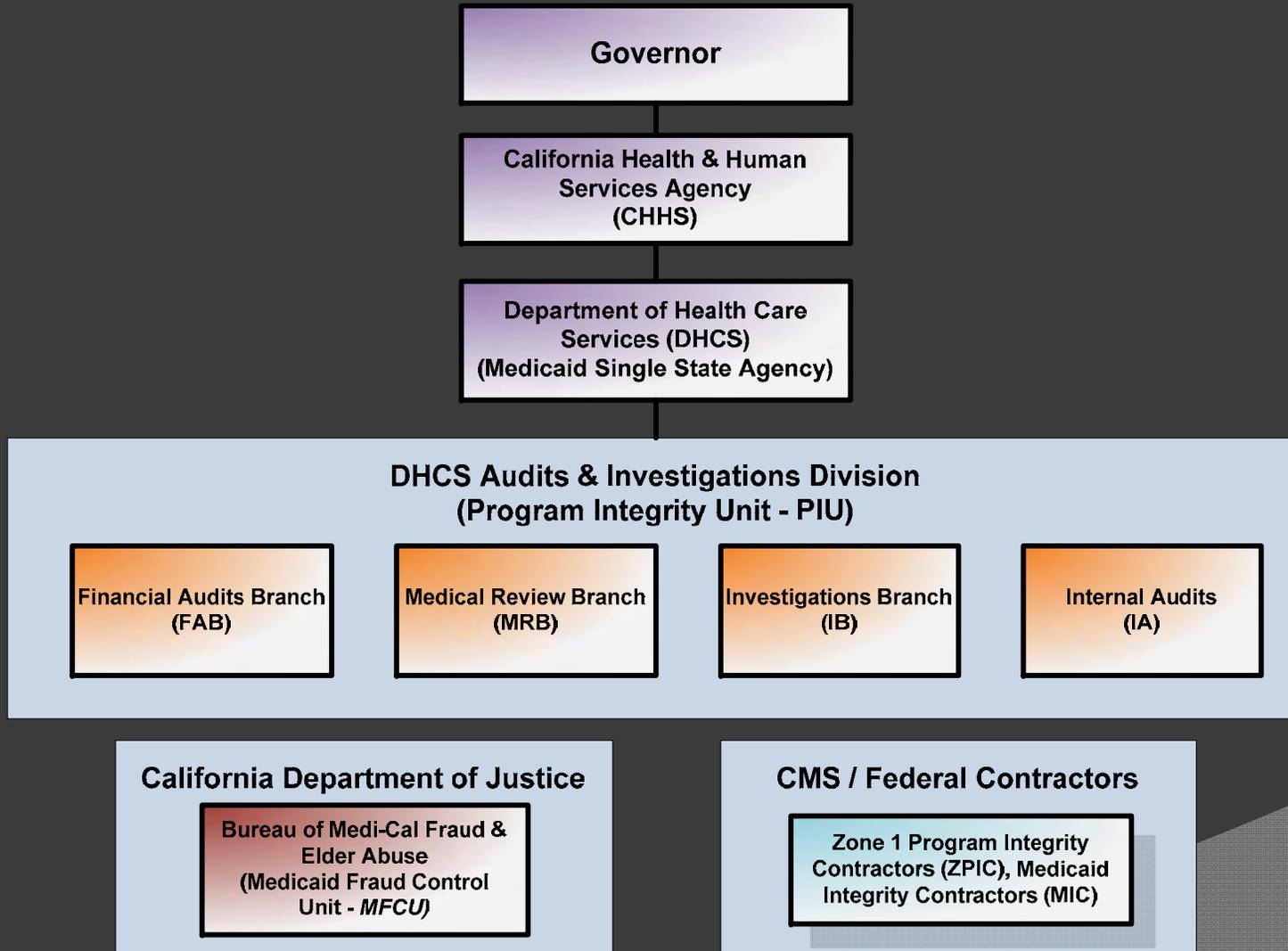


Medi-Cal at a Glance 2014-2015



- Total Budget - **\$90.6 billion** (\$17.4 state funds)
- Beneficiaries served – **11.3 million**
- Enrolled providers – **135,000**
- Average Weekly check-write – **\$330 million**
- **71% Managed Care, 29% FFS** (as of 10/14)

