

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

California Focused Program Integrity Review

Final Report

March 2016

Submitted By:

Annette Ellis, Review Team Leader

Barbara Davidson

LaShonda Mazique

Brent Person

Captain Debra Tubbs

Sean Johnson, Review Manager

**California Focused PI Review Final Report
March 2016**

Table of Contents

Objective of the Review..... 1
Background: State Medicaid Program Overview 1
Methodology of the Review..... 1
Results of the Review 2
 Section 1: Affordable Care Act Provider Screening and Enrollment 2
 Section 2: Managed Care Program Integrity 15
Technical Assistance Resources 32
Conclusion 33
Official Response from California..... A1

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review to determine whether California's program integrity procedures were in compliance with federal regulations that require enhanced provider screening and enrollment provisions under the Affordable Care Act. Additional goals of the review were to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state. The review also included a follow up on the state's progress in implementing the corrective action plan (CAP) that resulted from CMS's last program integrity review in Federal Fiscal Year (FFY) 2012.

Background: State Medicaid Program Overview

California's Medicaid program, known as Medi-Cal, is administered by the Department of Health Care Services (DHCS). The Medi-Cal program is the largest Medicaid program in the country. At the time of the review, approximately 11.2 million beneficiaries were enrolled in the program and total annual expenditures for State Fiscal Year (SFY) 2013-2014 were over \$65.7 billion. To help administer its comprehensive services, DHCS has entered into interagency agreements with several sister state agencies to provide services to special populations. In addition to providing specialty services, these sister agencies are also involved in enrolling providers. Their roles will be discussed in more detail later in this report.

Beginning September 2013, California expanded managed care into rural areas that were previously providing services on a fee-for-service (FFS) basis only. This managed care expansion (not to be confused with the Medicaid expansion under the Affordable Care Act) was implemented in 28 counties. Later, California was one of 27 states, along with the District of Columbia, that implemented Medicaid expansion under the Affordable Care Act. Like most states, California implemented its Medicaid expansion through managed care. California's program for the expansion population mirrors the services for the traditional Medicaid population. At the time of the CMS review, 76.3% of all beneficiaries were enrolled in managed care plans. More than 100,000 providers were enrolled in FFS by DHCS and 389 providers were enrolled solely as ordering or referring physicians (ORPs).

Methodology of the Review

In advance of the onsite visit, CMS requested that California and the MCOs selected for the focused review complete a review guide that provided detailed insight into the operational activities of the areas that were the subject of the review. A five-person team assessed the responses and any additional materials prior to the onsite visit.

California Focused PI Review Final Report

March 2016

During the week of August 11, 2014, the CMS review team visited DHCS and the Special Investigation Unit (SIU) at Health Net Community Solutions, Inc. (HN). Prior to going onsite, the review team interviewed three other MCOs: Gold Coast Health Plan (GCHP), California Health and Wellness (CHW), and Alameda Alliance for Health (AAH) by phone. At the time of our review, AAH was in a conservatorship that began in May 2014 when the State Department of Managed Health Care took over the plan due to fiscal concerns. As part of the onsite review, the team conducted interviews with agency staff involved in program integrity, provider enrollment, and managed care, along with staff from sister agencies that provide specialty services. To validate California's and the selected MCOs' program integrity practices, the team also reviewed a sample of provider enrollment applications, MCO investigations, actions against providers, and other primary data.

Status of Corrective Action

The 2012 PI Review resulted in numerous findings and vulnerabilities. The report specifically cited nine findings related directly to regulation and six vulnerabilities. Although the state has taken steps to address some of these findings and vulnerabilities, more attention is needed to make corrections and to mitigate risks. It is imperative that DHCS take the lead in ensuring that sister agencies have implemented all necessary corrective action.

The attached addendum provides a detailed listing of the 2012 findings and vulnerabilities. It also outlines the state's current status relative to each issue cited in that report.

Results of the Review

The focused review covering California's enrollment activities and managed care operations found the state to be in compliance with many of the program integrity requirements. However, the review team identified several areas of concern and instances of regulatory non-compliance in some of the program integrity activities, which create a risk to the Medicaid program. CMS will work closely with the state to ensure that all issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

The California DHCS has a CMS approved State Plan Amendment that has an effective date of January 1, 2013. The State Plan Amendment is specific to assure compliance with the Provider Screening and Enrollment requirements as outlined under Section 6401(a) of the Affordable Care Act and 42 CFR 455 subpart E. Although the State Medicaid agency (DHCS) is ultimately accountable for the screening and enrollment of all providers in the Medi-Cal program,

California Focused PI Review Final Report

March 2016

responsibility for some of the activities involved in the screening process are delegated to other state agencies. There were six agencies identified as having some responsibility for the activities involved in screening and enrolling providers in the Medi-Cal program. These six agencies are described below:

- The primary department is DHCS and its Provider Enrollment Division (PED). DHCS is responsible for screening and enrolling all FFS Medi-Cal providers (non-institutional and institutional) and certifying Drug Medi-Cal providers so that they may contract with their local county entities.
- Although DHCS is responsible for the enrollment of institutional providers, the California Department of Public Health (CDPH) has played an instrumental role in the screening process. CDPH is responsible for screening and reviewing applications for all institutional provider types and confirming that the provider meets all enrollment requirements for participation in the Medi-Cal program. Once CDPH confirms that the provider meets all enrollment requirements, a transmittal with the provider's information is sent to DHCS's PED. DHCS is responsible for inputting the provider's information into the Provider Master File, once the transmittal is received from CDPH.
- The California Department of Aging (CDA) is responsible for screening and enrolling Community Based Adult Services (CBAS) providers, specifically Adult Day Health Care (ADHC) centers.
- The California Department of Developmental Services (CDDS) contracts with regional centers that are responsible for screening and enrolling Home and Community-Based Service (HCBS) providers, which are referred to as "vendors".
- California Department of Social Services (CDSS) is responsible for screening and enrolling In-Home Supportive Services (IHSS) providers.
- The Department of Education works in coordination with the Safety Net Finance Division within DHCS and is responsible for the enrollment of the local education agencies. It was not included in the scope of this review.

Prior to the onsite review, CMS received completed review guide responses from four departments: DHCS, CDA, CDDS, and CDPH. While onsite, the CMS review team interviewed representatives from four sister agencies. Those agencies were DHCS, CDA, CDPH, and CDSS. The findings described below are from the review of these documents and the interviews held. As mentioned earlier, DHCS will ultimately be responsible for overseeing any corrective action that has been delegated to a sister state agency.

42 CFR 455.410: Enrollment and screening of providers

The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ORPs or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by either of the following:

- (1) Medicare contractors.
- (2) Medicaid agencies or Children’s Health Insurance Programs of other states.

The state is not in compliance with this regulation.

The DHCS PED does require all ORPs or other professionals providing services under the State Plan to be enrolled as a participating provider. At the time of the review, the state had 389 ORPs enrolled in the Medi-Cal program.

The CDA does not have oversight responsibility for ORPs or other professionals. The CDA further explained that it does not have ORPs in its system. CDA is responsible for enrolling CBAS providers. However, CMS did voice concern as to whether the physicians ordering the services would be considered ORPs and encouraged the state to review this issue further to ensure compliance. The state indicated that CDA and DHCS share the same Medicaid Management Information System that processes claims for CBAS and fee-for-service providers, implying that the claims for CBAS services would contain the identification of the ORP.

As mentioned earlier, CDDS contracts with regional centers that are responsible for screening and enrolling HCBS providers. Regional centers must meet specific guidelines established by the state. As CDDS was not interviewed further, no other details are available on the enrollment process. CMS has similar concerns with the services provided through regional centers and encouraged the state to review this further to ensure that the providers ordering these services would not be considered ORPs.

In CDSS, ORPs are not applicable due to having IHSS providers only; these providers are equivalent to personal care attendants. CDSS only oversees the IHSS providers. CMS has similar concerns with this system, as mentioned above.

