Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

California Comprehensive Program Integrity Review

Final Report

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the California Medicaid Program. The MIG review team conducted the onsite portion of the review at the California Department of Health Care Services (DHCS) offices. The review team also met with the California Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the DHCS Office of Audits and Investigations (A&I), which is primarily responsible for Medicaid program integrity oversight. This report describes two noteworthy practices, three effective practices, nine regulatory compliance issues, and six vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified six full or partial uncorrected repeat findings and two uncorrected repeat vulnerabilities from its 2009 review of California. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help California improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of California's Medicaid Program

The DHCS administers the California Medicaid program, Medi-Cal, within the State. The program services are delivered through a combination of fee-for-service (FFS) and three models of managed care health plans: Two-Plan, County Organized Health Systems, and Geographic Managed Care. As of January 1, 2011, the Medi-Cal program served 7,522,200 beneficiaries. The State had 120,414 providers participating in FFS and 20,456 providers participating in physical health managed care plans. Medicaid expenditures for Federal fiscal year 2011 totaled $54,064,095,492.

Program Integrity Section

The A&I is the organizational component dedicated to fraud and abuse activities. The A&I comprises three operational branches, Financial Audits, Investigations, and Medical Review. At the time of the review A&I had 196 authorized full-time equivalent positions allocated to Medicaid program integrity functions with 25 vacant positions. The table below presents the total number of investigations and overpayment amounts identified and collected for the last four State fiscal years (SFYs) because of A&I program integrity activities. Although some program

integrity responsibilities have been delegated to other State agencies and contractors through agreements, the ultimate responsibility for program integrity lies with A&I. This table represents only program integrity activities from the Medical Review Branch, unlike overpayment and recoveries reported for the State Program Integrity Assessment data collection that includes all components within the State Medicaid program.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities***	Overpayments Collected Through Program Integrity Activities***
2008	not available	not available	$39,360,396	$15,587,170
2009	not available	not available	$31,663,536	$11,771,327
2010	393	3,646	$24,345,240	$15,459,142
2011	507	3,110	$24,833,795	$24,159,859

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. The number of investigations conducted in SFYs 2008 and 2009 were not available because the program integrity tracking system was not operational until July 1, 2009.
** Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition. Full investigations in California are non-provider cases that are investigated by A&I.
*** According to the State, the identified and collected overpayments are related, but the amount collected is not equivalent to the amounts identified due to time lags between identification and collection.

Methodology of the Review

In advance of the onsite visit, the review team requested that California complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosure, managed care, and the MFCU. A four-person review team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of October 31, 2011, the MIG review team visited the offices of DHCS. The team conducted interviews with numerous DHCS officials, contractor staff, and the MFCU. To determine whether managed care entities (MCEs) were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed staff within the Medi-Cal Managed Care Division. The team also reviewed the managed care contract provisions and gathered information through interviews with three physical and two mental health MCEs. In addition, the team sampled provider enrollment applications, program integrity cases, and other primary data to validate California's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of DHCS A&I, but also considered the work of other departments within DHCS responsible for a range of program integrity functions, including provider enrollment and managed care. California operates its Children's Health Insurance Program (CHIP) as both a stand-alone Title XXI program and a Title XIX Medicaid expansion program. The expansion program operates under the same billing and provider enrollment policies as California's Title XIX program. The same effective practices, findings, and

vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP expansion program. The stand-alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, A&I provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

Results of the Review

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified two practices that merit consideration as noteworthy or "best" practices. The CMS recommends that other States consider emulating these activities.

Medi-Cal payment error studies

The State has developed a Medicaid payment error study to identify provider types at greatest risk for payment errors. These data runs have resulted in special focused reviews of pharmacies and adult day health centers. The State also conducts weekly random audits on various provider claims. Based on the results, the State develops new fraud control strategies and determines how best to deploy limited Medi-Cal anti-fraud resources. Error rates were reduced from 8.4 percent in SFY 2005 to 5.45 percent in SFY 2009 and the total savings was $339,663,123.

Multi-faceted provider education program

The DHCS maintains a web-based provider training program. The Medi-Cal Learning Portal is an easy one stop learning center for Medi-Cal billers and providers. Provider services that are available through the portal include provider seminars, webinars, and eLearning Tutorials.

