State of California

Attorney General's Medi-Cal Task Force Report

December 2006

A Technology-based Approach to Detecting and Preventing Fraud

Attorney General
Bill Lockyer

Table of Contents

I. Task Force Members

Dr. Greg Papadopoulos (Chairman) Executive Vice President, Research & Development and Chief Technology Officer Sun Microsystems, Inc.	
Dr. K. Mani Chandy Simon Ramo Professor of Computer Science California Institute of Technology	**Dr. Harold Sorenson** Professor Emeritus Department of Mechanical & Aerospace Engineering University of California, San Diego
W. Joseph Majka Vice President, VISA Fraud Control VISA USA	**Consuelo Woodhead** Assistant U.S. Attorney U.S. Attorney's Office Central District of CA, Criminal Division
Larry Singer Senior Vice President, Strategic Insight Office Sun Microsystems, Inc.	**Jason A. Woods** Director, Chief of Operations Chief Technology Office Sun Microsystems, Inc.

The authors of this report are information systems and/or technology experts having either senior executive or academic positions as technologists. The combined management background allowed the members to objectively inspect not only the systems and process issues related to Medi-Cal fraud, but also the staffing and management of the systems, especially as it relates to the IT systems management and fraud detection units.

We are pleased to report that the Department of Health Services (DHS) teams which support this system, including some dedicated professionals that have been involved with the program for nearly its entire duration, have been cooperative, available, and transparent to the study group. During the course of these interactions it was apparent there was a high level of professionalism, deep knowledge and expertise, and most impressive, a sincere level of commitment to the program and its beneficiaries.

It should also be noted that the DHS professionals have been constrained by an information system that is thirty years old, built in an age of computing whose architectural limits are well documented elsewhere in this report. Despite the limitations in system capabilities, DHS staff have done their utmost to ensure that they have exercised all available capabilities to fight fraud and maximize the value of the program dollars spent. The citizens of California should be proud of the work performed by DHS. This report provides recommended changes and next steps with respect to modernizing the systems and processes available to DHS and other agencies as they support this critical program.

II. Executive Summary

Nearly twenty percent of California residents depend on Medi-Cal to meet their basic heath care needs. Medi-Cal was designed to provide health and dental care assistance to those residents most in need including children, lower income individuals and families, elderly, and the disabled. As the number of participants in this program continues to increase, the challenge of maintaining and efficiently operating Medi-Cal continues to worsen. Additionally, in its current state, the ability to detect and prevent fraud and abuse in the system has proved very difficult. Experts believe as much as $3 billion dollars is lost each year to fraudulent claims in California's $34 billion Medi-Cal system.

The primary mission of the Attorney General's (AG) office is to provide leadership, information and education in partnership with state and local governments and the people of California to:

- Enforce and apply California's laws fairly and impartially;
- Ensure justice, safety, and liberty for everyone;
- Encourage economic prosperity, equal opportunity and tolerance; and
- Safeguard California's human, natural, and financial resources for this and future generations.

At present, the ability of the Attorney General's office to deliver on this mission and protect California's economic and social prosperity is seriously compromised by the State's current Medi-Cal information and payments processing system.

Specifically to combat fraud and abuse, Attorney General Bill Lockyer formed and leads a cross-functional Medi-Cal Fraud Task Force made up of leaders from industry, academia, and government. This report outlines the state of today's Medi-Cal system and presents a vision for a more modern technology-based approach to detecting and preventing fraud while improving quality of care for Medi-Cal beneficiaries. The report also includes three broad recommendations which the Task Force believes are in the best of interest for both the recipients of Medi-Cal services and California tax payers.

The initial mission of this Task Force was to investigate the options for supplementing the current Medi-Cal system to empower the AG's office with a modern technology-based approach for detection and prevention of fraud.

Techniques around fraud detection and advanced pattern recognition were investigated to determine a best practices approach to the design and architecture of modern Medicaid systems. Leveraging a modern systems architecture promises to dramatically improve the State's ability to detect and prevent fraud, and at the same time, delivers a higher quality of service to beneficiaries of the Medi-Cal program. However, after initial examination, the current structure of the Medi-Cal system is such that minor changes to the system will not yield significant improvements in either the ability to detect or prevent fraudulent behavior. We had to take a step back from the original mission presented to this Task

Force and instead determine the key design principles that are critical to modern, flexible, beneficiary-based Medicaid systems.

Characteristics of Modern Medicaid Systems

In modern Medicaid operations, questionable claims are detected upon initial entry into the system via sophisticated pre-payment edits, automatically flagged for review, and suspended (not paid) until resolved. A careful balance is struck between automatically suspending the right claims, and not suspending too many claims (creating a host of operational problems).

Moreover, adjudication decisions take into account the "medical context" by considering the patient's diagnosis as well as all relevant treatments given by other providers. When a new pattern of fraudulent claims is detected, pre-payment claim edits are easily and quickly added before too many get paid.

Finally, in most modern Medicaid shops the claims adjudication system provides an efficient, automated backbone for the entire operation. Business rules are separated from application logic making the system easy to update. Web-based access is given to Providers (and Patients) to improve communications and prevent honest misunderstandings about eligibility, coverage and benefits. Real-time decision support tools provide the means for end-users to get at data without necessarily relying on Information Technology (IT) programmers.

Challenges in California's Medicaid System

The primary challenge in California is that the Medi-Cal claims system is decades old and has become an impediment to the business operations of Medi-Cal. Claim systems of this era typically –

- Were designed to expedite the payment of claims versus the prevention of fraud;
- Make it 'easier to put data in, than to get it out';
- Are difficult and time-consuming to update; and
- Adjudicate on a claim by claim basis – versus "episode of care" – making detection of fraud and abuse that much more difficult.

The net result is that the California Medi-Cal program may be unduly exposed to fraud and abuse potentially costing the state billions of dollars which it can ill afford to waste. Beyond that, there are more modern Medicaid systems which could more fully automate the operation leading to significant gains in efficiency and ultimately improve the cost effectiveness of the California Medicaid program.

Secondly, because the current system lacks beneficiary-based data, it misses an opportunity to provide higher quality care to Medi-Cal beneficiaries. Physicians often have no access to the medical history of the Medi-Cal patients that they serve, making it

more challenging to diagnose and treat patients, and potentially subjecting patients to tests and procedures that were already tried by another doctor or worse, are contraindicated for the patient due to a condition that was not disclosed to the doctor.

Recommendations of the Task Force

The Task Force hereby offers the following recommendations for consideration.

Recommendation #1 – Continuously Measure the System

Author and renowned Harvard professor, Malcolm Sparrow has been a big proponent for better measurement to determine the size of the health care fraud problem. In his book, "License to Steal: How Fraud Bleeds America's Health Care System," he states:

> Without measurement, the debate focuses on the size of the problem, rather than on solutions[1].

Random, continuous, accurate, system-wide measurement provides critical information to operators, investigators, and officials. Not having this information in a timely manner not only complicates, but potentially misleads officials about the size and scope of the problem. Measurement also serves to determine baselines, measure progress, and set new targets with respect to fraud detection and prevention objectives. Additionally, adequate measurement data should provide improved accuracy and consistency in claims adjudication and analysis. Ultimately, continuous measurement provides the data necessary to better quantify the problem, make fact-based recommendations and monitor the changes that result.

Recommendation #2 – Replace the Medi-Cal Claims System

Once data from various sampling and measurement techniques is available, we can begin to internalize the learning back into the system. The learning and adaptation cycle can thus be reduced from years as exist in today's environment to weeks or days.

The Medi-Cal system should be put out to bid, and replaced by one that more fully utilizes up-to-date Information Technology to service the overall operation, while providing a better defense against fraud and abuse.

The changes made to the system to improve fraud and error detection have many additional benefits including:

- Allowing for consolidated, efficient, high-speed processing;
- Increased flexibility using modern decision support and data mining tools/techniques;
- Improving the overall beneficiary experience; and
- Prompting payment for majority of ethical and accurate claims.

[1] Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America's Health Care System (Boulder: Westview Press, 2000), pp. 149.

Recommendation #3 – Empower Medi-Cal Providers with Network Access and Identity Management

In order to realize a significant gain in overall efficiency in the California Medicaid program, it's critical that "doing business electronically" becomes the standard. The requirement to convert operations from paper based to electronic claims submission and processing gives administrators modern tools and techniques for accurately processing claims and simultaneously greatly improving their ability to detect, prevent, and prosecute fraud and abuse. An electronic network-based process also serves to increase beneficiaries' access to information concerning their own patient experience (medical records). It will therefore be important to provide online access to most, if not all, providers and beneficiaries.