Recommendations: Since the sister agencies have limited oversight of specific providers under their purview, the state should evaluate the role of the physicians and/or professionals ordering or referring to these services. The state should also evaluate whether these physicians and other professionals are being captured as ORPs through DHCS’s provider enrollment process or if the sister agencies should be enrolling these providers as ORPs. The state should consider streamlining the enrollment of all providers through one system to provide consistency in the enrollment process and to ensure that all providers are being screened according to the regulations.

42 CFR 455.412: Verification of provider licenses

The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider’s license has not expired and that there are no current limitations on the provider’s license.

The state is not in compliance with this regulation.

The DHCS has a process in place to validate a provider's license during enrollment and revalidation; this includes out-of-state providers. The DHCS checks the applicable databases and websites, such as the Medical Board of California website, to verify all applicants/providers have valid licenses. DHCS also confirms that there are no limitations on the license, during initial enrollment and revalidation. However, at time of the review, DHCS reported that it does not maintain a list of providers whose licenses are due to expire. The agency explained that this is the function of the Department of Consumer Affairs (DCA) which governs all licensing boards in the State of California. DHCS explained that there is not a process or mechanism in place to identify or track if a provider's license expires prior to the time of revalidation. It was also reported that DHCS does not receive notifications from DCA on an ongoing basis to alert the State Medicaid agency of any actions taken against a provider's license.

Prior to certification or recertification of a CBAS provider, CDA coordinates with CDPH to ensure that the license for each CBAS provider is current and does not have any license restrictions. CDPH maintains license tracking information and informs CDA via the CMS Form 1539 when a provider's license expires.

The CDDS verifies each regional center and vendor rendering services has a valid license and/or certificate and each vendor license is monitored for expiration and there are no current limitations.

The CDSS responded in the review guide, and confirmed during the interview, that 42 CFR 455.412 is not applicable to the IHSS providers, as these are non-licensed individuals.

Recommendation: The DHCS should develop policies and procedures to track providers' licenses that are about to expire and subsequently validate the renewed license through the DCA.

42 CFR 455.414: Revalidation of enrollment

The regulation at 42 CFR 455.414 requires that the State Medicaid agency revalidate the enrollment of all providers regardless of provider type at least every 5 years.

The deadline has been revised according to *Sub Regulatory Guidance for state Medicaid Agencies: Revalidation (2016-001)*. The purpose of this guidance is to align Medicare and Medicaid revalidation activities to the greatest extent possible. The new requirement is now a two-step deadline under which states must notify all affected providers of the revalidation requirement by the original March 24, 2016 deadline, and must have completed the revalidation process by a new deadline of September 25, 2016.

The state is potentially at risk of non-compliance with this regulation for both the March 25, 2016 and September 25, 2016 deadlines.

At time of the review, DHCS reported over 100,000 providers enrolled in FFS. Of these, 683 had been revalidated. However, there is some concern DHCS will not be able to complete the revalidation of all enrolled providers by the revised September 25, 2016 deadline. The DHCS stated it plans to address this by implementing a web-based provider enrollment process called Provider Application and Validation for Enrollment System (PAVE). Once PAVE is fully implemented DHCS anticipates a more organized approach to the revalidation process. The state reported during the review that the PAVE system is expected to be fully implemented by February 2015.

The CDA is in compliance with this regulation. The CDA indicated there are 244 CBAS providers currently enrolled in their system; all 244 providers have been revalidated. All CBAS providers are subject to revalidation of enrollment through the statutorily mandated certification process; this requires renewal of certification at least every 24 months. CBAS indicated it renews certification for approximately half of the total number of CBAS providers annually. However, CBAS providers are only required to disclose some (but not all) items listed under 42 CFR 455.104 and 42 CFR 455.106. The revalidation will not capture all social security numbers, unless it is an executive staff member. The criminal background checks will only be conducted on the facility administrator, program director, and fiscal officer.

The CDDS is not at risk of being in non-compliance with this regulation by September 25, 2016. CDDS revalidates its providers every 24 months. At the time of the review, of the 10,303 HCBS providers enrolled, 9,282 had been revalidated.

The CDSS is potentially at risk of being in non-compliance with this regulation by September 25, 2016. CDSS does have a revalidation process; however, it has not been implemented. CDSS is awaiting approval and further directive from DHCS PED on the proposed revalidation process. As of December 31, 2013, CDSS had 401,385 enrolled providers.

Recommendations: The state should continue to closely monitor its FFS operations to ensure that the new PAVE system will adequately revalidate all of its providers prior to the September 25, 2016 deadline. In addition, the state needs to address and confirm procedures for revalidating the IHSS providers.

42 CFR 455.416: Termination or denial of enrollment

The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. This includes situations where the Medicare program, another state Medicaid program, or a state's Children's Health Insurance Program has terminated a provider for-cause on or after Jan. 1, 2011, unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

The state is in compliance with this regulation.

The DHCS demonstrated compliance with this regulation. DHCS provided several links to regulatory and statutory requirements to show that policies and procedures are in place to deny or terminate providers who met the criteria set out in the regulation. The DHCS staff presented the review team with sample provider termination letters to further display its compliance with this regulation. However, a review of Medicare terminations in the CMS terminations database revealed that there were two providers still actively enrolled in the Medi-Cal program. For one of these, DHCS indicated that the provider would not be discovered until the September match against the database. For the other, the state had identified the provider in the previous month's match and the case had been referred for review.

The CDA and CDDS demonstrated compliance with this regulation. The CDA and CDDS provided several links to regulatory and statutory requirements to show that policies and procedures are in place to deny or terminate providers who met the criteria set out in the regulation. However, the CDA and CDDS do not upload for-cause provider terminations into the CMS terminations database via the Tibco managed file transfer. For-cause provider terminations are transmitted from CDA and CDDS to DHCS; subsequently, DHCS uploads all for-cause provider terminations to the Tibco server on behalf of the two sister agencies. Since July 1, 2012, the CDA reported that it had terminated one provider; the team verified that this provider was listed in the CMS database of terminations. In addition, the CDA staff presented the review team with sample provider termination letters to further display its compliance with this regulation.

The CDSS demonstrated partial compliance with this regulation. The CDSS provided links to California state statutes addressing the denial and termination process for IHSS applicant providers and enrolled providers who meet the criteria set out in this regulation. However, the CDSS has not uploaded any for-cause terminations via the Tibco server. CDSS explained it has been working in consultation with DHCS to determine the criteria for placing terminated individuals in the Tibco server database. The review team offered technical assistance to CDSS in gaining access to the Tibco server to begin uploading for-cause terminated IHSS providers.

Recommendation: Although the state is found to be in compliance by having procedures to screen providers and ensure that an applicant has not been previously terminated from Medicare or another Medicaid program, the state should ensure that processes are in place to import data of terminated providers from sister agencies into the CMS termination database.

42 CFR 455.420: Reactivation of provider enrollment

The regulation at 42 CFR 455.420 requires that after deactivation of a provider enrollment number for any reason, and before the provider's enrollment may be reactivated, the State Medicaid agency must re-screen the provider and require payment of associated provider application fees under § 455.460.

The state is in compliance with this regulation.

**California Focused PI Review Final Report
March 2016**

The state requires all providers with deactivated provider numbers complete enrollment process when requesting to be reactivated.

Recommendation: None

42 CFR 455.422: Appeal rights

The regulation at 42 CFR 455.422 requires that the State Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under State law or regulations.

The state is in compliance with this regulation.

The DHCS, CDA, CDDS, and CDSS are in compliance with this regulation. The State Medicaid agency does have administrative regulations that afford providers appeal rights and the information is included in provider agreements. In addition, the four agencies presented samples of their denial and termination letters that afforded the provider with appeal rights.

Recommendations: None

42 CFR 455.432: Site visits

The regulation at 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as “moderate” or “high” categorical risks to the Medicaid program.

The state is in compliance with this regulation.

The DHCS, CDA, and CDSS have demonstrated compliance with this regulation. DHCS followed Medicare guidelines in designating providers as moderate risk and high risk.

