Status of Medi-Cal Fraud Control Initiatives

Prepared by the
California Department of Health Care Services
Audits & Investigations Division

Fiscal Years 2018-19 & 2019-20

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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) 2018-19 and 2019-20. In 2003, the California Legislature enacted legislation that authorized additional resources and staffing to DHCS to combat fraud, waste, and abuse 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 required 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 required the report to include the following:

- Number of positions filled by division.
- Components of the initiative, including number of claims and recipient 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 18 years have passed since the original positions were approved. Since that time, all positions have been completely integrated into DHCS' overall anti-fraud efforts. Therefore, this report provides the results and statistics of DHCS' anti-fraud efforts instead of focusing strictly on the original 154.5 approved positions. This report has been required by each subsequent Budget Act since the 2008 Budget Act. The Budget Act of 2020 is the last budget bill to require this report, which will make this the final report.

(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 2020. Anti-fraud activities are defined as any duties that are 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 06/2020	Positions Performing Anti-Fraud Activities	Percentage of Total
Audits & Investigations	868	222	26%
Provider Enrollment	133	77	58%
Third Party Liability and Recovery	197	11	6%
California Medicaid Management Information System Operations	126	1	1%
Total	1,324	311	23%

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 2020, A&I's anti-fraud effort consists of 222 positions. Table 2 breaks down the anti-fraud positions by A&I branch, unit, and section.

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

A&I Branch/Unit/Section	Number of Positions	Percentage of Total
Special Investigations Unit	31	14%
Investigations Branch	76	34%
Medical Review Branch	100	45%
Analytics, Policy, and Intake Section	15	7%
Total	222	100%

The anti-fraud positions within A&I belong to the distinct sections, units, and branches described below. The remaining A&I employees 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. These non-anti-fraud activities are an integral component of California's overall Medicaid PIU efforts.

Special Investigations Unit (31 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 allocate 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. The IB is the lead investigative body for recipient fraud, including In-Home Supportive Services (IHSS) in California as authorized by California Welfare and Institutions Code (WIC) section 12305.82. Recipient fraud cases are referred to local and federal prosecutors for criminal prosecution.

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 (100 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 Rotating Provider Reviews.

Analytics, Policy, and Intake Section (15 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 In-Home Supportive Services 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 deny 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 who have been flagged as suspect in DHCS audits, investigations, referrals, etc. This “watch list” is updated monthly and is utilized by PED and A&I to prevent suspect providers from trying to enroll or re-enroll in the program.

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 existing third party coverage, and initiating the reimbursement process or purchasing alternative health care coverage, including an individual's other health coverage or Medicare premiums. As of June 2020, TPLRD had a total of 197 positions, 11 of which perform anti-fraud efforts.

California Medicaid Management Information System Operations Division

The CA-MMIS Operations Division maintains oversight of the medical fiscal intermediary's (FI's) processing and payment of approximately $22 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's contract and all services provided under the contract. Anti-fraud responsibilities within CA-MMIS reside in the Policy, Fraud, and Support Services Unit. The unit is responsible for the oversight and review of the FI's Procedure Code/Drug Code Limitation restriction and Suspended and Ineligible Providers' processes.

(2) Components of the Initiative

During FY 2018-19 and FY 2019-20, DHCS continued to employ components of the original initiative including the Error Rate Study, Fee-For-Service Reviews (formerly Pre-Check Write), and Enrollment and Re-Enrollment processes. Although DHCS did not separately track provider claims and recipient 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 changing Medi-Cal landscape, including the addition of other initiatives to address current fraud trends, 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), 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) with the goal of measuring improper payments and calculating error rates.

CMS calculates improper payments by reviewing all 50 states every three years on a 17-state-per-year rotational basis. The most recent PERM results were issued in November 2020, which covered FY 2017-18, 2018-19, and 2019-20. CMS only publishes the national rate and not state specific results. A summary of aggregate PERM results can be found on page 114 of the CMS Financial Report:

https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2020.pdf

Medi-Cal Payment Error Study

The Medi-Cal Payment Error Study (MPES) measures overpayments in FFS Medi-Cal and estimates the percentage of fraudulent billing. Because of the ongoing shift from the FFS healthcare delivery system to managed care, DHCS is reevaluating its payment error measurement approach for future studies.