Unfortunately, some California Medicaid providers don't have the means or the technical resources to purchase and support computers to connect into Medi-Cal. A system must be developed to train and provide financial assistance or financial incentives to Medi-Cal providers who need additional support in converting their operations to an electronic based claims system.

California should explore innovative ways to fund and support the technology and processes necessary to accomplish the goal of widespread access to Medi-Cal electronic records and electronic claims processing. This will simultaneously improve access to information and offer self-service capability to both beneficiaries and providers.

Identity management is a cornerstone of this recommendation because it is necessary in order to provide secure access to data records by a wide variety of people using a wide variety of devices. Identity management ensures that only the "right" individuals are given access to the system while facilitating access and limiting the number of passwords needed to protect the organization. The Health Insurance Privacy and Portability Act (HIPPA) also requires that the state protect the privacy of personal health information, making a state-of-the-art identity management system even more important.

Improving Beneficiary Care

While the original focus of the task force was to identify means of reducing fraud losses, the task force found that its recommended solution would also have a great impact on patient care. When fraud control strategies were reviewed by Medi-Cal stakeholders including the Office of the Attorney General, it was revealed that the proposed beneficiary-centered approach to maintaining medical records would enable new approaches to patient care that could have a big impact on quality of care.

New approaches to patient care are made possible by the availability of centralized medical records that can be retrieved based on patient ID. These medical records can be made available to both doctors and beneficiaries to enable better care. The current Medi-Cal system is focused on capturing payment data only. It therefore offers no patient medical records to be accessed by doctors or beneficiaries. In order to stem fraud losses it is necessary to maintain detailed medical records which include patient information. As a

result of these centralized electronic medical records, the following patient care improvements are made possible:

- Physicians can more accurately diagnose a patient's condition because they have access to the patient's medical history regardless of whether they've seen the patient before,
- Beneficiaries have greater access to information, thus helping to advocate better care for themselves,
- Electronic requests for prior authorization will expedite approvals so that providers can administer the proper care more quickly, and
- The resulting reduction in fraud losses leaves more dollars available for the care of beneficiaries, enabling Medi-Cal to serve a greater number of beneficiaries and to provide the best possible care.

Electronic Medical Records

In 2004, President Bush called for the widespread adoption of electronic medical records and asserted a 10-year goal of making electronic medical records available to most Americans in order to help improve patient care and reduce healthcare costs. The industry has recently developed standards for the interoperable electronic medical records, but these standards are not yet widely adopted. As one of the largest medical databases in the country, California's Medi-Cal program can offer its clout to help establish these standards within the industry, resulting in even greater benefits for Medi-Cal beneficiaries through interoperable medical records that can be more easily transferred to other institutions.

Reducing Risk in Large-scale IT Systems Procurement

Given that the replacement of the Medi-Cal application system is an enormous undertaking that may take several years to complete, the task force offers some additional recommendations for the procurement and implementation of the system. All systems implementations of this magnitude are subject to failures and setbacks that are normal in the course of a large-scale project implementation. The State of California must be aware of the expected risks and must take steps to mitigate them.

The task force offers the following recommendations regarding the procurement process:

- Require a services-based component architecture that isolates failures to individual system components where they are easier to identify and repair;
- Fund the design system architecture before proceeding to procure and implement system components; and
- Implement modern IT project management practices that help reduce project risk.

Next Steps

The task force recommends that the project be initiated immediately by funding a Request for Information (RFI) for a new claims processing system based on the ideas presented in this report. The RFI provides an opportunity to obtain ideas and background information from appropriate vendors so that a Request for Proposal (RFP) can be written

and the procurement initiated. The RFI process should be started immediately so that the procurement of the architectural design can be started soon.

III. Overview of Medi-Cal and Fraud

What's at Stake for California

Medi-Cal is California's implementation of the federal Medicaid program and combines federal Medicaid funding with California State funding to create the largest Medicaid program in the country in terms of number of people served (6.5 million)[2]. The total Medi-Cal budget for FY 2005-06 is $34 billion and includes $19 billion in federal funds. The program is designed to improve quality of life for California's most needy and vulnerable residents by providing access to critical services that promote their health, well-being, and ability to function in society. Eligible residents include children, lower income individuals and families, elderly, and the disabled. Without Medi-Cal, the needs of this community for health and dental care including both acute and long-term care would otherwise be unmet.

Although many people associate Medi-Cal with welfare, more than half of the budgeted funds pay for medical and long-term care for the elderly and adults with disabilities. Medi-Cal also provides essential support to California's safety net providers – institutions that deliver a significant amount of health care to the uninsured, Medi-Cal beneficiaries, and other vulnerable patients regardless of their ability to pay. Table 1 shows some additional statistics that highlight the importance of Medi-Cal contributions to California's population and to its economy[3].

People for whom Medi-Cal is the primary source of health coverage	**Significant services funded by Medi-Cal**
•One in six Californians under age 65 •One in four of the state's children •The majority of people living with AIDS	•42 percent of all births in California •Two-thirds of all nursing home days •Two-thirds of all revenue in California's public hospitals

Table 1. Important contributions from the Medi-Cal program

Medi-Cal provides payment to health care providers in compensation for delivery of essential health care services. It started as a fee-for-services health care program that was signed into law in 1966 and was later expanded to include dental care services and managed care services as shown in Figure 1.

[2] California HealthCare Foundation, Medi-Cal Facts and Figures: A Look at California's Medicaid Program, January 2006, pp. 3.
[3] Ibid, pp. 3.

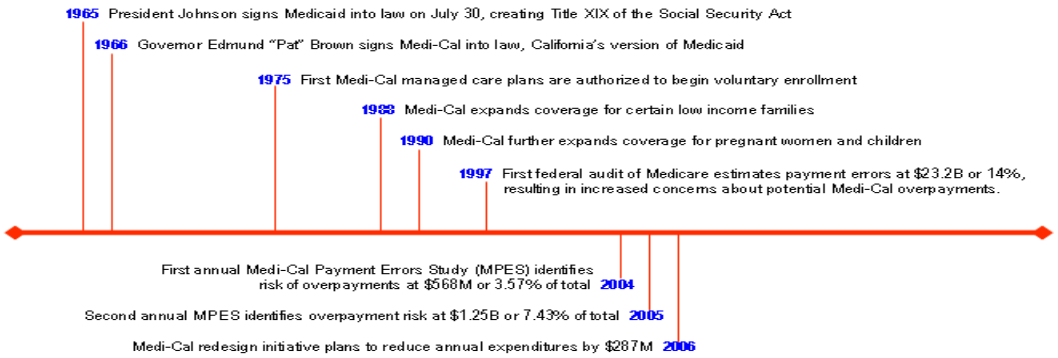

Figure 1. Major milestones affecting Medi-Cal

As the program has grown, so too have its annual expenditures (Figure 2). Some of the key factors that have contributed to the increasing costs for Medi-Cal include:

- Demographic trends have increased the number of people eligible for Medi-Cal;
- Program expansions and reforms have added new beneficiaries, yielding a 32 percent increase in the number of people since fiscal year 1998-99;
- Declining employer-sponsored coverage. (Between 2001 and 2003, children's coverage linked to parental employment declined by nearly 4 percent.[4]);
- Health care costs have risen at rates above the general inflation rate;
- Medical advances have improved patient outcomes, yet they have increased the cost of treatment; and
- Medi-Cal provides beneficiaries with a comprehensive range of benefits, exceeding the scope of benefits of other states and employer-based programs.

[4] California Health Care Foundation, Children's Health Insurance Programs: Facts and Figures, June 2006, pp 1, 23.