Pre and post-enrollment site visits are split between the DHCS Office of Audits and Investigations (A&I) and the CDPH. The A&I performs pre-enrollment and post-enrollment site visits for the majority of non-institutional providers, while CDPH conducts the site visits for mostly institutional providers. However, A&I has elected to go beyond the minimum standards for site visits and does not limit its visits to only moderate and high-risk providers. A&I conducts site visits on: individual and group practitioners, assisted living facilities, HCBS waiver providers, non-emergency medical transportation providers, DME providers, laboratories, and pharmacies.

The CDPH conducts pre-enrollment and post-enrollment site visits for CDA-enrolled providers and CDPH licensed and certified institutional providers. CDPH is responsible for conducting site visits for home health agencies, hospitals, skilled nursing facilities, intermediate care facilities, and dialysis clinics.

Recommendations: None

42 CFR 455.436: Federal database checks

The 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,

**California Focused PI Review Final Report
March 2016**

and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration Death Master File (SSADMF), the National Plan and Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The state is not in compliance with this regulation.

The DHCS does confirm the identity and exclusion status of providers, persons with ownership or control interest in the provider, agents, and managing employees of the provider during the initial enrollment and reenrollment by checking them against NPPES, LEIE, and EPLS. However, the DHCS only confirms the exclusion status of providers by checking them against the EPLS and LEIE on monthly basis after enrollment; it does not check persons with ownership or control interest, agents, and managing employees on a monthly basis. However, the state did indicate that persons with ownership or control interest, agents, and managing employees enrolled after May 2014 were being checked monthly against the LEIE. The SSADMF is not checked at the time of enrollment. DHCS indicated it plans to remedy this when PAVE is fully implemented in February 2015.

The CDA has not demonstrated compliance with this regulation. The CDA does not confirm the identity of providers, persons with ownership or control interest in the provider, agents, and managing employees of the provider during the initial enrollment and reenrollment process. During the interview, CDA indicated it is currently changing its enrollment application package to include the requirement of state-issued identification cards. However, CDA does confirm the exclusion status of providers, persons with ownership or control interest in the provider, agents, and managing employees of the provider by checking them against NPPES and LEIE at initial enrollment and reenrollment. The CDA does not check the SSADMF and EPLS at initial enrollment and reenrollment. CDA also indicated it does not check the LEIE and EPLS on a monthly basis thereafter. During the interview, the CDA revealed that it lacks the resources to conduct the required monthly database checks.

The CDPH collects disclosure information from institutional providers during their licensing. However, CDPH does not confirm the identity and the exclusion status of providers, persons with ownership or control interest in the provider, agents, and managing employees of the provider. The CDPH does not check the SSADMF, EPLS, LEIE, and NPPES at any point during the verification process.

The CDDS has not demonstrated compliance with this regulation. CDDS does confirm the identity and exclusion status of providers, persons with ownership or control interest in the provider, agent, and managing employees of the provider by checking them against the LEIE at initial enrollment and reenrollment. CDDS does not check the NPPES, SSADMF, and EPLS at initial enrollment and reenrollment. The CDDS also does not check the LEIE and EPLS on a

monthly basis thereafter.

The CDSS has not demonstrated compliance with this regulation. CDSS does confirm the identity and exclusion status of IHSS providers by checking them against the LEIE and EPLS at initial enrollment and monthly thereafter. However, the CDSS indicated that it currently does have a reenrollment/revalidation process and it is working with DHCS on ways to implement this process. CDSS further explained that the California statute does not require a specific time frame for revalidation of IHSS providers. The CDSS does not check NPPES and SSADMF at any time during the enrollment process. CDSS is primarily responsible for enrolling IHSS providers. Therefore, persons with ownership or control interest, agents, and managing employees of the provider would not be applicable.

Recommendation: The state should ensure that all agencies have access to and screen all required entities against the databases listed in the regulation. Consideration should be given to centralizing the provider database and/or having similar information technology systems across the agencies to ensure consistency and quality of database checks. If the PAVE system has the capability to provide this function, it should be utilized as a resource by all agencies as part of the state's interagency agreements.

42 CFR 455.440: National Provider Identifier

The regulation at 42 CFR 455.440 requires that the State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

The state is not in compliance with this regulation.

The DHCS claim forms did contain a field for the NPI of the ordering or referring physician or other professionals. However, there are no edits in place to reject claims that do not reflect ORPs or other professionals. By not being able to prevent these claims from being paid when the NPI of the ORP is not provided, the state is at risk of making payment for services that were ordered or referred by an unenrolled, and therefore, unscreened provider.

In addition, the sister agencies (CDA, CDDS, and CDSS) reported that this regulation was not applicable to them for the following reasons:

- The CDA only certifies and recertifies CBAS providers and does not process CBAS claims. Their claims are processed through DHCS.
- The CDDS indicated that this regulation was not applicable to them; however, they were not interviewed for further details.
- The CDSS providers do not submit claims; instead, the IHSS providers submit time sheets.

However, CMS expressed concerns about any physicians and/or professionals who may be ordering or referring services to providers who are performing under these agencies and encouraged the state to evaluate whether these agencies should be capturing ORPs in their claims system.

Recommendations: The DHCS should establish edits for capturing claims that are submitted without the NPI of ORPs. The state should re-evaluate the payment systems of the sister agencies and weather these systems need to capture the ORPs for the services under the purview of the sister agencies.

42 CFR 455.450: Screening levels for Medicaid providers

The regulation at 42 CFR 455.450 requires that the State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of “limited,” “moderate,” or “high.”

The state is in compliance with this regulation.

The DHCS has taken the lead to implement Affordable Care Act regulations with all departments. The risk designations mirror those of Medicare. The DHCS provided the *Medical Screening Level Requirements Provider Bulletin*, as well as a link to statutory requirements of this regulation. While reviewing Affordable Care Act sampling files, there was an indication that DHCS assigned risk levels to all enrolled providers. DHCS has authority to designate risk levels for CDA, CDSS, CDDS, and CDPH. Although CDA’s CBAS providers have not been deemed high risk, CDA conducts fingerprint checks for criminal background on any new administrator and program directors.

Further, the State Medicaid agency adjusts categorical risk levels from limited or moderate to high if:

- The State Medicaid agency imposes a payment suspension on a provider based on credible allegation of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment.
- The provider has been excluded by the OIG or another state’s Medicaid program within the previous 10 years.

A provider who was denied enrollment due to a temporary moratorium imposed on that particular provider type by the State Medicaid agency or CMS reapplies within 6 months of the moratorium being lifted.

Recommendations: None

42 CFR 455.460: Application fee

The regulation at 42 CFR 455.460 requires the State Medicaid agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.

The state is in compliance with this regulation.

The DHCS has a method for collecting application fees from Medicaid-only institutional providers. The DHCS has collected application fees from 566 providers from January 1, 2013 through June 11, 2014. During the sampling of provider files, the team saw evidence of the collection of application fees. There were copies of checks documenting the application fees collected.

For CDDS and CDSS, this regulation is not applicable for the following reasons:

**California Focused PI Review Final Report
March 2016**

<ul style="list-style-type: none">• The CDA only collects licensing fees, since CBAS providers are not considered institutional providers.• The CDDS enrolls regional centers and vendors that are HCBS waiver providers and not subject to an application fee.• For CDSS, the providers are individual IHSS providers and not subject to the application fee.
Recommendations: None

42 CFR 455.470: Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the State Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in a position to comply with this regulation to implement temporary moratoria.
The Secretary has not issued any moratoria that affect the state of California. However, the state has passed legislation to impose temporary moratoria and California has statutory language that allows it to impose its own temporary moratoria on enrollment of certain new providers in a geographical area or specific provider types across the state. DHCS has used its authority to impose moratoria to restrict enrollment on provider types to safeguard public funds or to maintain the fiscal integrity of the program. Since 2000, DHCS has implemented moratoria on four provider types and currently has three moratoriums in place: clinical laboratories; durable medical equipment providers for Los Angeles, Orange, Riverside, and San Bernardino counties; and non-chain/non-pharmacist owned pharmacies in Los Angeles County.
Recommendations: None

Provider Screening and Credentialing in Managed Care

In the California Medi-Cal program, managed care network providers do not have to be enrolled by the state, like a FFS provider, prior to joining a managed care network. Instead, the MCOs are responsible for performing the screening activities as part of their credentialing process when subcontracting with providers. In managed care, the inclusion of certain providers into a health plan's network of providers is not normally referred to as "enrollment" as it is in FFS. Instead, health plans "credential" primary care physicians and specialists, along with non-physician

California Focused PI Review Final Report March 2016

practitioners and/or other specialties, such as nurse practitioners and licensed mental health providers, prior to subcontracting with them.