First time users must complete a one-time registration to have access to the tool. The eLearning tutorials for providers are particularly unique because of the capability to take an on-line quiz after each tutorial, thus enhancing a provider's training and education about topics such as claims follow-up, common denials, computer media claims, crossover claims, internet professional claim submission, real time internet pharmacy claim form, recipient eligibility, and the UB-04 claim form.

In September 2011, DHCS collaborated with the CMS Center for Program Integrity and the California Medical Health Association in conducting a month long series of provider education events. The events were conducted weekly and at various locations throughout California. Topics included "Understanding the Impact of Fraud on Patient Care and Your Practice", "Protect Yourself and Your Medical Identity" and "Protect Your Practice-Monitoring Your Medical Record Documentation."

Effective Practices

As part of its comprehensive review process, the CMS also invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. California reported hospice and targeted durable medical equipment (DME) provider audits and the individual provider claims analysis report.

Hospice audits

Hospice audits were directed at the small percentage of hospice providers who failed to reimburse Medi-Cal for the share-of-cost they collected from patients in skilled nursing facilities. The A&I completed 117 hospice audits between July 2007 and June 2011. The total identified overpayment was $10,486,020.

Targeted power wheelchairs audits

The A&I used a U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) case as a trigger for initiating an audit targeted at claims for power wheelchairs, which were far more costly than power scooters. At the time of the review, A&I had completed reviews of 81 of the 183 identified DME providers to determine compliance with upper billing limits, rules and regulations. The State indicated that $2,538,805 in overpayments has been identified so far and the total overpayments are projected to be $11,714,606 once all reviews are completed.

Individual provider claims analysis report

The claims analysis report allows individual providers to see how their billing and/or prescribing trends compare with that of their peers statewide. The comparison with their peers is designed to positively change billing and/or prescribing behavior. For example, if a provider learns that he or she prescribes antibiotics more frequently than the average prescriber, he or she may modify the practice thus resulting in cost savings to the Medi-Cal program.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding methods and criteria for identification, investigation, or referral of suspected fraud cases for Home and Community-Based Services (HCBS) waiver programs, verification of receipt of services billed, and case referrals to the MFCU. Additional issues include not suspending payments and not following performance standards, not collecting disclosures, incomplete exclusion searches, and not reporting all adverse actions to HHS-OIG.

The State does not have methods and criteria for identification, investigation, or referral of suspected fraud cases for HCBS waiver programs. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 455.13 requires a State Medicaid agency to have methods and criteria for identifying suspected fraud cases and investigating those cases, and to have procedures for referring suspected cases of fraud to law enforcement officials.

During the 2009 MIG review, the team learned that HCBS waiver programs were housed in sister agencies, California Department of Social Services (CDSS) and Department of Developmental Services (DDS). The CDSS and DDS were not contractually required to report suspected fraud and abuse to DHCS. As a result, DHCS was unable to refer suspected cases of fraud to the MFCU or any other applicable law enforcement agency.

Although California has made changes to the infrastructure of its Medicaid program since the CMS 2009 review, problems still exist with CDSS and DDS. During the current review, the team determined that the HCBS waiver programs are not reporting suspected fraud to the MFCU or other applicable law enforcement agency.

Recommendations: Revise interagency agreements with CDSS and DDS to require reporting of suspected fraud and abuse cases to the State agency. Implement policies and procedures for identifying, investigating, and tracking potential provider fraud cases from all agencies outside of DHCS. Implement a policy and procedure for referring cases of suspected fraud to appropriate law enforcement. The MIG made this same recommendation for 42 CFR § 455.13 in the 2009 review report.

The State does not verify with beneficiaries whether services billed were received. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

The review team learned during the 2009 MIG review that CDSS's In-Home Support Services program and DDS' Regional Centers were not routinely conducting verification of recipient services. Although the State is conducting quality assurance in these programs, CDSS and DDS does not verify with beneficiaries whether services billed were received. This issue remains uncorrected from the last review.

***Recommendations*:** Implement procedures to verify with beneficiaries whether services billed were received. Require CDSS and DDS to conduct verification of services and provide oversight to ensure that all contractors are in compliance with 42 CFR § 455.20. The MIG made this recommendation regarding the CDSS and DDS waiver programs in the 2009 review report.

The State does not refer all cases of suspected provider fraud to the MFCU.

Under the Federal regulation at 42 CFR § 455.21, State Medicaid agencies must refer all cases of suspected provider fraud to the MFCU; promptly comply with requests for access to records or information, including computerized data, from the agency or its contractors, and from providers; and initiate administrative or judicial actions to recover improper payments from providers.