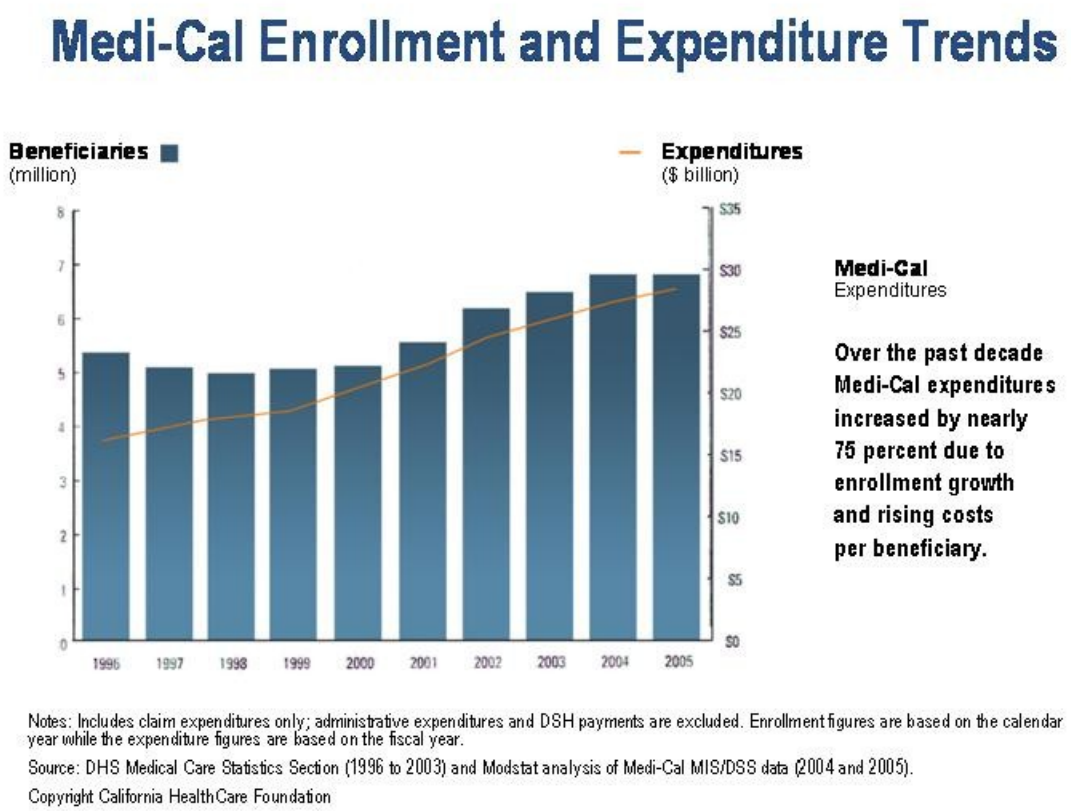

Figure 2. Historical perspective on Medi-Cal funding

Financial Losses Due to Overpayment

As Medi-Cal and other publicly funded health care programs have grown, they have been subject to financial losses resulting from inadequate controls governing payments to providers. While most health care providers in the Medi-Cal program are honest and committed to high quality care for Medi-Cal beneficiaries, there is a significant loss of funds to payment errors and outright fraud. It is sometimes difficult to distinguish between honest billing mistakes that result in overpayment, and fraudulent attempts to profit from the system. In either case, however, overpayments leave fewer state resources to serve the needy and can sacrifice the quality of health care for eligible beneficiaries.

Gaining Perspective on the Scale of the Problem

Public and industry awareness of health care fraud problems began to surface in the early to mid 1990's when some high profile scams were uncovered. However, the problem was not taken seriously at first. The first signs of fraud in the system were treated as though, they were anomalies. Many people believed that were simply a few bad apples in the system and that there was no need to worry about a systemic problem of any magnitude. Meanwhile, the situation continued to worsen.

By 1997, concerns about fraud in the federal Medicare program had reached a sufficient level to compel the Office of Inspector General (OIG) to institute an audit to estimate the extent of Medicare overpayments. The first such study, reported in July 1997 and based on claims paid during 1996, produced an overpayment estimate of $23.2 billion, or 14 percent of Medicare payments. Because the audit procedure did not include contact with patients and its requests for supporting documentation were made by letter, this estimate can be considered conservative. It would not have been likely to catch fraud schemes that involved falsified claims or documentation for services that were never rendered. If audited, fraudulent providers can just submit false substantiations of their original claims[5].

The Medicare study did, however, confirm that the extent of the problem was much bigger than most people thought. For this reason, it served as a milestone and turning point for health care fraud control. A similar study for Medi-Cal was not conducted until 2004, but the 1997 Medicare study helped focus more attention on the problem in California's Medi-Cal program.

Typical Health Care Fraud Scenarios

Health care fraud can take many forms, but the most common forms involve providers knowingly billing for unnecessary services, services that were not performed, or for more expensive services than they actually provided.

In his book, "License to Steal," Malcolm Sparrow does a good job of highlighting some of the most common types of fraud. Excerpts of some of his examples are included below to illustrate the breadth and scope of fraud scenarios that have been uncovered in recent years[6]:

- **Fictitious companies** – A company is incorporated using a fictitious name and submits a series of claims, usually between $200,000 and $1 million. By the time the Health and Human Services staff become aware of the scam, the company and John Doe have vanished.
- **Generalist criminals jumping into health care** – A convicted criminal whose professional experience spans a number of different fields such as pornography or night clubs, decides to turn his or her attention to health care and starts up a home health care agency or durable medical equipment (DME) company. After receiving certification as a provider, the business begins submitting false claims and may submit some real claims along with them to help hide the scam. Quality of patient care is far from important to these people.
- **Physicians** – Fraud is not confined to ancillary services such as equipment supply or home health care. There have been a number of cases of physicians billing for services that they never performed simply to "earn" the extra money. For example, an

[5] Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America's Health Care System (Boulder: Westview Press, 2000), pp. 91-2.
[6] Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America's Health Care System (Boulder: Westview Press, 2000), pp. 1-36.

ophthalmologist agreed to settle a whistle blower suit in which he routinely billed Medicare for endothelial microscopy for every cataract patient he treated, even though it is a rarely used pre-cataract procedure and he never performed it.

- **Dentists** – A dentist in Michigan pleaded guilty to abusing patients by pulling perfectly healthy teeth to create Medicaid eligibility for partial lower dentures.
- **Laboratories** – A New York laboratory owner was convicted of stealing $3.6 million from the Medicaid program between 1986 and 1998. His scam involved purchasing blood from addicts and Medicaid mills and then falsely charging Medicaid for thousands of blood tests that had never been ordered, refereed, or authorized by physicians, and were in no way medically necessary. He had been previously prosecuted for false billings as a physician and had lost his license to practice medicine. Yet there were limited controls in the system to keep him from entering the lab business.
- **Large corporations** – Some of the largest health care providers in the country have been the subject of scandals that involve tens of millions or hundreds of millions of dollars for scams that range from kickbacks to doctors to misrepresenting expenses in order to be reimbursed at higher rates. One large organization faced so many lawsuits that it was speculated to have a potential settlement with the government that would cost approximately $1 billion.
- **Teaching hospitals** – Teaching hospitals are generally among the most respected institutions in the health care industry. And yet it is not uncommon to uncover improper billing practices in these institutions relating to treatment provided by residents or interns under the supervision of a qualified physician. Teaching hospitals are permitted to bill Medicare or Medicaid for the services of a supervising physician if he or she was physically present at the time of the service, personally examined the patient, and assumed the same responsibilities as for other paying patients. If the attending physician is not present, then the services of the residents and interns are already covered by government grants for training and are not eligible for Medicare or Medicaid compensation.
- **Billing specialists** – Billing consultancies are often used by providers to gain efficiency in processing claims and to help the provider get as much compensation as possible from insurance companies or government agencies. These billing consultancies have traditionally been paid on a commission basis and are therefore incentivized to inflate claims. Many of them have reconfigured claims, unbundled laboratory tests, and manipulated clinical diagnoses to obtain higher reimbursements.
- **Meat for Money –** Some clinics have employed a practice of hiring "runners" to go find elderly, children, or homeless people who are covered by insurance and bring them into the clinic for procedures or tests that could be billed to Medicare or Medicaid. These and other similar approaches such as kickbacks for patient referrals or offering free eye exams and then billing for other services could allow clinics to generate a high volume of billing. They can then use legitimate patient information even though the claims are for medically unnecessary services or services that were never provided.
- **Cooperating patients** – Paying patients directly to cooperate in the lies about services provided can help make the scam more foolproof if investigators actually call the patients.