The credentialing process is similar in many ways to the screening and enrollment of FFS providers, but may include other elements related to a provider's ability to adequately perform the services for which the provider is subcontracting. Facilities in managed care networks are often screened in a similar manner as facilities for FFS. Most managed care health plans will conform to nationally recognized standards for credentialing, such as those through the National Committee for Quality Assurance. In California, health plans that have received a rating of "Accredited" or higher through accreditation shall have their credentialing processes "deemed" by the state and may be exempt from the DHCS medical review audit for credentialing.

The CMS team addressed whether there are provisions in California's Medi-Cal managed care contract that direct the MCOs to conduct enhanced provider enrollment and screening activities similar to the activities the state is required to conduct according to the regulations at 42 CFR 455 subpart E. Although these regulations are not required for MCOs, CMS does consider some of the provisions to be program safeguards that are prudent in managed care settings. CMS encourages states to delegate these requirements, through their contracts with their MCOs.

Provisions within 42 CFR 455 subpart E applicable to screening and credentialing providers in the managed care setting include:

- 455.412: Verification of provider licenses
- 455.414: Revalidation of enrollment
- 455.416: Termination or denial of enrollment
- 455.432: Site visits
- 455.436: Federal database checks

The state's model contract does include provisions related to some of the regulations at 42 CFR 455 subpart E, but does not directly require the contractor to conform to all of the regulations within this subpart. Instead, the contract stipulates that the MCO have written policies and procedures for "credentialing, recredentialing, recertification, and reappointment of physicians including Primary Care Physicians and specialists in accordance with the Medi-Cal Managed Care Division (MMCD) Policy Letter 02-03, Credentialing and Recredentialing." The contract further states that the MCO must verify non-physician practitioners, such as nurse practitioners and physicians assistants, according to the state requirements applicable to the provider category. Similar provisions are expected of the MCO when contracting with outpatient mental health facilities and licensed mental health practitioners. Although there is no state requirement that all managed care network providers be enrolled with the state, one plan (GCHP) did require that all network providers be enrolled with the State Medicaid agency before being credentialed. Each of the other three plans was responsible for screening and credentialing its network providers.

California Focused PI Review Final Report March 2016

Below are the provisions in 42 CFR subpart E applicable to managed care, the status as to whether each provision is addressed in the state's contract, and the information obtained from the MCOs on each provision.

- **Verification of Provider Licenses**
The contract does not specifically direct the MCO to verify that a provider's license is valid and is without limitations, but it does require that providers "must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified, or registered." All four plans stated that they are conducting primary source verification on providers' licenses at credentialing, recredentialing, and regularly thereafter, for any actions against the license during the time period between recredentialing.
- **Revalidation of Enrollment**
As mentioned above, plans are required to have policies and procedures for credentialing and recredentialing. The state's Policy Letter to health plans included the requirement for recredentialing every three years. The team found that all four MCOs were recredentialing their providers every three years, as required.
- **Termination or Denial of Enrollment**
The state's contract required that the MCOs "verify that their subcontracted providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on the Suspended and Ineligible Provider List." It further instructed the MCOs that "terminated providers in either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List cannot participate in the Contractor's provider network." Plans were directed to check the state's Suspended and Ineligible Provider List along with the HHS-OIG's LEIE to meet this requirement. The team found that all four plans were checking the LEIE, but only two of the plans (Health Net and Alameda Alliance) were checking the state's Suspended and Ineligible Provider List.
- **Site Visits**
The contract does not require MCOs to categorize providers according to risk level, but it does require a site visit as part of the credentialing process when both the facility and the provider are added to the MCO's provider network. The contract further stipulates that the MCO must submit policies and procedures for "Facility Site and Medical Record reviews." A review of the MCOs' policies revealed that all had policies related to conducting site visits.

California Focused PI Review Final Report March 2016

- **Federal Database Checks**

The contract requires that plans be compliant with 42 CFR 438.610 which addresses debarments and checking the SAM. In addition, the contract directs plans to check the LEIE. However, there is no mention of checking the SSADMF or the NPPES as part of screening or credentialing. The MCOs were found to have varying practices. GCHP checked its provider network at credentialing, recredentialing, and monthly against the LEIE. There were no checks against the SAM and the SSADMF for network providers. In addition, the plan did not check any of the required federal databases for its own employees, directors, and officers, or any of its subcontractors. CHW checked all federal databases (LEIE, SAM, and SSADMF) for providers at credentialing and recredentialing with monthly checks of the LEIE and SAM databases for network providers. Furthermore, the plan checked the LEIE and SAM for subcontractors and at the organizational level for employees, directors, and officers at date of hire and monthly thereafter. The other two plans, HN and AAH checked network providers against the LEIE and the SAM databases at credentialing, recredentialing, and monthly. Neither plan was checking providers against the SSADMF. Also, AAH was only checking the individual providers and his/her associated facility. They were not checking persons with an ownership or control, managing employees, or agents.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

The Medi-Cal Managed Care program falls under 1115 Waiver Authority. Managed care services for physical health, specialty mental health, and dental services operate within different divisions of DHCS. Given the size of California's Medicaid program and an emphasis on reviewing the state's response to Medicaid expansion under the Affordable Care Act, CMS chose to limit the scope of this review to the managed care system providing physical health services.

At the time of the review, the state had 76.3 % of beneficiaries enrolled in managed care plans. Based on data provided by the state, the total expenditures paid to physical health plans for the state fiscal year (SFY), July 2012-June 2013 was over \$12.6 billion. These expenditures include smaller specialty programs such as the Program for All-inclusive Care for the Elderly, Primary Care Case Management, and services for those dually enrolled in Medicare and Medicaid. These specialty programs were not included in the scope of this review. In addition, as the managed care expansion into formerly FFS areas did not occur until FY2013-2014, expenditures for these plans were not included in the 2012-2013 data.

California Focused PI Review Final Report March 2016

In California, DHCS has implemented one of the following six models of managed care in each of the state's 58 counties. The information provided was current at the time of the review:

- In the **Two-Plan** model, DHCS contracts with both a local initiative (county organized) and a commercial plan. Enrollment in one of these plans is mandatory for most populations in the county. This model is utilized in 14 counties and serves 4.3 million beneficiaries.
- The **County Organized Health System** model serves approximately 1.4 million beneficiaries or 22% of the population in 22 counties. In this model, DHCS contracts with a health plan created by a County Board of Supervisors and all Medi-Cal beneficiaries in the county are enrolled in the same managed care plan.
- In counties with the **Geographic Managed Care** model, DHCS contracts with several commercial plans. Although enrollment in managed care is mandatory for most populations, beneficiaries have more choices among plans. This model is implemented in two counties and serves 661,000 beneficiaries.
- For the **Regional** model, DHCS contracts with two commercial plans to serve each county. Enrollment in one of these plans is mandatory for most populations. This model is implemented in 18 counties and serves 551,000 beneficiaries.
- The **Imperial** model is unique to Imperial County. It is structured similar to the Regional model where DHCS contracts with two commercial plans and enrollment in one of them is mandatory for most populations. This model serves 43,000 beneficiaries in Imperial County.
- The **San Benito** model is also unique to this county. DHCS contracts with one commercial plan and most populations are passively enrolled in the managed care plan unless they choose regular FFS Medi-Cal. This model serves 6,000 beneficiaries in San Benito County.

