



Background

Joint Oversight Hearing Assembly Health and Accountability & Administrative Review Committees **A Review of the Drug Medi-Cal Program**

Thursday, September 26, 2013
State Capitol, Room 4202
10:00 a.m. to 1:00 p.m.

Hearing Overview

In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's Drug Medi-Cal (DMC) program. The investigative report alleged that, over the past two fiscal years, the DMC program paid \$94 million to 56 drug and alcohol rehabilitation clinics in Southern California that have shown signs of deceptive or questionable billing. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services.

In July and August 2013, the Department of Health Care Services (DHCS) ordered temporary suspensions against 48 alcohol and drug treatment programs at 132 sites where DHCS established credible allegations of fraud. According to DHCS, these actions are the first phase of an ongoing review of the DMC program by the department's Audits and Investigations (A&I) Division.

This joint hearing of the Assembly Health and Accountability and Administrative Review Committees will: 1) examine provider certification, claims payment, and auditing processes in the DMC program; 2) determine the extent to which state officials knew or should have known about the potential for fraud in the program; 3) evaluate DHCS's response; and 4) identify accountability measures and other reforms that are needed to strengthen the integrity and effectiveness of the DMC program going forward.

DMC Program Overview

The DMC program was established in 1980 to provide alcohol and drug treatment services to individuals enrolled in Medi-Cal, the state's health care services program for the poor. These services include outpatient drug free (ODF) services; which consist mostly of group counseling and some limited individual counseling for persons in crisis; narcotic treatment programs, which provide

methadone replacement therapy; day care rehabilitative services; and residential services for pregnant and parenting women. The caseload of the ODF program is around 150,000 individuals; the modality with the next-highest caseload is the narcotic treatment program, which is approximately 90,000. Total funding for the DMC program (which includes federal and realigned county funds) is about \$200 million; of that, \$65 million goes to ODF services. DMC services are delivered through counties, which contract with community-based providers, usually outpatient clinics, that provide treatment directly to clients. There are about 1,000 active DMC providers in the state. Each of these provider-clinics is required to be DMC-certified by the state in order to participate in the program.

When the program was established, DMC was administered by the Department of Alcohol and Drug Programs (DADP) under the terms of a memorandum of understanding with the Department of Health Services (now DHCS), the state agency ultimately responsible for all federal Medicaid and state Medi-Cal funds. Under the terms of the agreement, DADP was the designated single state agency responsible for administering and coordinating California's efforts related to alcohol and other drug abuse prevention, treatment, and recovery services. In 1980, the program offered two services: ODF counseling and outpatient methadone maintenance services. Since then, three services have been added: naltrexone, day care rehabilitative, and perinatal residential services.

The DMC program was significantly altered in 1992 by the *Sobky v. Smoley* decision. Prior to the decision, due to budgetary constraints, many Medi-Cal beneficiaries had little to no access to methadone maintenance services. Some were placed on waiting lists, and others resided in counties that did not opt to offer DMC services. In *Sobky v. Smoley*, a federal district court found that such limitations on DMC services violated federal Medicaid law's requirement that all beneficiaries receive services that are equal in amount, duration, and scope. For many years, the state's policy, in response to this decision, was to directly contract with providers that counties refused to contract with. Effectively, then, every DMC-certified provider was able to obtain a contract, either with the county or the state, to provide DMC services. In 2010, DADP issued a bulletin indicating that direct contracting between providers and the state were in conflict with state law requiring maintenance of the local continuum of services at the county level and that it would seek to terminate direct contracts with providers except in special circumstances. In 2011, a federal appeals court ruled that the bulletin constituted an underground regulation and invalidated it. Nonetheless, DHCS indicates that the number of direct contract providers has decreased since 2010 from 60 to 15.