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 percent had some indication that they contained a provider payment error. Findings revealed that 1.61 percent 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%).

Rotating Provider Review (formerly Random Claim Review)

In September 2019, A&I renamed the Random Claim Review to what is now the Rotating Provider Review (RPR). The RPR is a prepayment review of randomly selected billed FFS claims across all non-institutional Medi-Cal provider types. The RPR determines if the selected claims are eligible or ineligible for payment based on a review of documentation submitted by the providers. In the event a claim is ineligible for payment, the claim is denied payment and the provider will receive a Provider Education Letter (PEL) or be referred for an Audit for Recovery to resolve identified risks. In addition, an analysis of the provider's billing will be conducted a year from the date of the issuance of a PEL to determine if the provider's billing behavior is no longer consistent with identified risks. The provider may be referred for an expanded audit if the provider's billing behavior is determined to be consistent with identified risks.

Because the claims are randomly selected, the findings are not an accurate

representation of the entire FFS universe. However, the RPR serves as an avenue for program integrity to provide both proactive outreach on educating providers and for the identification of emerging potential payment error trends within the program. RPR informs and allows providers the opportunity to address any identified areas of concern, while surveilling the landscape of fraud, waste, and abuse. This surveillance data is reviewed to detect and identify adjustments to programmatic risk. These adjustments are then used to determine if a specific provider type may warrant an expanded audit or benefit from education such as an All Provider Letter.

From September 9, 2019 through June 30, 2020:

- A total of 166 claims representing 113 unique providers were reviewed.
- A total of 92 claims or 55 percent were determined to be valid.
- A total of 74 claims or 45 percent were determined to be improper.
- A total of 41 providers were issued a PEL.
- A total of eight providers were referred for an Audit for Recovery.

There are five general denial reasons identified for the RPR phases and other denial reasons specific to the distinct provider type detailed in the table below.

Table 3–Summary of Reasons for Denied Claims

Reason Claims Deemed Improper for Payment	Percent
Lack of response from the provider	49%
Partial documents submitted or claims missing one or more of the following items: • Eligibility Verification • Progress Notes • Treatment Authorization Request • Written Referral • Medi-Service Reservation	46%
Other	5%
Total	100%

Fee-For-Service Reviews (formerly 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, which may lead to A&I conducting FFS onsite reviews. Following the completion of this process, further actions may be taken in the form of an Audit for Recovery, administrative sanctions, PELs,

and/or contact the State Controller's office to stop payment on a check.

Provider Education and Outreach

Ongoing efforts to monitor Medi-Cal program integrity include A&I reviews, provider notification of unusual billing patterns, and anomalies in reimbursed claims data. PELs are issued for billing activities that deviate from provider peer billings within a specified timeframe. The PEL process, which began in May 2019, has allowed providers the opportunity to review and rectify their billing processes as appropriate, prior to being identified for potential administrative warning and/or audit.

Providers may be notified by PEL for billing concerns that appear to be unrelated to potential fraud, waste, or abuse. PELs are prompted by the following:

- Issues identified in FFS reviews that are ineligible for overpayment recovery.
- Questionable patterns identified by external agencies or other health care payers.
- Incoming calls to the A&I's Fraud Hotline that do not involve patient harm.
- Categorical issues detected through data mining and research methodologies.

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 2018-19 and 2019-20, DHCS reviewed 95,574 provider applications and denied 27,881 of the applications received. Many of these denials result from the applicant failing to return their application with additional information or corrections within 60 days and then being denied by operation of law. Others are for provider types that are not eligible to participate in the Medi-Cal program, failing to have an established place of business appropriate for the services the applicant is applying to provide Medi-Cal recipients, or otherwise not meeting program requirements. Table 4 highlights the number of applications submitted and denied for each respective fiscal year.