The DHCS memorandum of understanding with the MFCU requires A&I to refer cases of suspected fraud and abuse to the MFCU. However, all three branches within A&I conduct separate case investigations at any given time, but only the Investigation Branch has the

authority to determine a credible allegation of fraud and refer those cases to the MFCU. The remaining two branches refer their cases to the Investigation Branch for a credible allegation of fraud determination before a referral is made to the MFCU. Because each branch has its own process and procedures, there can be a significant delay in the MFCU's receipt of fraud referrals.

During case sampling, the review team noted that A&I spends a considerable amount of time developing a case to determine if a referral to the MFCU is appropriate. For example, during SFY 2011 A&I made 14 referrals to the MFCU at least one year after the preliminary investigation was conducted. Potential MFCU investigations may be compromised due to the breadth, depth, and timeliness of the State's investigations.

With a $54 billion Medicaid budget, California ranks in the top 10 of States in terms of total Medicaid expenditures. Yet it has an unusually low number of referrals to the MFCU. During the last three SFYs only 400 cases were referred to the MFCU. In addition, there were inconsistencies in the numbers of referrals that were reported by A&I and the MFCU. Between January 2012 and March 2012, the MFCU reported 10 referrals, whereas A&I reported 14 referrals. During the onsite review, A&I admitted there were glitches in its case tracking system.

Recommendations: Develop and implement policies and procedures across all divisions to expedite referral of all cases of suspected provider fraud to the MFCU. Make improvements to the case tracking system to ensure all cases are appropriately tracked.

The State does not suspend payments in cases of credible allegations of fraud and is not conforming to the regulatory performance standards.

The Federal regulation at 42 CFR § 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part; and 42 CFR § 455.23(d) requires that the State Medicaid agency make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

California is not suspending payments in cases of credible allegations of fraud because it does not have State authority to suspend payments. The State is unable to comply with this regulation until the language is codified into State law. The State further reported, and the MFCU confirmed, that they are not yet utilizing the referral performance standards for referrals to the MFCU.

Recommendations: Craft and submit bill language to codify the payment suspension requirements under 42 CFR § 455.23(a) into state law. Implement the *CMS-MIG Performance Standard For Referrals Of Suspected Fraud From A Single State Agency To A Medicaid Fraud Control Unit* in documenting all MFCU referrals as required at 42 CFR § 455.23(d).

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date or birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

As of March 25, 2011, the State agencies must capture SSNs and DOBs and enhanced address information for all persons with an ownership or control interest in providers seeking enrollment in a State Medicaid program. California has not changed its current FFS enrollment forms to include the requirement of the SSNs and DOBs for disclosing entities.

During the 2009 MIG review, DHCS was not collecting the full range of disclosures from the fiscal agent during the contracting process for persons with ownership or control interests, subcontractors and other disclosing entities. During the current review, the team determined that DCHS is not collecting disclosures from the fiscal agent and MCEs.

In addition, DHCS does not require CDSS and DSS to collect the same disclosures in HCBS waiver programs. Further, the California Department of Public Health (CDPH) Licensing and Certification Division does not promptly report disclosure information to the State agency as required by the regulation. Staff only report "actionable" information. This issue also remains uncorrected from the CMS 2009 review.

Recommendations: Develop and implement policies and procedures across all agencies for the appropriate collection of disclosures from disclosing entities, fiscal agents and MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, and MCEs. Modify disclosure forms for all agencies as necessary to capture all disclosures required under the regulation. Develop a cooperative agreement with CDPH to report disclosure information under 42 CFR § 455.104(b)(1) to DHCS. The MIG made the same recommendation in the 2009 review report.

The State does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.105(b) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

California's FFS disclosure statement packet requires the disclosure of business transaction information at the time of application and upon request. However, the provider agreement between the State and the provider does not contain specific language related to this regulation. The DHCS is using and accepting provider agreements dated "rev. 2/08". This issue remains uncorrected from the 2009 CMS review.

In addition, DHCS does not require CDSS and DDS to require disclosure of business transaction information, upon request, from vendors enrolled in waiver programs. This issue remains uncorrected from the 2009 CMS review.