As part of the 2011 State Budget agreement, AB 106 (Committee on Budget), Chapter 32, Statutes of 2011, transferred the administrative functions for the DMC program from DADP to DHCS, effective July 1, 2012. Specifically, AB 106 authorized transition activities to take place prior to July 1, 2012, consistent with an administrative and programmatic transition plan developed and submitted to the Legislature, after consultation with stakeholders, including clients, providers, counties, and the federal government. In the stakeholder process, a major critique of the transition plan was that it was too narrowly focused on physically moving the DMC program from DADP to DHCS, when AB 106 stated clear intent to improve access to alcohol and other drug treatment services and to improve state accountability and outcomes. Most stakeholder comments focused on streamlining administrative

hurdles and expanding covered services to reflect current best practices for treatment. However, stakeholders, particularly counties, also raised some issues related to promoting fiscal integrity in the program. One of the issues documented in the stakeholder process was a desire for greater clarity about the respective roles of counties and DHCS. Specifically, counties recommended that they, rather than DHCS, be given the lead role in deciding whether a provider should be DMC-certified.

Also in 2011, the state transferred, or “realigned,” \$184 million in funding for substance abuse treatment programs, including the DMC program, from the state to local governments. By moving funding and responsibilities to counties, realignment is intended, in part, to enable counties to implement creative models of integrated services.

Another major change to the DMC program will take place in 2014. Due to state law opting to expand Medi-Cal eligibility under the federal Patient Protection and Affordable Care Act (ACA), the state’s Medi-Cal-enrolled population is projected to increase by over 900,000 beneficiaries by 2020. About 10%, or 90,000, of these individuals are expected to seek substance abuse treatment. In addition, since Medi-Cal will be required to cover substance use disorder services as an ACA essential health benefit, DMC services that are currently limited to the perinatal population will be expanded to all Medi-Cal beneficiaries.

CIR/CNN Report Findings

On July 29, 2013, CIR published three reports on fraud in the DMC program in conjunction with a three-part series on CNN entitled “Rehab Racket.” The reports alleged that the DMC program paid \$94 million over the past two fiscal years to 56 Southern California providers with histories of questionable billing practices. The CIR reports focused on seven DMC providers in southern California, and allegations included the following:

- Busing of teenagers without drug problems from group homes;
- Fabricating patient treatment documents;
- Paying clients amounts between \$5 and \$40 for showing up to counseling;
- Counselors leaving in mid-session and allowing clients to spend counseling time chatting amongst themselves;
- Billing for patients who were incarcerated or dead;
- Billing for group counseling for dozens of clients on a day when clinic staff told reporters that no group counseling was offered;
- Billing for counseling 179 clients on a day when reporters staked out the clinic and documented fewer than 30 people entering and leaving;
- Billing for patients who did not show up to counseling sessions;
- Billing for pizza parties and basketball games as though they were counseling sessions;
- Billing for sessions when counselors were off work or at lunch; and,
- Filling out records of counseling sessions before they occur.

The reports suggested that the state’s oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to terminate contracts or prevent the problems from continuing.

DMC Processes and Controls

Provider Requirements

Providers and their satellite sites are required to be DMC-certified to be eligible to participate in the DMC program. In the DMC context, “provider” is the term used for a clinic that is certified to participate in the program; a provider, then, might be a clinic that employs numerous counselors and other substance use disorder treatment professionals. The certification process includes an on-site inspection of each facility conducted by DMC staff to establish eligibility and ascertain whether the provider is in compliance with DMC regulations and certification standards. These standards include a number of general requirements that providers must comply with related to fire safety; use permits; accessibility of services; physical structure; utilization review; employee and patient health records; and written administrative policies governing patient health records, personnel files, job descriptions, and professional codes of conduct.

The certification standards require each DMC provider to designate a licensed physician to serve as medical director. The medical director assumes medical responsibility for all patients and directs all medical care, either acting alone or with an organized medical staff. Services rendered by a DMC provider are covered only when determined to be medically necessary and prescribed by a physician. “Medical necessity,” for purposes of DMC, is defined according to the definition used for the Medi-Cal program as a whole: services that “are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.”