•**Communities and networks** – A ring of corrupt physicians, labs, and pharmacies can help build each others' revenues and make it harder to get caught. For example, patients could be paid to see a physician who gives them a false diagnosis for a fictitious ailment and issues a prescription for an expensive medication that is to be filled by a specific pharmacy that has hired another agent to then buy back the drugs in the parking lot at a greatly reduced price. The patient is compensated for the hour or so of their time it takes to visit both the doctor and the pharmacy.
•**No patients, faster money** – Some scam artists decide that it's not worth their time to actually see patients and pretend to provide them with medical care. Without patients, the only constraint on earnings is how fast the computer can generate false claims using patient lists from the black market and a range of provider numbers so that it's not as obvious. The trick is to make each claim fall within an acceptable billing range for a generic kind of medical service or supply so that it will pass through electronic claims adjudication without a hitch.

Results of 2005 Medi-Cal Payment Error Study

Managing fraud, waste, and abuse in the Medi-Cal program requires an ongoing effort to measure the extent of the problem over time and to monitor emerging trends. The California Department of Health Services (DHS) has completed its second annual Medi-Cal Payment Error Study (MPES) which is designed to identify the areas of the program that have the greatest risk for payment errors. Identification of risk is critical to guiding the development of fraud control strategies and the allocation of resources to those areas of the Medi-Cal program most vulnerable to fraud, waste and abuse. More importantly, it is also important to identify risks where Medi-Cal beneficiaries may not be receiving appropriate medical services, drugs, or supplies.

The 2005 MPES found that 91.60 percent of the total dollars paid in fee-for-services medical and dental programs were billed appropriately and paid accurately. The remaining 8.40 percent of the total dollars paid had some indication that they contained a provider error (Figure 3). Claim errors ranged from simple provider mistakes such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as forged physician signatures or billing for services not provided. As in the 2004 study, one of the most significant factors contributing to overall dollar errors was the apparent lack of medical necessity for the services provided.[7]

The 8.40 percent that were flagged as payment errors represents $1.4 billion of the total $16.8 billion in payments that were made in calendar year 2004 for fee-for-services medical and dental services. An additional analysis of these "at risk" payments was conducted to develop a more accurate assessment of potential fraud. The additional

[7] California Department of Health Services, Medi-Cal Payment Error Study: Fee-for-Service and Dental Programs (2005), pp. 1-2.

analysis showed that 5.17 percent or $869 million of these payments were not fraudulent, but simply in error and 3.23 percent or $542 million disclosed characteristics of potential fraud. This is to be considered an estimate of the potentially fraudulent claims. To determine exactly what percentage of the payment errors were indeed attributable to fraud would require a complete criminal investigation.

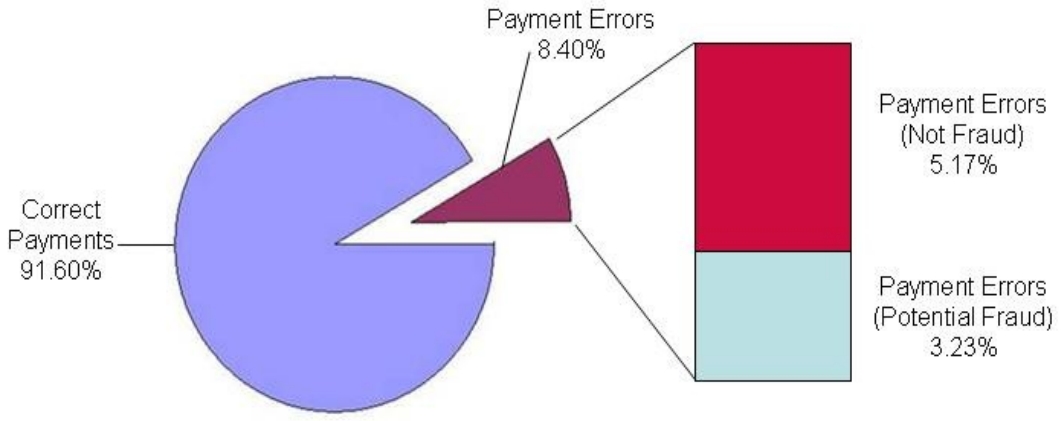

Figure 3. Results of 2005 Medi-Cal Payment Error Study

It is worth noting that while the 2005 MPES shows an increase in potential fraud as compared to the 2004 study, there is reason to believe that the increase is due to a more highly trained staff that executed the study, potentially resulting in an increase in the number of errors identified. It also appears that payment errors in MPES 2005 were more highly concentrated in stratums that were larger and had higher average dollar cost per error, thus affecting the overall percentage of payment error. [8]

Industry Estimates of Fraud Are Higher

The MPES results show a smaller fraud component than is traditionally estimated by industry experts. Harvard University professor Malcolm Sparrow often uses 10 percent as his estimate of fraud in our national health care system and says it could be as high as 40 percent[9]. In 1992, the General Accounting Office also estimated that 10 percent of healthcare spending might be lost to fraud[10]. In an audit of the federal Medicare program in 1997, auditors found that 30 percent of fiscal 1996 payments contained irregularities and they estimated that 12 percent or $23B of the funds were paid erroneously.

While fraud control improvements have been made since some of these original estimates, the DHS error rate of 3.57 percent seems comparatively low. Until larger sample size error studies are available, it may be best to use a range of 3.5 to 10 percent as an estimate of the size of the Medi-Cal fraud problem.

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[8] Ibid, pp. 4.
[9] Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America's Health Care System (Boulder: Westview Press, 2000), pp. 71-3.
[10] National Center for Policy Analysis Idea House, Fraud in Medicare (www.ncpa.org/~ncpa/health/pdh5.html).

Resource Allocation that Doesn't Match the Scale of the Problem

Even after gaining a better understanding of the size of the problem through measurement studies, most government programs have not allocated sufficient resources to adequately address the risk to their program dollars. It has been shown that fraud control units can often recoup double or triple what it costs for them to operate their unit by recovering overpayments from providers and seeking damages for fraud cases. Yet these units can only handle a certain volume of cases per headcount and industry estimates are that funds recovered by federal programs have averaged 0.07 percent of the program outlays. In 2000, it was estimated that Medicare was investing 0.007 percent of its total program dollars in fraud unit budgets. Even if these units were recovering 10 times their investments, it only adds up to 0.07 percent of total funds.

The Medi-Cal program invests approximately $41.2M in fraud control and prevention based on its FY05/06 staffing and budget numbers[11]. This represents 0.12 percent of the $34B FY 2005-06 program budget.

When comparing the prosecutorial productivity of the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) during the past eight fiscal years (1998/99 through 2005/06) with that of the previous eight (1990/01 through 1997/98), Department of Justice data show that the BMFEA's prosecution of health care fraud has increased by a staggering 116 percent[12] and that court-ordered restitution and penalties have increased by an even more impressive 730 percent[13]. In reviewing data going back as far as 1978, when the program was first established, the BMFEA has won more than six fold more restitution and penalties in the past eight years than in the previous twenty, combined. Yet, the BMFEA's recent success – and its recognition as the nation's premiere Medicaid fraud prosecutorial program by the Inspector General of the United States Department of Health and Human Services – only underscores the limitations of depending on a one-dimensional fraud control strategy that exclusively relies on the criminal prosecution of fraud.

To wit, for fiscal 2005-06, the BMFEA won a record $274.4M in court-ordered recoveries of funds that were embezzled from the Medi-Cal program. While this is the largest recovery in California history, it is still a small sum compared to the total potential fraud in the system. Using the conservative MPES estimate of 3.57 percent, the 2005-06 budget of $34B would yield $1.2B in payments that were at risk of fraud. If estimates of 10 percent are more accurate, then fraud losses could be as high as $3.4B for 2005-06, which would put the $274M in recoveries at only 12.4 percent of total fraud losses. The U.S. General Accounting Office (GAO) has estimated that some investments in fraud control can be expected to generate up to 200 percent return on investment (ROI)[14]. With such strong ROI figures and fraud losses that are much larger than recoveries, there is

[11] The Attorney General's office estimates its FY 05/06 fraud control spending at $41.2M for salaries across both its Audits and Investigations teams and its Medical Fraud Prevention Unit.
[12] BMFEA prosecuted 944 criminal cases in the recent 8 years versus 438 in the prior 8 years.
[13] Court-ordered restitution and penalties were $502.8M in the recent 8 years versus $68.9M in the prior 8 years.

indeed a mismatch between the size of the problem and the investment being made to address it.