Summary Information on the Plans Reviewed

The state contracts with 22 different MCOs (not including specialty programs) to provide services in its 58 counties. This review focused on four of these MCOs. CMS selected a cross-section of plans to review, based on the models discussed above, and took into account both large and small plans. Because health plans may contract with the state to serve different counties, they may be included in more than one model.

California Focused PI Review Final Report March 2016

The four plans selected represented the Two-Plan model, the County Organized Health System model, the Geographic Managed Care model, the Regional model, and the Imperial model. The four plans were contracted to cover 28 counties and served approximately 1.7 million beneficiaries at the time of the review. Total expenditures for three of the four entities for FFY 2012-2013 were over \$2 billion. The state contracted with the fourth entity in FFY 2013-2014, and data for these expenditures was not available at the time of the review. In addition, the data did not include expenditures for the counties that were expanded to include managed care in 2013-2014.

The most recent Medicaid beneficiary and provider enrollment totals for the four MCOs are:

- GCHP: 155,996 beneficiaries and 330 providers;
- CHW: 130,550 beneficiaries and 3,352 providers;
- HN: 1,362,794 beneficiaries and 18,770 providers; and
- AAH: 41,619 beneficiaries and 1,641 providers.

The GCHP is a county-based local managed care plan that the state contracted with in July 2011. It serves one county that has implemented the County Organized Health System model. CHW is a for-profit corporate managed care plan that the state contracted with in November 2013. It serves 18 counties which utilize the Regional model and is part of the Imperial county model. HN is a for-profit corporate managed care plan that the state contracted with in 1990. It serves seven counties which use either the Two-Plan model or the Geographic Managed Care model. AAH is a non-profit local managed care plan that the state contracted with in 1996. It serves one county that has implemented the Two-Plan model. Three of the four MCOs pay their network providers using a combination of FFS and capitation rates. A fourth MCO pays network providers using a combination of FFS, capitation rates, and an incentive model based on maintenance of medical loss ratio.

State Oversight of Managed Care

At the time of our review, the MMCD was responsible for the contracting and oversight of all physical health plans.¹ Within this division, the Plan Management Branch and the Program Monitoring and Medical Policy Branch are responsible for programmatic oversight.² The DHCS A&I Medical Review Branch is responsible for conducting MCO Medical Performance Audits and the A&I Investigations Branch is responsible for Medi-Cal fraud investigations. The Memorandum of Understanding (MOU) between A&I and the MMCD serves as a guide for the

¹ Since our review, and prior to the publication of this report, DHCS has reorganized its managed care oversight operations. The Managed Care Operations Division (MCO) provides contract oversight, and the Managed Care Quality and Monitoring Division (MCQMD) is responsible for quality and monitoring.

² The names for both branches have changed: PMB is now the Managed Care Systems Support Branch under MCO. Program Monitoring and Medical Policy Branch has become the MCQMD and the branches under this Division are the Program Monitoring and Compliance Branch and Policy and Medical Monitoring Branch.

California Focused PI Review Final Report

March 2016

duties and responsibilities of each division when conducting audits, providing technical assistance, and improving internal communication and coordination in the administration of the managed care program.

There were several areas of concern related to managed care oversight identified in the last comprehensive PI review in FFY 2012. Many of these areas remained uncorrected. Further details on these items can be found in the review of the status of the state's CAP located in this document.

MCOs' PI operations are routinely monitored by A&I as part of the state's periodic Medical Performance Audit. The A&I Medical Review Branch team responsible for this task, along with other non-managed care related activities, is comprised of a total of 29 clinical staff and 28 auditors in six field offices. Fraud investigations are handled by the A&I Investigations Branch, which is comprised of a total of 102 peace officers and 17 support staff located in eight field offices. Both teams cover the state's 58 counties. A&I provided the CMS team with a list of 102 cases of possible provider fraud or abuse received from the MCOs over the past four FFYs.

However, according to several MCOs, there is a lack of follow-up communication or feedback from the state regarding the status of investigations. During the interviews, one plan stated they did not receive any feedback from the state concerning the cases they had sent; therefore, the MCO did not know whether a case was referred on to the state's Medicaid Fraud Control Unit (MFCU). As a result, duplicate investigations may occur. In addition, the MMCD representatives do not have regular one-on-one meetings with the plans. According to the MCOs interviewed, there is little contact with state managed care staff. With little contact and oversight of the MCOs, the state would be unaware of each plan's investigation processes and the types of concerns being pursued related to their network providers.

MCO Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

The individual managed care plans are responsible for auditing and investigating their own providers. Each MCO is required to have a compliance program that is responsible for investigating fraud, waste, and abuse. All four MCOs interviewed had a compliance program; however, only two housed a SIU. Contractually, all MCOs are required to track suspected fraudulent providers and report the results of their preliminary investigations to the state within 10 working days. The MCOs refer suspected network provider fraud or abuse to A&I via the Program Monitoring and Medical Policy Branch of MMCD. A&I uses the preliminary investigation by the MCO as a basis to further investigate the case. A&I pursues the case based on their findings which may result in provider probation and/or fine. Some cases may be referred to the State Department of Justice, which houses the state's MFCU, for prosecution.

California Focused PI Review Final Report March 2016

The GCHP did not have a functioning or established SIU either internally or externally through a contracted vendor. Instead, the compliance department investigated all reports of fraud, waste, or abuse. The compliance department was comprised of two full-time equivalent staff members who spend half of their time on other non-program integrity functions. The compliance department was functioning without an audit plan and did not perform key program integrity functions to prevent or monitor fraud such as data mining, provider audits, or running algorithms. Complaints and investigations are maintained in an electronic compliance log and included, but were not limited to, questions about membership, reporting an incorrect address, grievances, and quality of care issues. The only suspected fraud case came from an outside source and was referred to the state by the MCO. The plan did have an external entity that conducted audits of two percent of claims each week; however, no other program integrity functions were being provided. The plan reported that such activities will be part of a request for proposal in FFY 2014-2015. There were a total of 84 cases listed on a case tracking report for the past four fiscal years of which two cases were indicated as suspected fraud and referred to the state. The MCO's contract with the state has been in effect for the last three years. During the three-year period, there were no recoveries from investigations. The MCO does not conduct any cost containment activities. The MCO reported that it is initiating a request for proposal for FFY 2014-2015 for a vendor to conduct cost-containment activities. The training reported by the plan consisted of quarterly meetings convened by the Department of Justice, the compliance officer, compliance specialist, and general counsel attended.

The CHW has an SIU that operates from its corporate office located outside of the state, but maintains a compliance department in California. The SIU is comprised of four individuals, but cumulatively they total one full-time equivalent staff member. The SIU staff members are responsible for looking at improper payments as well as conducting data mining, investigations, and audits. The plan also utilizes a vendor to conduct data mining and run algorithms. CHW generated its preliminary investigations from a variety of sources, such as referrals from the vendor conducting data mining, internal SIU edits, and algorithms. There were 19 cases identified as suspected fraud on a case tracking report. Seven of the 19 cases had been closed and placed on prepay review and one case was referred to the state. At the time of the review, the MCO had been operational for 10 months and reported a cost-avoidance from pre-payment reviews of \$1,935. The conferences and trainings attended and reported by the MCO consisted of a list of over 105 conferences and training events that were mostly focused on coding, and three training events focused specifically on fraud and abuse.

The HN has an SIU that operates from its corporate office in California. The SIU is comprised of three full-time equivalent staff members. The SIU functions in a triage capacity by assessing the complaint, determining what department should handle the complaint, such as a lost insurance card, and collecting documentation as appropriate. The SIU does not conduct any proactive data mining or audits. The plan contracts with two vendors to perform key program integrity functions such as data mining, review for improper payments, running algorithms, investigations, and audits. In the event there is an allegation of fraud, waste, or abuse, the plan

California Focused PI Review Final Report

March 2016

will refer to the contractor to conduct a preliminary investigation. The contractor conducts the investigation and returns the case file to the plan with its recommendations. If the contractor suspects fraud, it will recommend a referral to the state's MFCU. There were 30 cases on a case tracking report for the past four FFYs and seven of the 30 were referred to the state. The MCO reported that no recoveries were tracked until reporting year 2012/2013 with a total amount \$45,480 for the year. The plan attended two trainings in 2013 with the Office of Inspector General and the California Department of Insurance, respectively.