Regulations governing alcohol and other drug counselors require counselors in a DMC-certified clinic to be licensed professionals (licensed marriage and family therapists, licensed clinical social workers, psychologists, and physicians and surgeons, including psychiatrists) or registered or certified counselors. Counselors are registered with, or certified by, one of the certifying entities approved by the state (currently a list of six private organizations accredited by the National Commission for Certifying Agencies). To obtain certification, an individual must meet classroom training and work experience requirements. A person who is registered to become certified as an alcohol or other drug counselor is currently allowed to work as a counselor for up to five years while he or she fulfills the requirements of certification.

If, at the time of the initial on-site inspection, a provider is deemed to be in noncompliance with the DMC certification standards, the provider is issued a statement of deficiencies noted by DMC staff and given 30 days to submit a plan of correction to DHCS that describes how and when deficiencies were corrected and the method of monitoring to prevent recurrence of deficiencies and ensure ongoing

compliance. If the plan is not submitted within 30 days of receipt of the statement of deficiencies, the provider's application for DMC certification is terminated. DHCS indicates that the initial on-site inspection takes place prior to the commencement of services; therefore, the inspection focuses on physical plant characteristics and documentation of procedures rather than clinical requirements. DMC certification is not time-limited; recertification is only explicitly required when there is a change in scope of services, address, ownership, or substantial remodeling.

DMC regulations require providers to maintain individual patient records for each client. The record must contain identifying information and all required documentation gathered during the patient's treatment episode. The regulations require a list of activities that must be completed upon admission to a DMC program, including an assessment of the personal, medical, and substance abuse history for each beneficiary and the performance of a physical examination by a physician or other licensed health care provider. The physical examination may be waived by a physician with documentation that specifies the basis for not requiring a physical examination. In the ODF modality, counties and providers indicate that physical examinations are usually waived. Patient records are required to identify the applicable Diagnostic and Statistical Manual of Mental Disorders Third Edition-Revised or Fourth Edition (DSM-III or DSM-IV) diagnostic code.

In addition, providers must document an individual treatment plan for each patient, including a statement of problems, goals to be reached, action necessary to accomplish the goals, and target dates for completion. For the ODF modality, regulations require individual narrative summaries to be recorded by counselors for each patient for each counseling session. Between five and six months of admission, a provider must justify continuing services for a client, with redetermination of medical necessity by a physician. Upon discharge, providers must complete a discharge summary that includes treatment duration; reason for discharge; a narrative summary of treatment; and the beneficiary's prognosis.

Claims Payment

The DMC claims payment structure involves multiple steps. The process begins with counties or direct providers uploading claims through DHCS's web portal, which conducts automatic reviews for completeness. Complete claims move to DHCS's Short-Doyle Medi-Cal (SDMC) II system for claim adjudication that, among other things, verifies compliance with federal confidentiality requirements. Approved and denied claims are then uploaded to DMC's accounting system where they receive both automated and manual quality reviews and other detailed edits. From there, claims pass to DMC's accounting division where they are further reviewed to ensure that the affected contracts have sufficient funds to cover the claims before payment schedules are generated. DHCS accounting staff generates a claim schedule and submits it to the State Controller's Office (SCO) for processing. The SCO generates and mails payment to the counties or direct providers for the approved claims. Claims payment information is then passed back to the counties and providers through the SDMC system.

Utilization Review

DMC regulations require DHCS to: 1) provide administrative and fiscal oversight, monitoring, and auditing of DMC services; 2) perform utilization review; and 3) recover improper payments. Utilization review is carried out through post-service, post-payment (PSPP) reviews of DMC providers. PSPP reviews must verify that: providers meet documentation requirements; each beneficiary meets the admission criteria, including clinical diagnosis and medical necessity; and each patient has a treatment plan.