Medi-Cal Administration



Audits & Investigation Overview

A&I At a Glance

DHCS Audits & Investigations Division (Program Integrity Unit - PIU)

Financial Audits Branch
(FAB)

Medical Review Branch
(MRB)

Investigations Branch
(IB)

Internal Audits
(IA)

Information
Technology Unit
(ITU)

Administrative
Support Unit
(ASU)

- **2014/15 Total Authorized Operating Budget - \$92.7 million**
- **759 total authorized positions (706 filled) as of 10/1/14.**

A&I Overview (as of 10/1/14)

759 total authorized positions

- **355 Financial Audits Branch (47%)**
- **231 Medical Review Branch (30%)**
- **128 Investigations Branch (17%)**
- **14 Internal Audits (2%)**
- **18 Administration (2%)**
- **13 I.T. Services (2%)**

** 105 new employees since January 2013.*

A&I Classifications (as of 10/1/14)

759 total authorized positions

- **137 Management (18%)
(all branches, all disciplines – 84 audit related)**
- **349 Auditors (46%)**
- **86 Investigators - peace Officers (11%)**
- **81 Medical/Clinical (11%)**
- **17 Research (2%)**
- **36 Analysts (5%)**
- **47 Administrative (6%)**
- **6 Information Technology (1%)**

A&I Primary Role & Responsibilities

- ✓ Designated by CMS as the **Program Integrity Unit (PIU)** for California's Medicaid program
- ✓ Medi-Cal's **anti-fraud program**
- ✓ Statutory **financial audits**
- ✓ Criminal and administrative **investigations**
- ✓ **Internal audits**
- ✓ **FQHC** program oversight
- ✓ **Special audits, reviews and projects**

Departmental Responsibilities

Objective - Continue to be a relevant and value-added organization to the Department and Medi-Cal program as a whole.

- We protect the Department by helping to **identify areas of risk and exposure**.
- We provide **independent and sound data** to programs so that they can make the most **informed decisions** possible (e.g., rate setting, corrective action plans).

Departmental Responsibilities

- **Our belief** - the greater DHCS leadership and programs involve A&I in its efforts, the higher the “confidence level” they will have in the programs they oversee.
- Therefore, we will continue to **encourage DHCS programs to solicit our program integrity services** as part of their overall program administration due diligence.
 - ✓ **Incorporating program integrity efforts early on** will help avoid situations from “blowing-up” in the future.

A&I ROI – 2010/11 Through 2013/14

A&I has historically paid for itself & has placed no financial burden on the State General Fund

	2010/2011	2011/2012	2012/2013	2013/2014
Demands	\$100,200,000	\$106,300,000	\$200,200,000	\$187,800,000
Recoveries	117,700,000	102,100,000	176,900,000	198,900,000
Cost Changes (Impact on Rates / Cost Reimb)	306,000,000	252,000,000	307,000,000	55,600,000
Cost Savings (Sanctions)	80,500,000	47,000,000	28,700,000	27,700,000
Cost Avoidance (Enrollment)	7,800,000	27,700,000	25,900,000	24,200,000
TOTAL (Excluding Demands)	\$512,000,000	\$428,800,000	\$538,500,000	\$306,400,000

2013/2014 Production

Financial Audits Branch

- ✓ 3,216 Audit Reports Issued

Medical Review Branch

- ✓ 916 Audits & Reviews Completed
- ✓ 3,840 Random Claims Review

Investigations Branch

- ✓ 7,581 Cases Opened
- ✓ 7,207 Cases Closed
- ✓ 146 D.A. Filings / Prosecutions
- ✓ 95 Arrests

** Note The scope and hours associated with each activity above varies.*

Report Medi-Cal Fraud

DHCS MEDI-CAL FRAUD HOTLINE

1-800-822-6222

The recorded message may be heard in English and Spanish

REPORT MEDI-CAL FRAUD ELECTRONICLY

e-mail: stopmedicalfraud@dhcs.ca.gov, or

Complete the Online Complaint Form @ www.dhcs.ca.gov



- A&I receives over **1,200 fraud complaints** each month.
- **New logo, email address and live call center** will be introduced in the coming months.