While the criminal prosecution of Medi-Cal fraud is a vital component of any comprehensive fraud control strategy, it would be myopic and unwise to regard it as a stand-alone panacea to the problem. As demonstrated above, no matter how effective prosecutors may be at recovering stolen taxpayer dollars, a reactive "pay-and-chase" approach to combating health care fraud is limited in its overall efficacy. Instead, the task force urges a strong prosecutorial response to health care fraud, and an even stronger, more aggressive preventative approach. Toward this end, the task force has proposed a mix of prevention and control strategies in the recommendations contained in this report. Regardless of how much focus is on prevention versus recovery, the scale of the investment needs to be in line with the size of the risk.

The Myth of Managed Care as a Panacea for Fraud

Most of the initial health care fraud schemes that were uncovered focused on ways of manipulating the fee-for-services system and getting paid for services that were either not provided, not necessary, or were inflated by billing for higher cost services than were actually provided. When managed care programs came into existence and providers were being paid a capitated rate per patient regardless of whether or not services were rendered, it was natural for people to think that this would solve the fraud problem by removing the incentive to provide extra services and making it impossible to bill for services not rendered.

However, changing to a different type of payment system simply changes the behavior of people that are determined to manipulate the program for their own benefit. In managed care situations, the incentive for a greedy provider would be to provide as few services as possible to patients while getting paid to offer those patients a general plan. Thus managed care plans eliminate some of the more familiar ways of committing fraud, but open the door for other types of fraud that may be even more dangerous because they involve risk to the lives of patients who receive inadequate care.

An example of how this type of fraud can impact patients is illustrated by an investigation that occurred in New York in 1995. New York State health investigators posed as patients and called the 18 largest managed care programs in the state asking to set up routine doctor visits for services such as prenatal care, child immunizations and annual checkups. They had so much trouble just getting these initial appointments that 13 of the 18 providers were cited for providing substandard care[15].

While managed care systems may indeed be cost-effective and can offer protection against certain types of fraud, one can see that proper access to care in these programs must be closely monitored in order to detect schemes where patient fees are being

[14] Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America's Health Care System (Boulder: Westview Press, 2000), pp. 135.
[15] Ibid, pp. 102.

diverted to greedy entrepreneurs' pockets instead of being used to support actual health care services for Medi-Cal beneficiaries.

Medi-Cal Redesign Program

As the second largest expenditure in the state budget behind K-12 education, Medi-Cal has attracted the attention of Governor Schwarzenegger and the state legislature and is being targeted for cost savings through a redesign of the program. When fully implemented, the Medi-Cal Redesign is expected to both improve Medi-Cal coverage for eligible beneficiaries and reduce Medi-Cal expenditures by more than $287 million annually.

Implementation of the proposed reforms will take place over a period of several years and will include several initiatives as shown in Table 2.

Redesign Initiative	Description
Increase access to care and improve health outcomes through managed care expansion	•Take advantage of managed care features of high quality care with greater beneficiary access and lower cost by expanding managed care. •Expand managed care to 13 additional counties over a period of 12 to 18 months.
Stabilize the financing of California's Safety Net Hospitals	•Negotiate a new five-year hospital financing waiver with the federal government to allow California to continue contracts with selected hospitals serving low-income and vulnerable populations.
Modify the Medi-Cal benefit package	•Align the Medi-Cal dental benefit package with private employer-based and public sector health coverage programs by placing an annual limit of $1,800 on dental services for adults.

Table 2. Components of Governor Schwarzenegger's Medi-Cal redesign program

The Need for Fraud Control

The state's ability to detect and prevent fraud can impact both the quality of care for Medi-Cal beneficiaries and at the same time reduce the overall cost of the program and serve a greater number of beneficiaries.

Medi-Cal fraud diverts the state's scarce funds intended for vital services into the hands of criminals, thus reducing the number of beneficiaries that could be served. Fraud can also contribute directly to public health risks through needless medical procedures or an unwarranted delay of, reduction in, or denial of care to beneficiaries by a managed care plan. Curbing these abuses will therefore make additional funds available to care for additional beneficiaries as well as promote greater quality of care within the system.

IV. Roles and Responsibilities for Management of Medi-Cal Program Components

Oversight and implementation for the California Medi-Cal program is spread across a number of different agencies and utilizes third-party businesses for claims adjudication and payment. Each of these organizations is responsible for one or more components of the overall program. It is the opinion of the task force that the overall functioning of the program would benefit from information systems that make it easier for these organizations to cooperate in their efforts to both control fraud and to deliver high quality services to program beneficiaries.

The following sections provide a brief overview of the responsibilities and functions performed by the primary organizations involved in fraud prevention and control in the Medi-Cal program.

The task force believes that the right organizations are in place for combating fraud, but that these organizations could be much more effective if given better access to information and the ability to share information across organizational boundaries. Further discussion about how these organizations could utilize information systems to work more efficiently and effectively is provided in the *Conclusion and Recommendations* section of this report.

Department of Health Services (Health Services)

The goal of Health Services is to protect and improve the health of all Californians. As part of that goal, the Medi-Cal program is one of the top 4 priorities that Director Sandra Shewry has laid out for Health Services. Many parts of the Health Services organization are involved in management, operation, and oversight of the Medi-Cal program. Those that are most important to fraud prevention and detection are described below.

Medical Care Services (MCS)

Medical Care Services is responsible for the overall coordination and direction of health care delivery systems supported by Health Services. It directly operates Medi-Cal and the program's eligibility, scope of benefits, reimbursement, and other related components.

Payment Systems Division (Payment Systems)

The mission of Payment Systems is to ensure the effective overall administration, oversight, and monitoring of the Medi-Cal fiscal intermediary contractors who are responsible for receiving and processing claims and for maintaining the Medicaid Management Information Systems for both the medical and dental programs. It also ensures that Medi-Cal is the payer of last

resort. In addition, this division administers and monitors the Medi-Cal managed care enrollment broker contract.

Medi-Cal Managed Care Division (Managed Care)
Managed Care coordinates audit-planning activities with audits and investigations to target problem managed care plans or specific problem areas.

Medi-Cal Benefits (Benefits)
Benefits is responsible for determining the scope of benefits to be covered by the Medi-Cal program.

Medi-Cal Operations (Operations)
Operations is responsible for the prior authorization of services provided to Medi-Cal beneficiaries.

Medi-Cal Policy (Policy)
Policy is responsible for administering the policy development, interpretation, and implementation of the State's Medi-Cal program in the determination of program eligibility, program benefits, and program rate provisions. Policy integrates Medi-Cal policy formulation with other programs within the Department so that services rendered to beneficiaries are oriented toward appropriate and cost-effective health care and is consistent with the federal Centers for Medicare and Medicaid Services (CMS) Medicaid program and departmental objectives.

Licensing and Certification

Licensing and Certification promotes the highest quality of medical care in community settings and facilities.

Provider Certification Section (Provider Certification)
Provider Certification reviews the provider survey application packets to ensure that providers have met the required health, safety, and quality-of-care standards, and makes the final determination regarding Medi-Cal certification.

Audits and Investigations

Audits and Investigations is the central coordination point for Health Services' antifraud activities.

Medical Review Branch
Using multidisciplinary teams consisting of physicians, registered nurses, pharmacists, analysts, and auditors, the Medical Review Branch conducts various reviews, audits, and other activities in its efforts to prevent fraud.

Investigations Branch

The Investigations Branch reviews complaints of fraud and is the central point for referring cases of suspected Medi-Cal provider fraud to the California Department of Justice and the Federal Bureau of Investigation (FBI). The Medi-Cal Fraud Prevention Bureau conducts on-site fraud risk assessment surveys to detect high-risk Medi-Cal providers and performs follow-up reviews to identify and prevent continuing fraudulent billing of the Medi-Cal program.

Office of the Attorney General – California Department of Justice

Californians reelected Bill Lockyer as their 30th Attorney General in November 2002. As the chief law officer of California, it is the duty of the Attorney General to see that the laws of the state are uniformly and adequately enforced. The California Department of Justice carries out the responsibilities of the Attorney General through its various divisions.

Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA)

The Attorney General's Bureau of Medi-Cal Fraud and Elder Abuse works aggressively to investigate and prosecute those who would rob taxpayers of millions of dollars each year and divert scarce health care resources from the needy. Protecting patients in nursing homes and other long-term care facilities from abuse or neglect is another primary objective of the BMFEA. This law enforcement agency is composed of prosecutors, special agents, and forensic auditors who conduct criminal and civil investigations and prosecutions of theft from the Medi-Cal program.

California State Controller

The California State Controller acts as the Chief Financial Officer of California and must ensure that the state's $100 billion budget is properly managed. As such, elimination of waste and fraud in the Medi-Cal program is a priority for the State Controller which conducts periodic audits of Medi-Cal finances and cooperates with other agencies in fraud control efforts.