As mentioned earlier, AAH has been under a conservatorship since May 2014. The review focused on how the plan had performed in the past and on its current operations. The new compliance manager stated the unit would be changing their policies and procedures to actively detect and investigate fraud. In the past, with only one investigator and six staff members, the compliance department had been more reactive than proactive. They indicated that, although they had conducted two preliminary investigations, nothing had been reported to the state or the MFCU in the last four years, and they only reported provider complaints to the state on an annual basis. Annual reporting prevents the state from having ongoing and current knowledge of complaints against providers that are being reported to the MCO throughout the year. According to the new compliance manager, there is currently no internal data mining being conducted. They have one vendor doing data mining. The vendor provides reports each month, and the compliance department conducts the audits. The MCO indirectly recovers overpayments from providers by offsetting future payments. If the compliance department receives an outside complaint, the investigator conducts a desk audit; no onsite audits are conducted. The compliance department is responsible for providing training to the plan's roughly 225 employees. In addition, the plan provides provider training on fraud, waste, and abuse during its New Provider Orientation, through its online provider manual, in its provider newsletters, and via fax blasts.

From the team's review, it became evident that the level of network provider oversight through audits and/or data mining was often minimal or less than would be expected. This lack of ongoing monitoring makes the managed care system vulnerable to ongoing fraudulent or abusive practices by network providers. In addition, communication between the state and the MCOs regarding the status of ongoing cases appears to be lacking. Open and ongoing communication is essential in monitoring providers and maintaining a working relationship between organizations.

Overpayment Recoveries

The state's contract does not require MCOs to return overpayments to the state. As a result, there have been no MCOs that have identified and/or returned overpayments (including fraud or abuse) to the state during the past four FFYs. MCOs are required to report recoupments in an annual financial report. There are specific guidelines in the contract that allow DHCS to recover the amounts disallowed by an offset to the capitation payments to the contractor when the

**California Focused PI Review Final Report
March 2016**

contractor fails to comply with federal Medicaid requirements or when there has been an improper payment made to the contractor.³

At the time of the review, the GCHP, under contract with the state for three years, reported it had no recoveries or cost savings. According to financial documents received by the state, GCHP had received approximately \$672 million in SFY 2012-2013.

The CHW, under contract for less than a year, reported no recoveries, but did have \$1,935 in cost avoidance.

The HN reported that it did not separately track recoveries prior to 2012; the recoveries from SFY 2012-2013 were \$45,480 for medical services and approximately \$217,000 for pharmacy. In relation to its expenditures, HN had received approximately \$1.4 billion in expenditures from the state in SFY 2012-2013. The HN also indicated that it had not reported the recoveries to the state.

The AAH had not directly recovered overpayments from providers as a result of fraud and abuse investigations. Instead, any identified overpayments were offset from future payments. It did not provide any numbers of identified overpayments. AAH had received approximately \$355 million in SFY 2012-2013.

Table 1.

Selected MCO	Overpayment s Recovered 2014	Overpayments Recovered 2013	Overpayment s Recovered 2012	Overpayment s Recovered 2011
GCHP	0	0	0	Operational 07/2011
CHW	0	Contracted 11/2013	N/A	N/A
HN	\$45,480.50*	Not tracked	Not tracked	Not tracked
AAH	0	0	0	0

**This reflects identified overpayments for medical services only. Pharmacy was not included.*

Overall, the amount of overpayments recovered by the MCOs appears to be quite low for the amount of expenditures that they are receiving from the state. In addition, it is not clear whether all MCOs are adequately reporting their collections of overpayments to the state as required by their contract. Although MCOs may not be required to return overpayments from their network

³ Exhibit B: Budget Detail and Payment, Section 11: Recovery of Capitation Payments, Paragraphs B and C.

California Focused PI Review Final Report March 2016

providers to the state, it is important that they are providing a clear accounting of any recoupments, so that these dollars can be factored into establishing annual rates. Without these adjustments, MCOs would be receiving inflated rates per member per month.

Terminated Providers and Adverse Action Reporting

The MCOs may terminate a provider according to their own policy. . In addition, the state's contract requires MCOs to track suspended or excluded providers on the state's list of suspended and ineligible providers and the HHS-OIG's List of Excluded Individuals and Entities. The contract states that the plan must notify the Medi-Cal Managed Care Program/Program Integrity Unit within 10 state working days of removing a suspended, excluded, or terminated provider from its provider network and confirm that the provider is no longer receiving payments in connection with the Medi-Cal program. MCO provider terminations are also reported to DHCS on a quarterly report, but there is no official action taken to share this information with other MCOs or to determine if the provider is enrolled in the FFS Medicaid program.

During interviews with the MCOs, various policies and procedures were found. The GCHP and CHW indicated that they report terminations for any reason to the state. HN indicated that, contractually, it is only required to report for-cause terminations. AAH stated that it does not inform the state when a provider has been terminated, even though the state requires MCOs to report any providers who are terminated for-cause in order to receive approval from the state. Instead, their policy requires that a termination report be filed upon final decision or recommendation made by the Peer Review Committee for the following reasons:

- A licentiate's application for membership is denied or rejected for a medical disciplinary cause or reason.
- A licentiate's membership is terminated or revoked for a medical disciplinary cause or reason.

**California Focused PI Review Final Report
March 2016**

Below is a chart highlighting enrollment and termination numbers among the MCOs. Only one MCO reported any for-cause terminations in the past three FFYs. Of the other three plans, one was not yet operational during the time period requested and the other two reported no for-cause terminations.

Table 2.

Selected MCO	No. Providers in FFY 2014	No. Providers Enrolled in Last 3 Completed FFYs		No. Providers Disenrolled or Terminated in Last 3 Completed FFYs*		No. Providers Terminated for Cause in Last 3 Completed FFYs	
		FFY13	FFY12	FFY13	FFY12	FFY13	FFY12
GCHP	330	FFY13	79	FFY13	0	FFY13	0
		FFY12	18	FFY12	0	FFY12	0
		FFY11	N/A	FFY11	N/A	FFY11	N/A
CHW	3,352	FFY13	N/A	FFY13	N/A	FFY13	N/A
		FFY12	N/A	FFY12	N/A	FFY12	N/A
		FFY11	N/A	FFY11	N/A	FFY11	N/A
HN	18,770	FFY13	1,923	FFY13	1	FFY13	1
		FFY12	1,583	FFY12	5	FFY12	1
		FFY11	1,894	FFY11	2	FFY11	1
AAH	1,641	FFY13	294	FFY13	131	FFY13	0
		FFY12	245	FFY12	75	FFY12	0
		FFY11	151	FFY11	108	FFY11	0

**These include a variety of reasons that are not due to fraud, abuse, or quality of care, such as retired, deceased, did not meet credentialing requirements, etc.*

Overall, the reporting of terminations appears to vary among the MCOs. There is no effort to ensure that information related to a provider terminated for-cause from one plan is communicated to other plans where that provider may be participating; this would allow the other plans to audit the provider’s billing practices. In addition, not checking whether terminated network providers are participating in FFS leaves the state vulnerable to ongoing abuses of the Medicaid program by fraudulent providers.

MCO Compliance Plans

The MCOs are required by contract to have a compliance plan that meets the requirements of 42 CFR 438.608. The DHCS A&I Medical Review Branch conducts on-site reviews that include verification of MCO compliance with contract requirements. According to the MOU between the MMCD and A&I, it is the responsibility of A&I to ensure that the compliance plan has met the required seven elements.

California Focused PI Review Final Report March 2016

All four MCOs provided compliance plans that have been submitted to the state. A review of these plans revealed that they were in compliance with 42 CFR 438.608.