Workload Drivers

1. Statutorily mandated area of responsibility with **no defined audit widgets or deliverables.**

- Expected caseload is not specified, but rather is driven by complaints received, data mining and risk assessments performed by staff that identify targets for review.

2. Statutorily mandated area of responsibility with **defined widgets or deliverables within a specified time requirement.**

- Statute or regulation will typically specify that a specific provider type must be reviewed / audited within a specific time-frame.

Audit Types

- **Financial Audits**
- **Compliance Audits**
- **Performance Audits**
- **Internal Audits**
- **Agreed-Upon Procedures**

Audit Scope – Example Provider Types

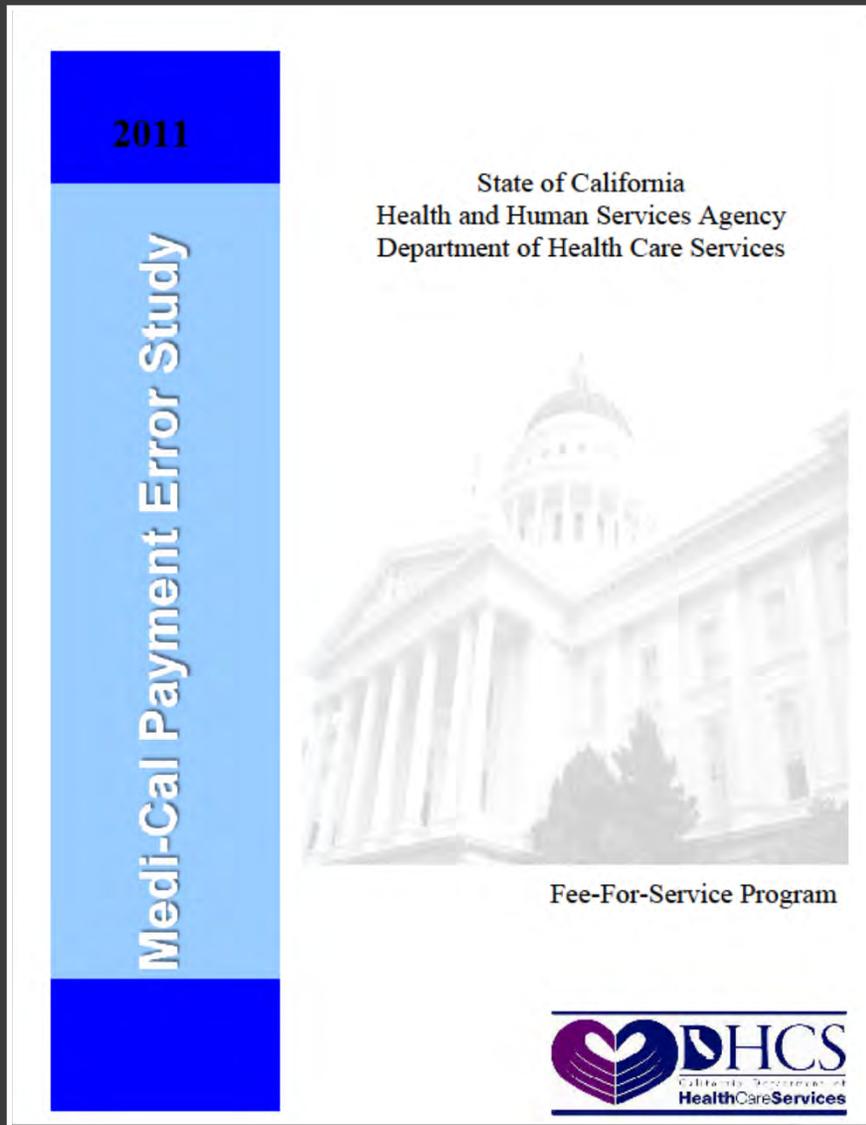
Institutional Providers

- Hospitals
- Skilled Nursing Facilities