Health Authority Law Enforcement Task Force (HALT)

The Health Authority Law Enforcement Task Force (HALT) is a multi-agency, multi-jurisdictional group of enforcement professionals from many different organizations including the Los Angeles County Department of Health Services, California State Department of Health Services Medi-Cal Fraud Division, Los Angeles County Sheriff's Department, Los Angeles Police Department, County Counsel, the Los Angeles County District Attorney's Office and the Los Angeles City Attorney's Office. HALT was assembled in order to combat and deter criminal activity which has an adverse effect on the public's health and well being.

U.S. Department of Justice – Criminal Division/Fraud Section

The Fraud Section plays a unique and essential role in the Department's fight against sophisticated economic crime. The Section is a front-line litigating unit that acts as a

rapid response team, investigating and prosecuting complex white collar crime cases throughout the country.

Fraud and Public Corruption Section (FPC)

The Fraud and Public Corruption Section (FPC) is responsible for the investigation and prosecution of a variety of white collar crimes. These include economic crimes, such as tax violations, thefts, and embezzlements, as well as business, banking, securities, telemarketing, credit card, computer, identity theft, mail, wire, health care, and consumer frauds.

Federal Bureau of Investigations – Health Care Fraud Unit

One of the primary missions of the Health Care Fraud Unit is to ensure the success of criminal investigations which have a national impact on the health care fraud crime problem. Investigative resources are concentrated on multi-district investigations of large health care corporations suspected of committing fraud against both public and private payers of health care benefits. Investigations are coordinated with other law enforcement agencies and regulatory agencies such as the Department of Health and Human Services Office of Inspector General (HHS-OIG).

U.S. Department of Health and Human Services (HHS)

The U.S. Department of Health and Human Services (HHS) is responsible for the federal Medicaid program which provides the federal funding to California's Medi-Cal program. HHS is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services (CMS) provide direct oversight and management of the federal Medicaid program.

Office of Inspector General (OIG)

The mission of the Office of Inspector General (OIG) is to protect the integrity of HHS programs as well as the health and welfare of the beneficiaries of those programs. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.

Non-government Organizations

Electronic Data Systems (EDS)

EDS is the fiscal intermediary organization responsible for claims processing and payment for the fee-for-services program within Medi-Cal. EDS is a large multi-national corporation that provides a broad portfolio of business and technology solutions and outsourcing services to help organizations improve business performance.

Delta Dental

Delta Dental performs claims adjudication and processing for dental claims for Medi-Cal beneficiaries under a capitated contract that pays a fixed fee for every Medi-Cal beneficiary eligible for dental services. Delta Dental then pays providers for dental services based on fee-for-services claims submissions.

V. Operation of Fee-for-Services and Managed Care Plans

Both fee-for-services and managed care plans are managed and operated under the supervision of Department of Health Services (DHS) and the component organizations discussed in Section III. The current method of operation for both of these plan types is described in the sections that follow.

Fee-for-Services

Under the fee-for-services program, beneficiaries may obtain service from any provider (e.g. physicians, nurses, pharmacies, medical equipment suppliers, and hospitals) that has agreed to accept Medi-Cal payments. Medi-Cal then reimburses the provider for each procedure, examination, or item that the beneficiary receives. Figure 4 illustrates the responsibilities of fee-for-services providers in conducting their operations in a manner that will enable them to be reimbursed by Medi-Cal.

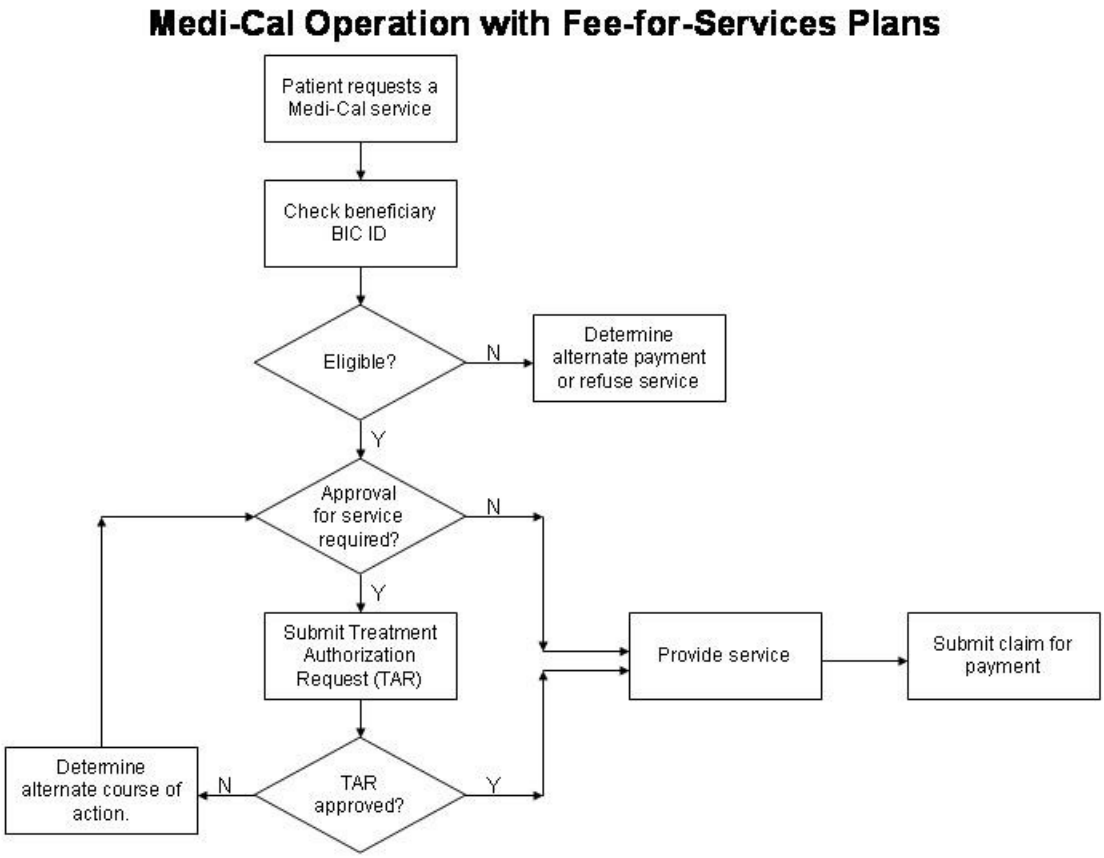

Figure 4. Medi-Cal operations with fee-for-services plans

Fee-for-services providers must first verify that a patient is eligible for Medi-Cal services by obtaining the patient's Beneficiary Identification Card (BIC) number from their BIC card and verifying that it is valid. If the beneficiary's BIC number is valid on the first day of the month, it is valid for the entire month. A provider can verify a beneficiary's eligibility for the current month and the previous 12 months, but never any future months.

Once the BIC has been verified, the provider can file claims for services provided to the patient, and in some cases, for relatives of the patient. For example, a BIC can be used as proof of eligibility of a beneficiary's new born baby until the baby is issued its own card.

There are certain limitations on payment for numerous services and procedures that require the provider to obtain prior authorization from the Medi-Cal program before offering the service or procedure. Virtually all surgeries, expensive durable medical equipment, medical procedures and/or services outside the normal everyday healthcare or dental services require a Treatment Authorization Request (TAR). The provider is required to submit a TAR to justify the expensive treatment or service. Paper-based TAR submissions are mailed to a regional field office of the Medi-Cal Operations Division (MCOD) where they are reviewed by a Medical Consultant, usually an RN, medical doctor, or other healthcare expert, prior to approval or denial. If a provider provides a service or procedure prior to the authorization of a TAR, the provider risks not being reimbursed for those services if the TAR is denied.

Once a properly authorized service or procedure is performed, a claim can immediately be submitted for reimbursement by Medi-Cal. Claims processing and payment is described in detail in the section below labeled, *Electronic Claims Processing by EDS*.

Managed Care

As of August 2004, enrollment in managed care plans represented 52 percent of the total Medi-Cal eligible beneficiaries[16]. The basic operation of the different types of managed health care plans is that providers receive a monthly fee or capitation payment from the state for every enrolled beneficiary. In return the provider agrees to provide a specific set of health care services. Comprehensive plans typically cover inpatient care, limited skilled nursing services, and most outpatient services. The scope of services covered in a plan is determined by a contract that the provider has with DHS. The types of services that are covered may vary from plan to plan and between managed care models.