In the PSPP process, DHCS personnel contact the provider approximately one week in advance of the review and advise the provider on what records will be needed so that services are not interrupted during the review period. After conducting an entrance conference with the provider, DHCS personnel request beneficiary records and assess the records for compliance with DMC regulations. The provider is then given a summary of DHCS's findings and offered technical assistance on how to achieve compliance with DMC regulations. If deficiencies are found, DHCS is required to recoup overpayments resulting from services not rendered, services rendered at an uncertified location, services rendered without medical necessity, and services billed with incorrect codes. Violations of some provider requirements require recoupment; others are deemed "programmatic deficiencies." In either case, providers are required to submit a corrective action plan within 60 calendar days. For county contracted providers, responsibility for ensuring that the plan is submitted falls upon the county. Due to realignment, DHCS only recovers the federal part of reimbursement for county-contracted providers; for direct contract providers, DHCS recovers the entire overpayment and returns the non-federal portion to the counties.

Audits and investigations

Documentation provided by DHCS outlines the process of fraud investigation and referral in the Medi-Cal program at large. For DMC, a potential fraud case would have to be referred by PSPP personnel to the A&I Division within DHCS before beginning the audit and investigation process. For the broader Medi-Cal program, the process can require numerous consecutive actions before a potential fraud case is referred to the California Department of Justice (DOJ) for investigation and prosecution. At the beginning of the process, staff from the Medical Review Branch (MRB) within A&I analyze data from numerous sources, including various systems, contractors, researchers within MRB, and news articles. MRB staff attempt to identify areas of exposure, red flags, and unusual trends within this data. Then Xerox, the state's contracting fiscal intermediary, compiles data on these providers for a report called the "weekly suspect list," which is subsequently considered at a weekly Field Audit Review meeting. This meeting is attended by various subject matter experts, including medical and pharmaceutical consultants, nurse evaluators, MRB field office staff, research staff, an actuary, and a team from Xerox. If, at the meeting, a case is determined to create a suspicion of fraud, the case goes directly to the A&I Investigations Branch for the case intake process. Otherwise, if the case needs to be worked further, the field audit process begins.

Prior to a field audit, MRB research and clinical staff examine the provider's records, Xerox produces a final audit package that contains a detailed report of beneficiary claims data for the provider, and the case is assigned to the appropriate field office. After the field office receives the case, it determines whether an in-depth audit for recovery is required, or whether a "quick hit" review should first be conducted to determine whether an in-depth audit is warranted. If the "quick hit" yields a credible allegation of fraud, the case is referred to the Investigations Branch of A&I for intake. Otherwise, an audit report is completed and determination is subsequently made of whether an in-depth audit for recovery is required. In an audit for recovery, either statistical analysis of claims data or a line-by-line audit methodology is proposed prior to assigning the case to field office staff. Then audit fieldwork is performed and the auditors determine whether there is a credible allegation of fraud. If no credible allegation has been found, an audit report is produced that determines the amount to be recovered from the provider.

The case intake process begins when one of the prior processes has produced a credible allegation of fraud. At the same time, according to documents provided by DHCS, the purpose of the case intake process is to have the Investigations Branch within A&I also determine whether there is a credible allegation of fraud. To make this determination, investigations personnel consult with MRB staff for their expertise, field personnel conduct a preliminary investigation, if necessary, and a checklist provided by DOJ is referenced to help determine whether there is a credible allegation. If a credible allegation is not found, but further research is warranted, the case is referred back to MRB for further data collection and analysis. If a credible allegation of fraud is found, the case is referred to DOJ.

At the time of referral to DOJ, payments to providers are not automatically suspended. According to DHCS documents, delaying payment suspension serves two purposes: keeping the provider ignorant that a criminal case is being pursued and reducing pressure on DOJ and A&I to justify continued suspension while the case is being investigated. Within 60 days, DOJ must decide whether or not to accept the case. After that, A&I regularly meets with DOJ to discuss the status of open cases, including the issue of when payment suspension should be imposed.