- Federal Qualified Health Clinics

Non-Institutional Providers

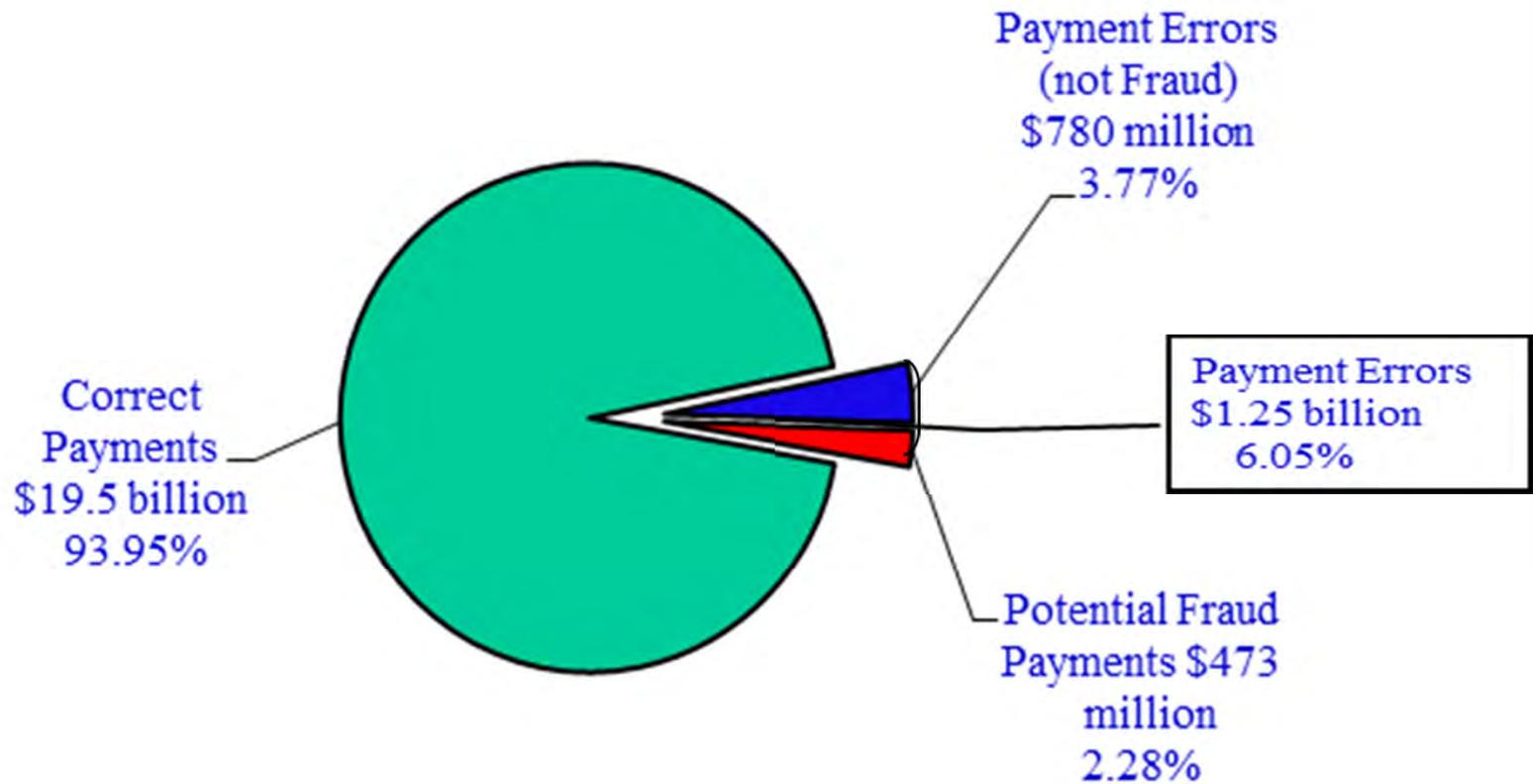
- Physicians
- Pharmacy
- Labs
- Durable Medical Equipment
- Dental

2011 Medi-Cal Payment Error Study (MPES)



- MPES estimates dollar loss in the Medi-Cal Fee-For-Service (FFS) programs by identifying payment errors.
- It breaks down the estimated payment error rate into non-fraud and potential fraud.
- The potential fraud subset is a unique MPES feature.
- It improves anti-fraud prevention by zeroing-in on current risks.

Payment Proportions Paid Correctly and in Error, Including Fraud (Estimated Annually)



Fraud, Waste & Abuse Defined

Fraud, Waste and Abuse Continuum

Overpayments to health care providers can result from a variety of reasons from simple billing errors and mistakes to fraud, waste and abuse.