Recommendation: Revise the provider agreements and interagency agreements to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The MIG made this same recommendation in its 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

California's FFS disclosure statement requests criminal conviction information related to Federal health care programs "within 10 years of the date of this statement," not "since the inception of those programs" as required by the regulation. The State indicated that disclosure information is forwarded to the Office of Legal Services who, subsequently, forwards the information to the appropriate local branch of HHS-OIG. Additionally, sister State agencies responsible for program integrity oversight of the HCBS and IHSS waivers are not forwarding criminal conviction information to DHCS. This is a repeat finding from the 2009 CMS review.

Recommendations: Develop and implement policies and procedures for the appropriate collection of disclosures from providers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers who have been convicted of a criminal offense related to Medicare, Medicaid, or Title XX since the inception of the programs.

Modify disclosure forms as necessary to capture all disclosures required under 42 CFR § 455.106. The MIG made the same recommendation in its 2009 review report.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System[1] (EPLS) no less frequently than monthly.

The DHCS only checks the LEIE for FFS providers, persons with an ownership or control interest in the provider, and agents and managing employees of the provider upon enrollment and reenrollment. The EPLS database is not used at any time to conduct exclusion checks on applicable disclosing entities.

Moreover, there was no evidence that disclosure information is collected from fiscal agents and MCEs, leaving DHCS unable to complete subsequent checks of the LEIE and EPLS in accordance with the regulation.

In addition, the State terminated a provider in 2002, and included that provider on the State list of Suspended and Ineligible Providers. However in early 2012, California discovered that the provider was employed as the medical director of a hospice organization during the State-initiated termination.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database (MED)) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities. Modify the managed care and fiscal agent contracts to require LEIE and EPLS searches upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the entities, or who is an agent or managing employee of the entities. Search the State's exclusion list to ensure that the State does not pay Federal funds to excluded providers.

The State does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

[1] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

The DHCS is not reporting to HHS-OIG when the State denies enrollment to a provider or disenrolls a provider, or when a provider voluntarily disenrolls to avoid a formal sanction. This remains uncorrected from the 2009 CMS review.

Recommendations: Develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions taken on a provider's participation in the Medicaid program pursuant to 42 CFR § 1002.3(b)(3). The MIG made the same recommendation in its 2009 review report.

Vulnerabilities

The review team identified six areas of vulnerability in the State's program integrity practices. These involve incomplete exclusion searches, not verifying receipt of services with managed care enrollees, not capturing disclosures from MCE network providers and not reporting adverse actions to HHS-OIG.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the Medicaid Management Information System, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS[2] on a monthly basis.

Four of the five MCEs interviewed were not conducting monthly checks of the LEIE and EPLS for their network providers. The DHCS does not contractually require the MCEs to conduct monthly checks to screen their employees for excluded parties.

[2] On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities pursuant to 42 CFR § 455.436.

Not verifying with managed care enrollees whether services billed were received.
The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

Two of the five MCEs interviewed had no process to verify that services had been received. Another MCE indicated that it does have a verification process and explained that the process involves pulling a sample of services from one date of service within a quarter. This process could, however, violate the requirement that the verification take place within 45 days of the date of service that is in effect for FFS providers.

Recommendation: Develop and implement procedures to verify with MCE enrollees whether services billed by providers were received per 42 CFR § 455.20.

Not capturing ownership and control disclosures from network providers. (Uncorrected Repeat Vulnerability)
Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

Five of the six MCE network provider applications reviewed do not request names of owners or those with controlling interest in subcontractors directly or indirectly owned by disclosing entities or the name of other disclosing entities in which the named owners or those with

controlling interests have an ownership interest. This issue was also identified in the 2009 CMS review.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all MCE network providers as identified in 42 CFR § 455.104. Include contract language requiring MCEs to notify the State of such disclosures on a timely basis. The MIG made the same recommendation in the 2009 review report.

Not adequately addressing business transaction disclosures in network provider contracts.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or HHS information about certain business transactions with wholly owned suppliers or any subcontractors.

California's MCE provider participation agreements do not include language requiring network providers to submit the specified business transaction information upon request that would otherwise be required of FFS providers under 42 CFR § 455.105. Of the six managed care network provider agreements that the CMS team reviewed, none contained language requiring the disclosure of certain business transactions with wholly owned suppliers or any subcontractors upon request.

Recommendation: Modify the managed care provider agreements to require disclosure upon request of the information identified in 42 CFR 455.105(b).