Plans are required to provide all medically necessary services, as well as a number of additional services that extend beyond the scope of benefits offered in the Fee-For-Service program, such as Initial Health Assessments, Health Education, Preventive Services such as periodic Screens and Exams, as well as ongoing Case Management and coordination of care. They may also file fee-for-services claims with the managed care program for services that are over and above normal healthcare services. Providers may file claims with Managed Care Plans for services that go beyond the normal scope of a Plan's benefit structure. Plans are required to provide and pay for any service covered

[16] Medical Care Statistics Section, Department of Health Services, Interim Managed Care Annual Statistical Report, August 2004, page 9.

within each Plan's contract, and those services that are specifically excluded from each contract, must be billed to the Fee-For-Service system. Some of these services may or may not require a TAR before reimbursement is made. Durable medical equipment (DME) and Laboratory Services are routinely covered under health plan contracts. Some drugs are indeed carved out of health benefit packages. This is true of Aids and Psychiatric drugs, as well as some drugs used in treating and preventing alcohol and drug abuse program.

Figure 5 illustrates how Medi-Cal managed care plans operate to deliver services to beneficiaries under the capitated payment arrangement.

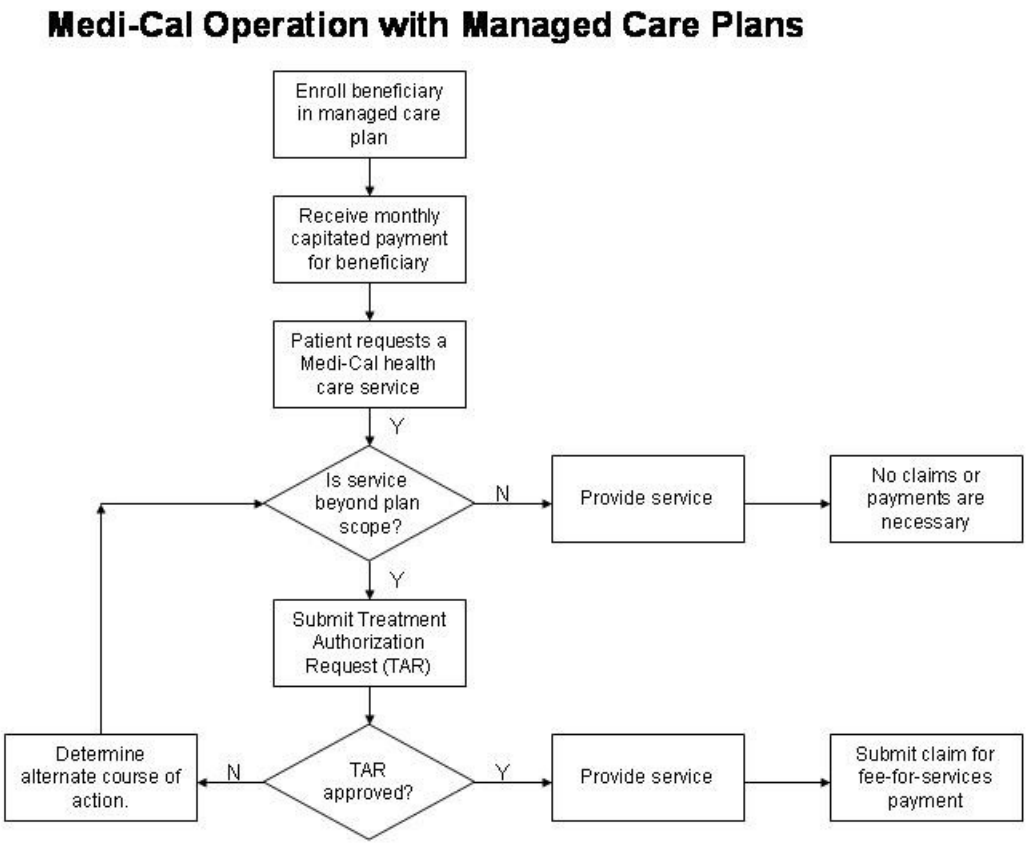

Figure 5. Medi-Cal operations with managed care plans

Beneficiary Enrollment

Potential beneficiaries must complete an application for the Medi-Cal program in order to receive approval to utilize program benefits. Beneficiary applications are accepted or rejected based on factors such as income status, assets, age, and pregnancy status. Applications are mailed or delivered to a local welfare office (operated by counties) where they are reviewed and processed. Applicants that meet the basic criteria are approved and receive a Beneficiary Eligibility Card (BIC) as proof of eligibility for services. If enrolling in a managed care plan, they can enroll with their provider only after they have been given a beneficiary ID number.

The Medi-Cal program currently spends $5.9M for staff to oversee and manage beneficiary enrollments that are received from the counties where the paper-based enrollment applications are processed. An opportunity for significant savings exists if the beneficiary enrollment process is converted to an online electronic process[17].

Provider Enrollment

The enrollment process for physicians and providers to participate in the fee-for-services program involves a provider application that is mailed to the Provider Enrollment Branch of the California Department of Health Services where it is reviewed and processed. The cover letter that accompanies the enrollment application states that it can take up to 180 days for a provider to be notified of the status of their application and up to 90 days if they've applied for a preferred provisional provider status.

The Medi-Cal program currently spends $5.5M for staff in its Provider Enrollment Branch which processes applications for fee-for-services providers. An opportunity for significant savings exists if this provider enrollment process is converted to online electronic process[18].

Enrollment for managed care providers is handled by the Medi-Cal Managed Care Division (MMCD) which contracts directly with managed care providers for health care services.

Electronic Claims Processing by EDS

As the fiscal intermediary for the fee-for-services program, EDS is responsible for processing claims and making payments to providers that have delivered authorized services to Medi-Cal beneficiaries. This section describes the approach used to process and pay these claims.

It is important to note that the current claims payment system for Medi-Cal was designed for efficient processing and payment of provider claims and not for fraud control. The processes are built around an assumption that Medi-Cal providers are honest in their submission of claims. Thus there are no steps in the claims adjudication process that systematically look for potential fraud. The process does, however, contain several checkpoints that are designed to identify improperly documented claims such as those which have missing information or improper data. The process also prevents mistakes such as redundant claims and claims for unauthorized procedures.

When a claim fails one of the screening tests for accuracy and completion of data, the claim is sent back to the provider asking that it be corrected and resubmitted. The

[17] Source: General Attorney's office. Data is based on FY 05/06 salaries only for Medi-Cal Eligibility Branch (MEB) staff. Additional spending is incurred by counties to staff the receiving and processing of paper-based beneficiary applications. These numbers are expected to be reduced to $5.7M in FY 06/07.
[18] Source: General Attorney's office. Data is based on FY 05/06 salaries for DHS Provider Enrollment Branch staff. Additional overhead costs such as employee benefits and general overhead or operating costs are not included.

assumption is that the error was unintentional and the claim can be properly processed and paid if the provider corrects the documentation.

Claims Processing Workflow (Fee-for-Services)

The fee-for-services claims processing workflow contains the following primary steps as outlined in Figure 6:

- Create clean electronic claims records;
- Reject invalid claims;
- Manually reprocess failed claims; and
- Remit payment for accepted claims.

Further detail on each of the major steps in the process is provided in the sections that follow.