Fraud, Waste & Abused Defined

- **Fraud** – An intentional deception or misrepresentation made by a person for personal gain for himself or some other person.
- **Waste** – Overutilization of services, or other practices that result in unnecessary costs. Not considered criminal, but rather misuse of resources.
- **Abuse** – Bending the rules for personal gain. An individual's activities that are inconsistent with sound fiscal, business, or medical practices thus resulting in unnecessary costs and reimbursement for services that may not be medically necessary.

Who Commits Fraud?

- **Most individuals and organizations** that work with Medi-Cal are **honest**.
- However, **anyone** can commit fraud
 - ✓ Health care providers and suppliers
 - ✓ Business owners and employees
 - ✓ Medi-Cal beneficiaries



Types of Fraud & Abuse

1. False Statement & Claims

- ✓ Unbundling
- ✓ Upcoding
- ✓ Billing for services/supplies not provided, or services not medically necessary
- ✓ Physician signs orders for unnecessary lab & diagnostic tests
- ✓ Patient lies about medical condition to obtain costly prescription drugs to sell on the black market
- ✓ Misrepresentation of utilization data to obtain better rates.

Source: California Research Bureau, California State Library, "Fraud and Abuse in the Health Care Market of California." November 1997.

Types of Fraud & Abuse

2. Bribery & Self-Referrals

- ✓ Involves collusion between two or more parties
- ✓ One party channels business to second party for a "kickback." Example includes patient referrals known as "capping."
- ✓ One party refers patients to another medical facility owned by the same party.

3. Underutilization

- ✓ Systematic pattern of substandard medical treatment to boost profits (managed care environment).

Source: California Research Bureau, California State Library, "Fraud and Abuse in the Health Care Market of California." November 1997.

Fraud, Waste and Abuse Laws

- Medi-Cal Fraud Statute
- False Claims Act (FCA)
- Anti-Kickback
- General Whistleblower Protections
- Prohibitions on Self-Referral
- Unfair Business Practices



Audit & Investigative Approach

Primary Federal & State Agencies Health Care Fraud Investigations

1. Federal Entities

- ✓ US Dept of Justice (USDOJ) – US Attorney
- ✓ USDOJ – FBI
- ✓ HHS – Office of Inspector General (OIG)
- ✓ Centers for Medicare & Medicaid Services (CMS)

2. State Entities

- ✓ DHCS – Audits and Investigations (a.k.a. Medicaid Program Integrity Unit)
- ✓ CA DOJ – Bureau of Medi-Cal Fraud and Elder Abuse (a.k.a. Medicaid Fraud Control Unit)

A&I Audit & Investigative Activities Typical Workflow

1. **Targets identified** via fraud complaints/referrals (internal & external), data mining & data analytics.
2. **Field reviews performed** via a combination of auditors, clinicians and investigators.
3. Investigators perform **preliminary investigations** of cases involving **alleged criminality**.
4. **Fraud referral** sent to the CA DOJ if a **credible allegation of fraud is established** for criminal investigation and prosecution where warranted.

Protecting & Recovering Public Health Care Dollars

Three Pronged Approach



Administrative Remedies

- Mandatory Suspension
- Permissive Suspension
- Payment Suspension
- Temporary Suspension
- Civil Money Penalty
- Post-Service Pre-Payment Monitoring
- Provider Prior Authorization
- Procedure/Drug Code Limitation
- Barred From Reapplication



Federal & State Partnerships



DHCS works collaboratively with federal and state partners on joint engagements.

Challenges & Opportunities

The Changing Medi-Cal & Healthcare Landscape

- **Affordable Care Act** implementation.
- The shift of Medi-Cal's primary health care delivery model from **fee-for-service to managed care**.
- The Medicaid expansion continues to increase the **dollar magnitude of the Medi-Cal program** in California and hence the lure of fraudsters looking to exploit the program for financial gain.
- The **ever-changing fraud schemes** within the Medi-Cal program.

Affordable Care Act (ACA) New Fraud Prevention Expectations

- Assess the feasibility of deploying **enhanced data analytics** (e.g. predictive modeling).
- Implementation of the new **credible allegation of fraud** and related **payment suspension** requirements.
- Implementation of **Recovery Audit Contractors (RAC)**.
- **Enhanced enrollment screening** requirements and authorities.