Table 4–Summary of Applications Submitted and Denied

Provider Applications	FY 2018-19	FY 2019-20	Total
Submitted	47,167	48,407	95,574
Denied	12,048	15,833	27,881

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

Effective March 5, 2019, all providers requesting enrollment, reporting changes to existing enrollments, completing revalidation, or continued enrollment applications, must submit their applications through Provider Application and Validation for Enrollment (PAVE). In addition, as of March 5, 2019, PED no longer accepts paper applications. A list of all provider types that enroll 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 recipients.
- 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.
- Electronically manages 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. PAVE's ease of use and PED's improved and shortened application review timeframes over the past few years have encouraged enrolled providers to submit new applications reporting changes to their enrollment. The information in these complete applications helps meet the revalidation requirements.

Medi-Cal Promoting Interoperability Program (formerly Electronic Health Record Incentive Program)

The Medi-Cal Promoting Interoperability Program, formerly known as the Electronic Health Record (EHR) Incentive Program, provides incentive payments to Eligible Professionals (EP) and Eligible Hospitals (EH) as they Adopt, Implement, Upgrade (AIU), or demonstrate Meaningful Use (MU) 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 2009. DHCS' Health Interoperability Management Division conducts pre-payment reviews for AIU and MU while A&I conducts risk assessment and audits of EPs and EHs for AIU and MU. In FY 2018-19, A&I completed 18 audits (6 of which resulted in the collection of $78,500 for noncompliance). In FY 2019-20, A&I completed 7 audits (4 of which resulted in the collection of $46,750 for noncompliance).

Targeted Investigations

DHCS receives approximately 1,500 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 a PEL to a provider and/or recipient, or a referral made to another governmental agency. Table 5 reflects complaints received by A&I during FY 2018-19 and 2019-20. The table categories are based on the outcomes of those complaints as of August 2020.

Table 5–Summary of Complaints and Outcomes

Outcomes	FY 2018-19	FY 2019-20	Total
New Complaints	17,139	18,968	36,107
Referrals Made to Other Agencies	320	560	880
Cases Opened	2,668	3,043	5,711
Educational Letters Sent to Providers	3,062	3,903	6,965

In addition, A&I utilizes advanced data analytics to gain an understanding of emerging fraud trends and program vulnerabilities, which include providers prescribing expensive unnecessary drugs, such as benzodiazepines and Xanax; providers paying kickbacks in exchange for recipient access; marketing to attract recipients to a particular provider and location; providers falsifying medical and billing records; and providers creating fake identities of recipients, 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 and antipsychotic medications without reasonable evidence of medical necessity.

The Opioid Crisis

In 2017, the U.S. Department of Health and Human Services declared the Opioid Crisis a public health emergency. Prescription opioid misuse and opioid use disorder continue to be a topic of national concern that is being addressed by all Medicaid programs.

DHCS has always placed a high priority against the illegal diversion, abuse, and misuse of prescription opioids within the Medi-Cal program. DHCS regularly take actions to monitor and investigate opioid-related concerns. These actions include filing criminal violations against offenders; identifying fraudulent overpayments for recovery; and cooperating with and assisting federal, county and other state authorities.

To combat the rising opioid epidemic, DHCS has established key relationships within the law enforcement community to fight opioid diversion. DHCS is embedded within the Drug Enforcement Administration (DEA) Pharmaceutical Task Forces in San Diego, Los Angeles and Orange Counties; Ventura County Sheriff's Pharmaceutical Task Force; Federal Bureau of Investigation Health Care Fraud Task Force in Fresno; as well as the DEA's annual "Drug Take Back" events. DHCS also works regularly with allied agencies at the federal, state and local levels on a case by case basis. Participation and collaboration with DHCS' partner agencies allows information to be gathered and exchanged efficiently, resulting in a more thorough investigation of opioid

diversion and rigorous sentencing and restitution outcomes.

DHCS clinical staff monitors overprescribing of opioids, an effort that has increased in priority due to the current opioid crisis. DHCS has identified practitioners who have engaged in inappropriate prescribing of opioids through its routine utilization monitoring.

Results of this work include the sanction of pharmacies and other providers suspected of Medi-Cal fraud and/or patient harm, the assessment of civil fines, and prosecution of individuals engaged in fraudulent activities. In one multi-agency investigation involving the filling of fraudulent prescriptions by a provider in collusion with street level users, five individuals were federally indicted. Another case involved the manufacturing of false prescriptions for opioids and then diverting the illegally obtained drugs. One of these individuals involved received a six-year prison term.

