CALIFORNIA LEGISLATURE

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# 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.

Since August 2013, the Department of Health Care Services (DHCS) has ordered temporary suspensions against more than 50 providers for which DHCS has 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 provides 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. 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 certified by the state in order to participate in the program.

When the program was established in 1980, 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.

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 is able to obtain a contract, either with the county or the state, to provide DMC services. Most providers directly contract with counties; 15 currently contract directly with DHCS.

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. While most stakeholder comments focused on streamlining administrative hurdles and expanding covered services to reflect current best practices, some stakeholders, particularly counties, also raised issues related to promoting fiscal integrity in the program. The counties expressed a desire for greater clarity about the respective roles of counties and DHCS and specifically recommended that they, rather than DHCS, be given the lead role in deciding whether or not 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.

## 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.

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.

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.

## *Staffing Requirements*

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.

## *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.

### *Monitoring and Referral*

DHCS refers cases of suspected criminal fraud to the DOJ for prosecution under the terms of a MOU. However, potential fraud cases must undergo a complex process within DHCS before being referred to DOJ for investigation and prosecution. At the beginning of the process, staff from the Medical Review Branch (MRB) of DHCS analyzes data from numerous data sources and attempts to identify red flags and unusual trends within this data. Then the state's fiscal contractor compiles data on these providers for a report called the "weekly suspect list," which is subsequently considered at a weekly field audit review meeting attended by subject matter experts, including medical and pharmaceutical consultants, nurse evaluators, MRB field office staff, research staff, an actuary, and the provider review unit team. If a case is determined to create a suspicion of fraud, the case goes directly to the DOJ. To make this determination, DHCS investigations personnel consult with MRB staff for their expertise and field personnel conduct a preliminary investigation, if necessary, using a checklist provided by DOJ to help determine whether or not there is a credible allegation of fraud. 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 is found, the case is referred to DOJ.

## Other State Anti-Fraud Efforts

### *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.

### *California State Auditor (CSA) Activity*

In August 2013, the Joint Legislative Audit Committee approved a request for a CSA 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 the CSA; 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.

According to CADPAAC, 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.

### *Los Angeles County Recommendations*

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.

## 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 and enrollment, claims payment, and auditing processes from the 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.