***** Focus is on fraud prevention *****

IP-CAR Project

The Individual Provider Claims Analysis Report (IP-CAR) is a “provider report card” that highlights a provider's billing pattern for various procedures or services and compares the billing pattern to his or her peers.



- Encourages providers to become more conscientious about their billing.
- Offers providers peer billing information with which to compare themselves.
- Encourage providers to bill accurate diagnosis codes.
- Educates providers on how to conduct a self-audit.

Program Integrity A Balancing Act

GAO

Testimony
Before the Committee on Finance,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, June 28, 2005

MEDICAID

States' Efforts to Maximize
Federal Reimbursements
Highlight Need for
Improved Federal Oversight

- We all need to be proactive with oversight otherwise CA could be the next headliner.
- Up-front due diligence is key.

Medicare paid \$5.1B for poor nursing home care

AP By GARANCE BURKE | Associated Press – Thu, Feb 28, 2013

SAN FRANCISCO (AP) — Medicare paid billions in taxpayer dollars to nursing homes nationwide that failed to meet basic requirements to look after their residents, government investigators have found.



Audit: Utah's Medicaid program lacks oversight
August 18, 2009

Lack of oversight in billing matters questioned at DOA

By NICOLE CARTRETTE Staff Writer | Posted: Friday, March 22, 2013 3:00 pm

Program Integrity A Balancing Act

NY Inspector General ousted for overaggressive Medicaid penalties

June 22, 2011 | By Karen Cheung-Larivee

New York Gov. Andrew Cuomo yesterday asked state Medicaid Inspector General to resign from office, reports *WAMC Northeast Public Radio*.

Overly aggressive program integrity measures can also have negative consequences

- Provider communities in both NY & TX have been less than pleased with fraud-fighting tactics.
- TX legislature, however, have been pleased with the PIU's efforts & recoveries.

In Medicaid Fraud Investigations, a Controversial Tool

by [Emily Ramshaw](#) | July 20, 2012 | [8 Comments](#)

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This article is the third of an occasional series on the consequences of state efforts to curb spiraling health costs, and the dollars lawmakers might target in the future.