Other State Anti-Fraud Efforts

Fraud Control in Medi-Cal

According to DHCS's website, before 1999, Medi-Cal fraud was recognized to be widespread without a systematic departmental strategy for prevention and detection. Governor Gray Davis subsequently established the Medi-Cal Fraud Taskforce and the Anti-Fraud Program. By 2003, DHCS had "strategically transformed" its response to Medi-Cal fraud detection and deterrence by "reengineering [operations] and evaluating all levels of health care fraud." Additionally, AB 1765, (Oropeza), Chapter 157, Statutes of 2003, further provided DHCS with additional resources to combat Medi-Cal fraud by funding an additional 161.5 dedicated staff positions – the majority in the division of Audits and Investigations – for anti-fraud activities. DHCS reports that its anti-fraud program "routinely measures the Medi-Cal program to determine the magnitude of fraud and abuse; uses technology and analytic

analysis for the early detection of new fraud schemes; and, continually increases deterrence of fraudulent or abusive behavior through cost effective strategically planned programs.”

DHCS regularly conducts the Medi-Cal Payment Error Study (MPES), which consists of an annual random sampling of paid Medi-Cal fee-for-service claims. In the last published MPES, DHCS reported a decline in its estimated payment error rate from 6.56% in 2007 to 5.45% in 2009 with an estimated fraud payment rate of 1.16%. Extrapolating to the program as a whole, this amounted to an estimated \$842 million in payment errors and \$228 million in potential fraud payments.

In addition, DHCS participates in the federal payment error rate measurement (PERM) program. PERM was developed by the federal Centers for Medicare and Medicaid Services (CMS) to comply with the federal Improper Payments Information Act of 2002, which requires CMS to annually review Medicaid programs and report estimates of improper payments to Congress. PERM involves the participation of each state once every three years. California’s first PERM year was 2007; its second was in 2010; and its third is in 2013. While state-by-state numbers are not published in the PERM results, the overall national error rate is declining. The overall error rate was estimated at 10.5% for the 2007 fiscal year (FY); and by FY 2010, the second year that California participated, the error rate had declined to 6.7%. It is unclear whether California’s MEPS or PERM studies include DMC claims.

Bureau of Medi-Cal Fraud & Elder Abuse

Federal law establishes a framework for each state to operate a Medicaid Fraud Control Unit (MFCU), tasked with investigating and prosecuting Medicaid provider fraud and patient abuse. California’s MFCU is the Bureau of Medi-Cal Fraud and Elder Abuse (Bureau) within DOJ, which employs dedicated prosecutors, special agents, and forensic auditors. Each MFCU is reimbursed with federal funds for 75% of its costs. The Office of Inspector General (OIG) certifies, and annually recertifies, each MFCU. OIG collects information about MFCU operations and assesses whether they comply with statutes, regulations, and OIG policy. OIG also analyzes MFCU performance. DOJ indicates that the Bureau continues to be one of the most aggressive and successful MFCUs in the nation. In FYs 2010-11 and 2011-12, the Bureau reports that it received 503 Medi-Cal fraud referrals and 192 Medi-Cal fraud complaints. Of these 695 cases, 143 resulted in convictions and a total of \$47 million in monetary orders, and four resulted in acquittals (the remaining 548 were not prosecuted). During the same period, the Bureau negotiated settlements or obtained judgments in 53 civil prosecutions for a total of \$578 million in monetary orders.

Bureau of State Audits (BSA) Activity

In August 2013, the Joint Legislative Audit Committee approved a request for a BSA audit of the DMC program. The audit scope and objectives will include a review and evaluation of DMC laws and regulations; state and county roles and responsibilities; the provider eligibility process; the extent of fraudulent activity over a specified five year period relative to providers in Los Angeles County and two other counties chosen by BSA; and, the number of compliance regulators and investigators that is reasonably sufficient to effectively address the occurrence of fraudulent activity. To the extent

possible, the audit will make recommendations of statutory or regulatory changes that may help further prevent fraud in the program.

County DMC Fraud Controls

County participation in DMC is optional; however, all but 13 California counties currently maintain a program. The counties that do not run a DMC program are Alpine, Amador, Calaveras, Colusa, Del Norte, Inyo, Modoc, Mono, Plumas, Sierra, Siskiyou, Trinity, and Tuolumne. If a county chooses not to participate in DMC and a certified provider within that county indicates a desire to provide these services, DHCS executes a service contract directly with the provider. Providers may contract with more than one county; a provider in one county may therefore serve the DMC population from a neighboring county with limited access to providers.