Not capturing criminal conviction disclosures from network providers.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

All five MCEs interviewed revealed that they do not request disclosure of criminal convictions in health care-related crimes from their network providers that the Federal regulations at 42 CFR § 455.106 would otherwise require from FFS providers. The network provider applications do request health care-related criminal conviction disclosures but only "within 10 years of the date of this statement," not, "since the inception of those programs" as required by the regulation. In addition, they do not request similar disclosures from persons with ownership or control interests, agents, or managing employees.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing

employees of network providers as identified in 42 CFR § 455.106. Include in the contract, language requiring MCEs to notify the State of such disclosures on a timely basis.

Not reporting all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Four of the five MCEs interviewed reported that they do not notify the State of actions taken on a provider application. The State Medicaid agency does not have clear policies and procedures or contract requirements directing the MCEs to report any program integrity-related adverse actions the MCE takes on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality. This issue remains uncorrected from the 2009 CMS review.

Recommendations: Require contracted MCEs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG pursuant to 42 CFR § 1002.3. The same recommendation was made in the 2009 review report.

Conclusion

The State of California applies some noteworthy and effective practices that demonstrate program strength and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

Although California has made changes to the infrastructure of its Medicaid program since the 2009 CMS review, problems still exist with sister agencies. The CMS recognizes these changes, but the State did not go far enough to include all agencies outside of DHCS. The CMS has assisted California in strengthening its program integrity program by providing onsite courses in CPT Coding (Federal fiscal years 2010 and 2011) and Interviewing and Interrogation (October 2012), along with opportunities to attend trainings at the Medicaid Integrity Institute. The CMS recommends that California continue to work on enhancing the entire Medicaid program infrastructure, so there is more accountability and consistency among all sister agencies.

The identification of nine areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, six areas of vulnerability were identified. The CMS is particularly concerned over the eight uncorrected repeat findings and vulnerabilities. The CMS expects the State to correct them as soon as possible.

To that end, we will require DHCS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of California will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If California has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of California on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

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JAN 3 1 2013

Mr. Robb Miller, Director
Division of Field Operations
Medicaid integrity Group
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Dear Mr. Miller:

The Department of Health Care Services (DHCS) is pleased to provide you with its response to the November 2012 final report entitled "California Comprehensive Program Integrity Review" issued by the Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG). CMS conducted a comprehensive program integrity review of the California Medicaid Program and reported nine regulatory compliance issues and six vulnerabilities.

DHCS agrees with six of the regulatory compliance findings. The six regulatory compliance findings are that the State: (1) does not have methods and criteria for identification, investigation, or referral of suspected fraud cases for Home and Community-Based Services waiver programs; (2) does not refer all suspected fraud to the Medicaid Fraud Control Unit; (3) does not suspend payments in cases of credible allegations of fraud and is not conforming to regulatory performance standards; (4) does not capture criminal conviction disclosures from providers or contracts; (5) does not conduct complete searches for individuals and entities excluded from participating in Medicaid; and (6) does not report all provider participation adverse actions to the Department of Health & Human Services- Office of Inspector General (HHS-OIG).

There is partial agreement with the two regulatory compliance findings. First, the Medi-Cal Dental Services Division (MDSD), the Provider Enrollment Division (PED), and the Medi-Cal Managed Care Division agree with the finding that the State does not capture all required ownership and control disclosures from disclosing entities. However, the California Department of Developmental Services (CDDS) disagrees with this finding. CDSS requires providers to utilize the modified disclosure form which captures all disclosure required by 42 Code of Federal Regulations (CFR) § 455.104(b)(1). Next, MDSD and PED agree with the finding that the State does not adequately address business transaction disclosure requirements in its provider agreement or contracts; however, the California Department of Social Services (CDSS) does not agree with the finding since they require providers to utilize the modified disclosure form which captures all disclosures required by 42 CFR § 455.105(b) CDDS and CDSS disagree with the

finding that the State does not verify with beneficiaries whether billed services were received. CDDS and CDSS verify receipt of services with beneficiaries as required by 42 CFR § 455.20.

The MIG identified six vulnerabilities in the State's program integrity practices. These include incomplete exclusion searches, not verifying receipt of services with managed care enrollees, not capturing disclosures for ownership, control, business transaction, and criminal conviction from MCE network providers, and not reporting adverse actions to the HHS-OIG. DHCS agrees with the vulnerabilities.

DHCS has prepared corrective action plans to implement the recommendations made by the MIG. DHCS appreciates the work performed by MIG and the opportunity to respond to the final report. Please contact MS. Raj Khela, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

Toby Douglas
Director

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