A&I will continue to expand its efforts through enhanced data analytics, Credible Allegation of Fraud Referrals, see the Credible Allegation of Fraud section below.

(3) Cost Savings and Cost Avoidance

During FY 2018-19 and 2019-20, DHCS continued to achieve significant positive results related to its anti-fraud initiatives totaling $404 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 6–Summary of Return on Investment (ROI)

Division	ROI FY 2018-19	ROI FY 2019-20	Total
A&I	$167,474,123	$197,184,412	$364,658,535
CA-MMIS	$19,964,689	$19,070,176	$39,034,865
Total	$187,438,812	$216,254,588	$403,693,400

A&I Cost Savings and Cost Avoidance

A&I's overall ROI during FY 2018-19 and 2019-20 was $1.1 billion. Of this amount, $365 million was directly related to anti-fraud efforts detailed in this report. The other $694 million of ROI was the result of financial audits. The total average ratio for savings in FY 2018-19 and 2019-20 was $5.19 for every $1 spent ($5.48 for FY 2018-19 and $4.90 for FY 2019-20).

Table 7–Summary of Cost Savings and Cost Avoidance

Category	FY 2018-19	FY 2019-20	Total
Cost Avoidance (Denied Enrollment)[1]	$116,357,205	$134,043,300	$250,400,505
Cost Savings (Change in Billing Behavior)[2]	$11,894,675	$39,634,277	$51,528,952
Recoveries[3]	$39,222,243	$23,506,835	$62,729,078
Total	$167,474,123	$197,184,412	$364,658,535

CA-MMIS Cost Savings

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

Table 8–Summary of CA-MMIS Cost Savings

Category	FY 2018-19	FY 2019-20	Total
Savings	$22,182,988	$21,189,084	$43,372,072
Minus 10% fee Paid to Fiscal Intermediary (FI) for cases accepted by A&I[4]	$2,218,299	$2,118,908	$4,337,207
Total	$19,964,689	$19,070,176	$39,034,865

Credible Allegation of Fraud Referrals

The written form or referral evidencing an allegation of fraud is called a Credible Allegation of Fraud. 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.

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[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 A&I.

[4] As of September 30, 2019, Conduent no longer provides Fiscal Intermediary services. Cost containment provisions are no longer provided in the current Gainwell contract.

Table 9 highlights Credible Allegations of Fraud referred to the Department of Justice during FY 2018-19 and 2019-20.

Table 9–Summary of Credible Allegation of Fraud Referrals

Provider Type/Case Type	Number of Credible Allegation of Fraud Referrals
Adult Day Health Care	12
Alternative Birth Centers	1
Assistive Device & Sick Room Supply Dealers (DME)	3
Clinical Laboratories	9
Community Clinics	26
Congregate Living Health Facility	3
Dental	17
Family PACT	10
Ground Emergency Medical Transportation	1
Home Health	1
In-Home Supportive Services	45
Long Term Care Facility	1
Nurse Practitioner	4
Pharmacy	81
Physicians/Physicians Group	62
Rural Health Clinic/Federally Qualified Health Center	8
Non-Provider Type	6
Total	290

(4) Provider Sanctions

Under WIC section 14304, DHCS may impose administrative sanctions on Medi-Cal providers. During FY 2018-19 and 2019-20, the following actions were taken:

Table 10–Summary of Provider Sanctions Imposed

Actions Taken	Actions Imposed FY 2018-19	Actions Imposed FY 2019-20	Total
Temporary Suspensions & Payment Suspensions[5]	43	28	71
Civil Money Penalties (1st, 2nd, 3rd warning notices)[6]	35	22	57
Procedure Code Drug Limits[7]	5	0	2
Total	80	50	130

[5] Temporary Suspension & Payment Suspension–A Temporary Suspension may be placed on a provider if a provider is under investigation by DHCS 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.

[6] 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.

[7] 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 CA-MMIS Division verifies the providers information, instructs the FI 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.