Key to Finding the Right Balance

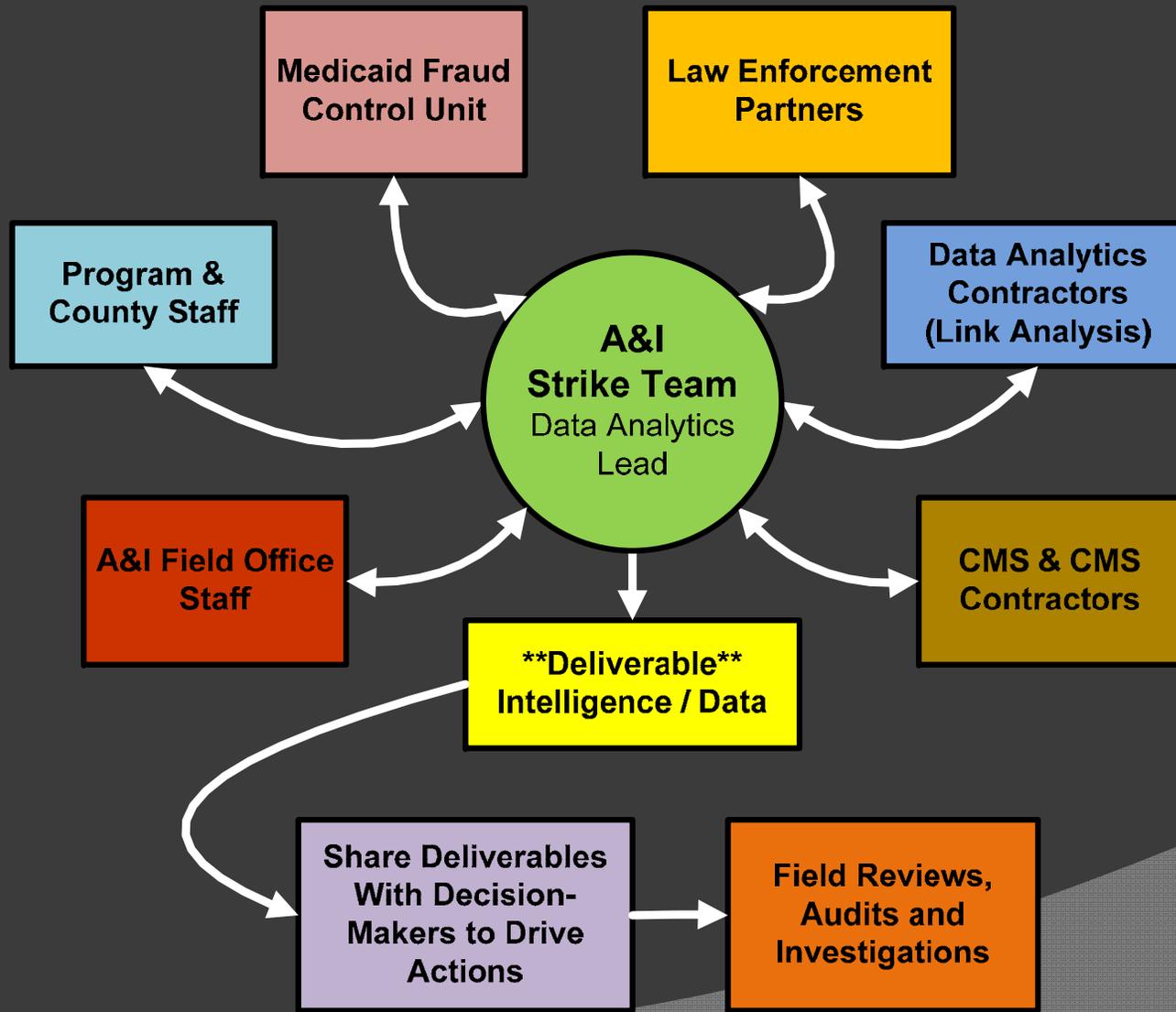
- Ensure that program integrity efforts are in **alignment with Director's Office vision.**
- Let the **data drive the decisions.**
- **Consistency** in our execution.
- Message to internal DHCS partners: We all must be **proactive and not reactive**, based upon identified areas of exposure and evidence. We should **not wait until an issue "blows up"** in the press before acting. At that point, the damage has been done.

DMC in the News



- **CNN / CIR Story Airs** on 7/29/13
<http://cironline.org/reports/lax-oversight-leaves-california-drug-rehab-funds-vulnerable-fraud-5037>
<http://www.cnn.com/2013/08/02/health/rehab-racket-siu-cir-part-four/>
- **Legislative hearings** follow
- **Limited Scope Review** cites significant problems
<http://www.dhcs.ca.gov/dataandstats/reports/Pages/DrugMedicalProgramLimitedScopeReview.aspx>

DHCS Strike Team



Actions Taken on DMC Providers (as of 1/7/15)

- **547 sites visited** (100% of providers)
- **75 providers temporarily suspended** (T/S)
 - 95 Parents
 - 138 Satellites
 - 233 Sites Total**
- Billings for T/S sites FY12/13= **\$57.3 million**
- **8 good cause exceptions = \$5 million**
- **3 T/S under review**
- **93 fraud referrals** sent to the Medicaid Fraud Control Unit (MFCU) / DOJ (4 closed no action)

Note: Variance between total suspended providers and total fraud referrals is due to adjustments for good cause exceptions, rescinded suspensions and lifted suspensions.

Data Analytics



- Data analytics tools have been a **tremendous resource and asset** to DHCS' strike team efforts.
- DHCS will be pursuing a **procurement for a full-scope data analytics tool** this fall.
- Ultimately, the data analytics tool will **accelerate Audits & Investigations' (A&I) case development efforts**.
- The tool will also allow to **take a "deeper dive"** into a program that is significantly increasing scope and dollar magnitude each and every year.

Keys to Our Future Success

- Continued use of **new technologies** to help us do more with less and keep pace with the ever-evolving fraud schemes.
- Continued **cooperation and collaboration** among internal and external business partners.
- Work towards **expanded data sharing**.
- **Continued funding** for anti-fraud activities and resources.



CA Association of State Auditors

Thank You