Payment Suspensions

The MCOs are required to report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse by subcontractors, members, providers, or employees has occurred. According to the state's contract, MCOs "shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within ten working days of the date Contractor first becomes aware of, or is on notice of, such activity." DHCS refers the suspected fraud cases to the MFCU in a joint consideration of suspending the provider. There is no contractual requirement for the MCO's to suspend payments to network providers in the event of credible allegation of fraud.

None of the four MCOs interviewed initiated suspensions at the plan level. GCHP indicated that it will initiate a suspension, if instructed to do so by the state. At the time of the review, there had been no provider payments suspended. CHW utilizes tax-related levies as a mechanism to divert payments from the provider. HN utilizes its prepayment audit process as a mechanism to pend claims until further documentation is provided to support the services billed. AAH had procedures in place to conduct prepayment reviews, although there were no providers under prepayment review status at the time of our review.

Meetings and Training

The team learned that there were different activities occurring around the state for training of managed care staff and MCOs. The DHCS holds a web-based program integrity tutorial course that MMCD staff must initially take. Other training with managed care staff addresses suspected allegations of fraud, what constitutes a referral, and how to refer. In addition, MMCD holds a monthly task force meeting which includes training for attendees. The MFCU attends these meetings and partakes in discussion of suspected allegations of fraudulent providers. Plans may attend these meetings, but it is not mandatory.

The A&I unit from southern California further commented that they work directly with county plans and dual plans and provide training and education on how to investigate, identify, and refer potential fraud and abuse to A&I. The A&I staff observed that some of the MCOs' SIU staff appeared to have limited experience in detecting and investigating potential fraudulent behavior. However, according to A&I in the Sacramento office, there is limited training with the plans and their SIU units located in the northern part of the state due to budget restraints.

Verifying Services with Beneficiaries

The team also looked at specific contractual requirements that the state imposes on the MCOs regarding verifying services with beneficiaries. It was learned that the state does not have a contractual requirement that directs the MCOs to verify services with beneficiaries. Instead, DHCS contracts with a Health Services Advisory Group to perform the work related to verification of services. This allows the state to take an “in-house” look at services being provided in the managed care setting and provides a similar standard of verifying services with beneficiaries that is expected of the state in FFS.

Recommendations for Improvement in Managed Care

1. The state should move toward having all network providers enrolled in the DHCS provider enrollment system and establish this as a mandatory requirement for all MCOs. This will allow for consistency in the screening and enrollment of providers and minimize the risks associated with having varying degrees of screening among the MCOs.
2. Given the limited audit work in at least two MCOs, along with the low number of overpayments and terminations that the MCOs reported, it is imperative that the state ensures that any managed care entity with which it contracts has an established and functioning program integrity infrastructure that includes adequate systems and staff to prevent, detect, and investigate provider fraud.

Although all MCOs were found to be compliant with having a compliance program under 42 CFR 438.608, a key aspect of the compliance plan is having processes in place for auditing. It would be prudent for the state to increase its oversight of the quality of the auditing programs that MCOs have implemented to ensure that the plans have sufficient resources, trained staff, and an audit work plan in place to protect the Medi-Cal program.

3. Based on the apparent lack of knowledge of several MCOs with regard to provider fraud and abuse investigations and a lack of such emphasis in some of the MCOs’ operations, the state should ensure that, in addition to having adequate staff as mentioned above, contracts with MCOs should also require plans to ensure that all compliance department and SIU staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by providers. The state may want to assist in providing some of the training that is unique to their policies, but training could also be met through professional organizations and through the MCOs’ own compliance department. Costs for such training need not require additional funding and would be included in the administrative fees that the plans already receive.

California Focused PI Review Final Report March 2016

4. The state should schedule more frequent one-on-one meetings with MCOs to review the status on their program integrity activities and conformance with contract requirements, such as, but not limited to, audit work plans, results of audits and investigations, and any subsequent actions taken, such as reporting terminated providers and recovery of overpayments. It is recommended that this frequency be not less than quarterly.

Status of Corrective Action Plan

As part of the focused review, the CMS review team evaluated the status of the state's CAP submitted in response to CMS's last review of the state in 2012. Given the scope of the CAP, the team relied on interviews and documents the state submitted. Below is the status of the state's respective corrective action for each finding and/or vulnerability that was identified in the 2012 review. As noted earlier, DHCS' role as the State Medicaid agency is critical in providing oversight of sister agencies and ensuring that all necessary corrective action is taken to protect the Medi-Cal program.

Previous Finding in 2012 - 42 CFR 455.13: 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)

Status at time of 2014 Review: *Not fully corrected.*

The state reported that the Clinical Assurance and Administrative Support Division identified 13 interagency agreements that needed the fraud, waste, and abuse reporting language. The Clinical Assurance and Administrative Support Division prepared the necessary amendments to add the recommended fraud reporting language. At the time of the review, all but four of the amendments had been fully executed.

Previous Finding in 2012 - 42 CFR 455.20: The state does not verify with beneficiaries whether services billed were received. (Uncorrected Repeat Finding)

Status at time of 2014 Review: *One finding found to be not applicable. One area still not corrected.*

The CDDS reported that it received guidance from CMS that the 45-day requirement for sending verification of services did not apply to them since their billing did not go through the Medicaid Management Information Systems. CDDS vendors issue an annual listing of services to beneficiaries. Therefore, the team found that further corrective action was not necessary.

The CDSS disagreed with the findings and did not issue any new corrective action steps, but will continue with current procedures. The CMS team informed CDSS of the intent of the requirement and that some of the steps mentioned were not considered processes for verifying

**California Focused PI Review Final Report
March 2016**

with beneficiaries that services were received. Instead, the actions described were related to training of providers, relying on beneficiaries to oversee providers, or an annual assessment of satisfaction with the level and type of services received.

Previous Finding in 2012 - 42 CFR 455.21: The state does not refer all cases of suspected provider fraud to the MFCU.

Status at time of 2014 Review: *Corrected.*

The state has developed a flow chart of procedures for case development, tracking, and referrals to the MFCU. In collaboration with the MFCU, a new MOU was developed. The two departments meet monthly on a formal basis and communicate regularly between these meetings. A formal conference was held in January 2013 with over 200 staff from A&I and the MFCU. Although it appears that the state has implemented procedures for improving processes, the team did not review any records to determine if cases are being appropriately referred to the MFCU at this time.

Previous Finding in 2012 - 42 CFR 455.23(a) and (d): The state does not suspend payments in cases of credible allegations of fraud and is not conforming to the regulatory performance standards.

Status at time of 2014 Review: *Corrected.*

On September 29, 2012, Senate Bill 1529 was codified into state law to include the payment suspension requirements under CFR § 455.23(a). Senate Bill 1529 amended sections of California Welfare & Institutions Code relating to payment suspensions. DHCS has processes in place to meet the payment suspension requirements.

The state developed a flow chart that is reflective of the new policies and procedures in handling cases where there is a credible allegation of fraud. The state has also developed a new referral form which is in use. However, the team did not review any records to determine if payment suspensions are occurring in response to cases where there is a credible allegation of fraud.

Previous Finding in 2012 - 42 CFR 455.104: The state does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Status at time of 2014 Review: *Not fully corrected across the state.*

The state's disclosure form was revised in November 2011. The form from 2011 had indicated to applicants that the Social Security number was optional. The state law was changed so that the Social Security number is mandatory. The state's disclosure form was revised again in July

**California Focused PI Review Final Report
March 2016**

2014. This form is now in use by DHCS for FFS providers, in the Long Term Care division, and in the dental division. It has been deemed corrected for these programs

In addition, the PED within DHCS amended the interagency agreement with the CDPH to get access to the CDPH database where they maintain ownership and control information for institutional providers. However, PED is re-evaluating the quality of data to ensure that it meets all of 455.104 and 455.106 disclosure requirements. Not corrected.

The CDDS disclosure form does not correctly solicit for persons with an ownership or control interest. It only asks for individuals to disclose and not for other corporations that might have an ownership interest. It also does not solicit for the information related to corporations with an ownership or control interest, such as all other business addresses and tax identification number. Not corrected.