Current DMC regulations contain only three broad mandates for counties: 1) maintain a system of fiscal disbursement and controls over DMC providers in their jurisdictions; 2) monitor to ensure that billing is within established rates; and 3) process claims for reimbursement. According to a 2004 document prepared by DADP, “administrative responsibilities of counties remain unspecified, vary with the administrative composition and needs of each county, and are reflected in each county budget.” According to the County Alcohol and Drug Program Administrators Association of California (CADPAAC), contracting requirements and monitoring protocols vary significantly from county to county. Some counties require quarterly monitoring visits to each of their providers and have standardized audit questions they ask, including a review of patient charts and treatment plans. CADPAAC states that other counties do monitoring visits less often, but at least once per year, and select a random percentage of charts to review. County monitoring staff may also sit in on treatment groups, and are available for technical assistance.

CADPAAC indicates that San Diego County has a peer review system where each provider is required to put a certain percentage of its DMC budget towards a quality control and improvement process. These funds support a contracted facilitator who, in conjunction with the county’s quality improvement staff, facilitates regional meetings where each DMC provider is required to bring files for peer review. These regional meetings occur one to two times per month in each region of the county. All programs within that region must participate in this process, and they review each other’s files using the DMC standards. The facilitator provides technical assistance and interpretation where necessary, and provides regular DMC training for all program providers.

CADPAAC also indicates that, when a county substantiates reports of provider problems, such as an uncertified counselor conducting a counseling group or a violation of group size requirements, the county disallows DMC charges and notifies the state. CADPAAC indicates that the state has occasionally asked the county to subsequently follow up, investigate, and issue a corrective action plan, while keeping the state “in the loop.” CADPAAC states that county staff works with providers to improve quality, but that counties sometimes terminate contracts if a provider is not amenable to correction.

In response to the CIR/CNN investigative reports, the Los Angeles County Department of Public Health issued a report making recommendations for changes to the DMC program. Among the many recommendations are: 1) increase the role of the County in the provider certification process; 2) immediately notify counties when DHCS refers a provider to DOJ for prosecution; 3) expand certification review to require applicants to demonstrate the ability to meet treatment standards and the use of evidence-based treatment or best practices; 4) make initial certification provisional and require providers to pass two annual audits before becoming DMC certified; 5) limit providers' use of physical examination waivers when establishing medical necessity; 6) clarify the definition of "medical necessity" for substance use disorder treatment; and 7) require better assessment of patients at the beginning of treatment.

Federal Fraud Prevention Initiative

The ACA provides additional resources and tools to enable CMS to expand efforts to prevent and fight fraud, waste, and abuse. As part of its efforts, CMS is now using a predictive analytic technology called the Fraud Prevention System (FPS) to identify the highest risk claims for fraud, waste, and abuse in the Medicare system. According to CMS, the FPS has stopped, prevented or identified \$115 million in payments, resulting in an estimated \$3 saved for every \$1 spent. Currently, FPS is limited to the Medicare program. However, under federal law, CMS is required to determine whether to expand the use of predictive analytics to include Medicaid and the Children's Health Insurance Program by April 1, 2015. Although Medicaid is administered and organized in a distinctly different way than Medicare, CMS anticipates that there are opportunities to transfer the knowledge and lessons learned about Medicare through the FPS to states for uses applicable to their Medicaid programs.

Conclusion

Allegations in the CIR/CNN reports and related actions by DHCS suggest that current controls in the DMC program have been woefully inadequate to prevent and detect fraud in the program. While some of the problems may be explained by the former administration of the program under a separate agency, the program continues to retain separate and distinct certification/enrollment, claims payment, and auditing processes from broader Medi-Cal program. Policymakers want answers about why these processes failed and assurances that processes are being developed to ensure that program services are effectively and efficiently provided to those who need them.