Within the managed care division, contract managers ensure that disclosures are submitted; however, no one is ensuring the quality of the information submitted. When A&I auditors conduct onsite reviews, they check the disclosures. If the proper disclosures are not found, DHCS will require the health plan to do a CAP. This may be of concern as the state is continuing to contract with the plans without checking disclosures **before** contracting. Not corrected.

Previous Finding in 2012 - 42 CFR 455.105(b): The state does not adequately address business transaction disclosure requirements in its provider agreements or contracts. (Uncorrected Repeat Finding)

Status at time of 2014 Review: *Not corrected in two sister agencies – CDDS and CDSS.*

DHCS revised its Provider Agreement and the revised form now has the correct language for 42 CFR 455.105(b).

Dental Services: The dental contract now contains language referencing 42 CFR 455.105 in Exhibit A, Attachment 2.

California Department of Developmental Services: At the time of the review, the CDDS Vendor Provider Agreement had not been updated or published.

California Department of Social Services: CDSS disagreed with the finding stating that effective December 27, 2011, emergency regulations required providers to disclose information related to business transactions as required by 42 CFR, § 455.105(b). However, a review of their IHSS Provider Enrollment Form that can be found on their website shows that it was revised in April 2012, but does not contain any language related to 42 CFR 455.105 or any reference to the regulation. It should be noted that these providers are part of a consumer-directed program and

**California Focused PI Review Final Report
March 2016**

are not directly enrolled with the State Medicaid agency. The agreement section of the Provider Enrollment form does inform the provider that if the beneficiary receives IHSS services through Medi-Cal, then the provider “will be considered a Medi-Cal provider of personal care services, and will be required to comply with all Medi-Cal program rules relating to the provision of services.”

Previous Finding in 2012 - 42 CFR 455.106: The state does not capture criminal conviction disclosures from providers or contractors. (Uncorrected Repeat Finding)

Status at time of 2014 Review: *Not corrected.*

The state’s disclosure form (DHCS 6207) still has not been revised to address the correct language at 42 CFR 455.106. The state reported that it is still in the process of amending its regulation. Once department regulation is changed, it will update the form. There is currently a regulation package being prepared to present to legislation for changes.

The CDDS form was revised in July 2011. The criminal conviction language related to 42 CFR 455.106 is contained in the definition of “Excluded Individuals and Entities” in the instruction section of the form. However, it is missing the time frame of “since the inception of the program” or “ever.” The form does not directly solicit for disclosure of health care-related criminal convictions, and instead, asks for disclosure of excluded individuals and entities as defined earlier in the document.

Previous Finding in 2012 - 42 CFR 455.436: The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

Status at time of 2014 Review: *Corrected.*

In the dental program, the dental fiscal intermediary does check the exclusion status of the provider, persons with an ownership or control interest in the provider, agents, and managing employees of the provider.

For DHCS PED, the Managing Employees, Owners, Control Interest, and Agents system changes went into effect May of this year. The state is now able to capture all names and do monthly checks.

Previous Finding in 2012 - 42 CFR 1002.3(b): The state does not report all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Finding)

Status at time of 2014 Review: *Not corrected.*

California Focused PI Review Final Report March 2016

The state reported that it is unable to implement this regulation due to concerns of litigation without due process. Not all sanctions are reported. Exclusions and temporary suspensions are reported.

Previous Finding in 2012 - Vulnerability #1: Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

Status at time of 2014 Review: *Not corrected.*

The state's managed care contract does not require that MCOs check all of the required databases. Instead, the contract requires MCOs to check the LEIE on the HHS-OIG's website and the state's Suspended and Ineligible Providers List on the state's website. There is reference to 42 CFR 438.610 and to 48 CFR subpart 9.4 related to debarments and mention of Executive Order 12549. There is no mention of SSADMF or NPPES. The state reported that contract amendments have not occurred. They are obtaining technical assistance from MFCU as part of their contract revisions.

PED will be adding all network providers to the ORP system. The new PAVE system will capture these. A webinar for providers is scheduled for August 26, 2014. Managed care network providers are expected to be added in October 2014.

In the MCOs, complete searches were still not being done at the plan level.

Previous Finding in 2012 - Vulnerability #2 related to 42 CFR 455.20: Not verifying with managed care enrollees whether services billed were received.

Status at time of 2014 Review: *Corrected.*

The state contracts with a technical vendor that sends out a questionnaire to beneficiaries. The vendor compiles the results and provides a report to the state. There is no contract language requiring MCOs to do this.

Previous Finding in 2012 - Vulnerability #3 related to 42 CFR 455.104: Not capturing ownership and control disclosures from network providers. (Uncorrected Repeat Vulnerability)

Status at time of 2014 Review: *Corrected.*

Initially, the state indicated that the federal regulations are in their contract in the "Deliverables" section. A review of this section revealed that this pertained to disclosures that the plan must submit, not its sub-contractors. However, further research found that in the "Provider Network" section, the state makes reference to language that must be included in the subcontract. This includes the following, "Subcontractor's agreement to provide Contractor with the disclosure

**California Focused PI Review Final Report
March 2016**

statement set forth in 22 CCR 51000.35, prior to commencing services under the Subcontract.” Research of 22 CCR 51000.35 reveals that these are the Provider Enrollment Regulations and this section makes reference to the disclosure requirements at 42 CFR 455.104, 105, and 106.

In addition, contractors must submit their sub-contract boilerplate. The state reviews the boilerplate subcontracts.

NOTE: MCO credentialing materials were not reviewed in-depth to determine if they were in compliance.

Previous Finding in 2012 - Vulnerability #4 related to 42 CFR 455.105: Not adequately addressing business transaction disclosures in network provider contracts.

Status at time of 2014 Review: *Corrected.*

Same as Vulnerability #3.

Previous Finding in 2012 - Vulnerability #5 related to 42 CFR 455.106: Not capturing criminal conviction disclosures from network providers.

Status at time of 2014 Review: *Corrected.*

Same as Vulnerability #3.

Previous Finding in 2012 - Vulnerability #6 related to 42 CFR 1002.3(b): Not reporting all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Repeat Vulnerability)

Status at time of 2014 Review: *Not corrected.*

The state reported that this has not been added to the contract.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for California to consider utilizing:

- Consult with other states on how they have implemented the provider screening and enrollment provisions under the Affordable Care Act. This can be done by regularly attending the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities. In addition, if not already doing so, consider participating in the Technical Advisory Group's ad hoc workgroup for provider enrollment.
- Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html>
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to California based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at <http://www.justice.gov/usao/training/mii/training.html>.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the State Medicaid agency is responsible for correcting the issue.

We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

CMS looks forward to working with California to build an effective and strengthened program integrity function.

Official Response from California
April 2016



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

August 4, 2016

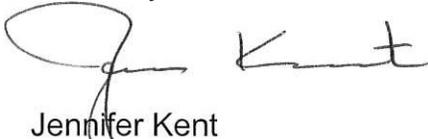
Ms. Laurie Battaglia
Acting Director
Division of State Program Integrity
Centers for Medicare & Medicaid Services
7500 Security Blvd., Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Ms. Battaglia:

The California Department of Health Care Services (DHCS) is pleased to provide you with its responses to the Centers for Medicare and Medicaid Services' (CMS) focused review of California's program integrity procedures and processes. DHCS appreciates the opportunity to provide comment to the CMS report.

Please contact Ms. Sarah Hollister, External Audit Manager, at (916) 650-0298 if you have any questions.

Sincerely,



Jennifer Kent
Director

Enclosure

A1

Official Response from California
April 2016

Ms. Laurie Battaglia
Page 2

cc: Mari Cantwell
Chief Deputy Director, Health Care Programs
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Karen Johnson
Chief Deputy Director, Policy and Program Support
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Bruce Lim
Deputy Director, Audits & Investigations
1500 Capitol Avenue, MS 2000
P.O. Box 997413
Sacramento, CA 95899-7413