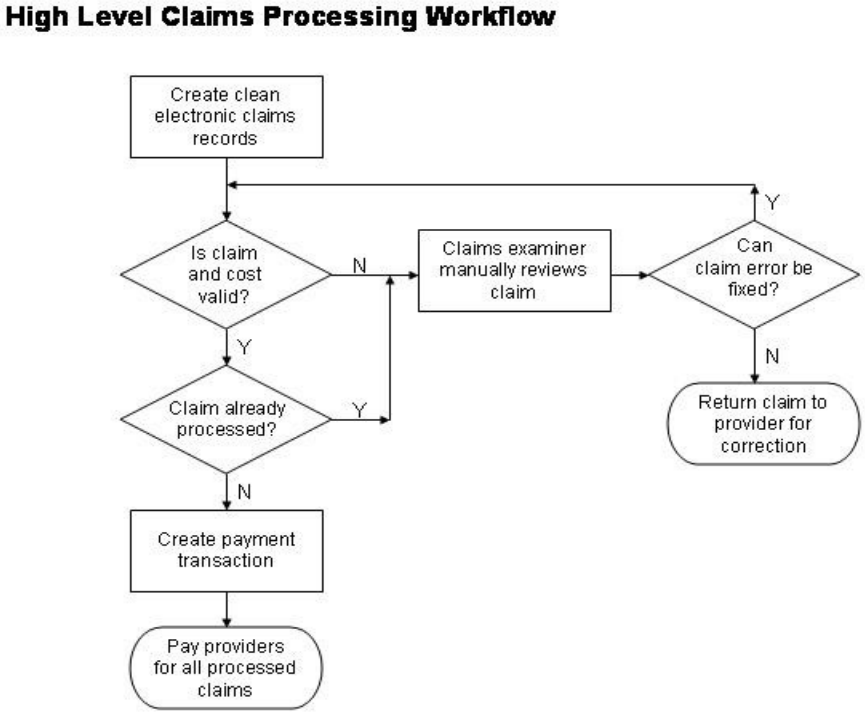

Figure 6. High level overview of Fee-for-Services Claims Processing

Step 1 – Create Electronic Claims Records

All claims are processed electronically even though some are initially submitted as paper claims. Optical Character Recognition (OCR) and Key From Image (KFI) technology is used to digitally encode the most important information from paper claim forms, enabling these claims to be processed electronically along with claims that are submitted electronically.

The first step in processing a paper claim is to manually review the claim for computer readability using OCR technology. Most paper claims are digitized using OCR technology, but those that are deemed unfit for OCR processing are manually entered using KFI technology. The OCR system also flags unreadable inputs to be manually verified and corrected if necessary. After the initial data entry step, the mandatory data from the paper claim resides in an electronic record that can be treated the same as a claim that was initially submitted as an electronic claim.

The next step is a data cleansing step in which provider data is validated and the system verifies that all mandatory fields are the appropriate character length and contain valid characters. In other words, this check is simply to verify that there is enough information to process the claim. Those claims that fail this test are reviewed manually to determine if the data error is obvious and can be corrected without contacting the provider. For errors that cannot be easily corrected, the claim is returned to the provider requesting correction of the invalid or missing data. All claims that pass this test are deemed ready for processing.

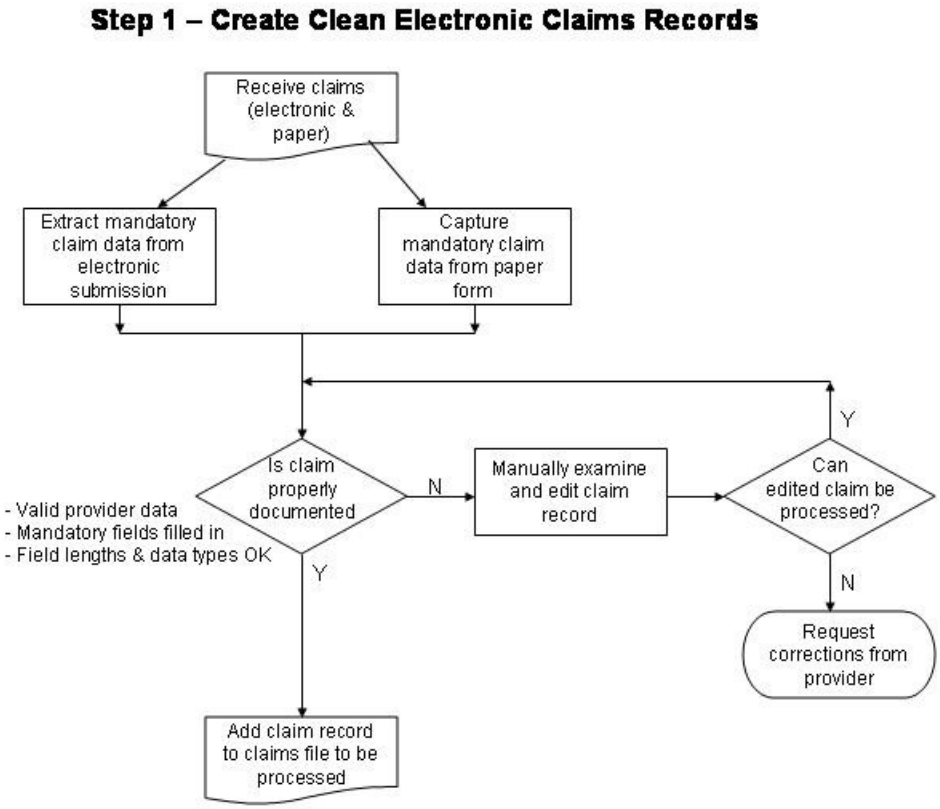

Figure 7. Workflow processes for creating and verifying electronic claims records

It is worth noting that most large providers submit their claims electronically. Therefore, the majority of claims that are processed by EDS already arrive in electronic form. However, most of the smaller providers submit their claims on paper forms rather than electronic. While the total number of paper forms is less than the number of electronic

submissions, there are many more small providers than there are large providers. Thus the majority of providers use paper forms for their claims submissions.

This is important to note because there is a lot of data on paper claims that does not get transferred to the electronic record. Only the mandatory fields from the paper claim are recorded. Any explanatory notes are lost in the process. This means that paper claims are more likely to be misinterpreted when processed and have greater opportunity for fraud because there is little information on which to decide whether or not to pay the claim. Because the majority of providers submit all of their claims on paper, the majority of providers have limited risk of their claims being scrutinized for fraud.

Step 2 – Reject Invalid Claims

There is a daily adjudication process in which all claims that have been pre-processed and deemed fit for electronic review are subject to a series of tests designed to ensure that the claim falls within the normal bounded ranges and is a claim category that Medi-Cal is authorized to pay. It is important to note that none of these tests are designed to detect fictitious documentation of services. If a provider submits a fictitious claim for services, it will be processed and approved as long as it looks like a normal claim and does not break any rules.

The claims are tested for the following criteria:

- Is the treatment or procedure authorized without requiring a TAR?
- Is pricing for the treatment or procedure within the valid range?
- If the claim is for a prescription, is it an approved type of prescription and within the valid price range for that type of prescription?
- Is the provider an approved and active provider?
- Was the Medi-Cal eligibility of the beneficiary verified before providing the service?
- If a TAR was necessary, was the TAR approved?
- Has the beneficiary satisfied their Share of Cost requirements (Share of Cost is like a deductible)?
- Does the claim appear to be a duplicate (matches another claim that was already paid)?

If the claim meets all of these criteria, it is considered to be a valid claim and will be paid as described in Step 4 below. If it fails any of these criteria it is set aside to be reviewed manually as defined in Step 3 below.

Step 3 – Manually Reprocess Failed Claims

Claims that failed any of the tests defined in step 2 above are reviewed manually by a claims examiner. The claims examiners are looking for valid reasons that the claim might be outside the bounds of the range that would have been approved. If they determine that the claim should be paid, they can update the necessary field or fields to override the initial claim entry. For example, the claims examiner may determine that the claim should have been categorized differently or was priced too high. After they edit the claim record to adjust it, the claim is staged to be reprocessed to ensure that any overrides performed on the claim do not impact other audit features.

If the claim is determined to be in error and cannot be adjusted by the claims examiner, it is returned to the provider stating a reason for the failure and the provider is asked to correct the error and resubmit the claim.

Step 4 – Remit Payment for Accepted Claims

All claims that are approved through the above steps are automatically paid. Each week, the approved claims are processed and sorted by provider ID for subsequent payment. Current account balances are maintained for each provider and the State Controllers Office is given a tape each week that identifies the outstanding balances to be paid to each provider.

There are no pre-payment tests to look for abnormalities in the amounts paid to a given provider. So, if a provider's weekly or monthly claims total suddenly grows by an order of magnitude or more, the payment is made without question.

VI. Requirements for Successful Fraud Management

While today's Medi-Cal system employs significant resources for fraud control and fraud prevention, the current payment processing system is not an integral part of the fraud control effort. As mentioned in the above descriptions about how claims are currently processed, today's claims adjudication process is designed to catch errors in documentation and invalid claims. However, it does not directly address fraudulent claims. Most fraud control activities today are either preventive measures designed to limit the ability of suspicious providers to submit fraudulent claims, or they are audits and investigations that occur after payments have already been made.

Figure 8 shows the extent to which the current claims processing environment is integrated with fraud control activities.

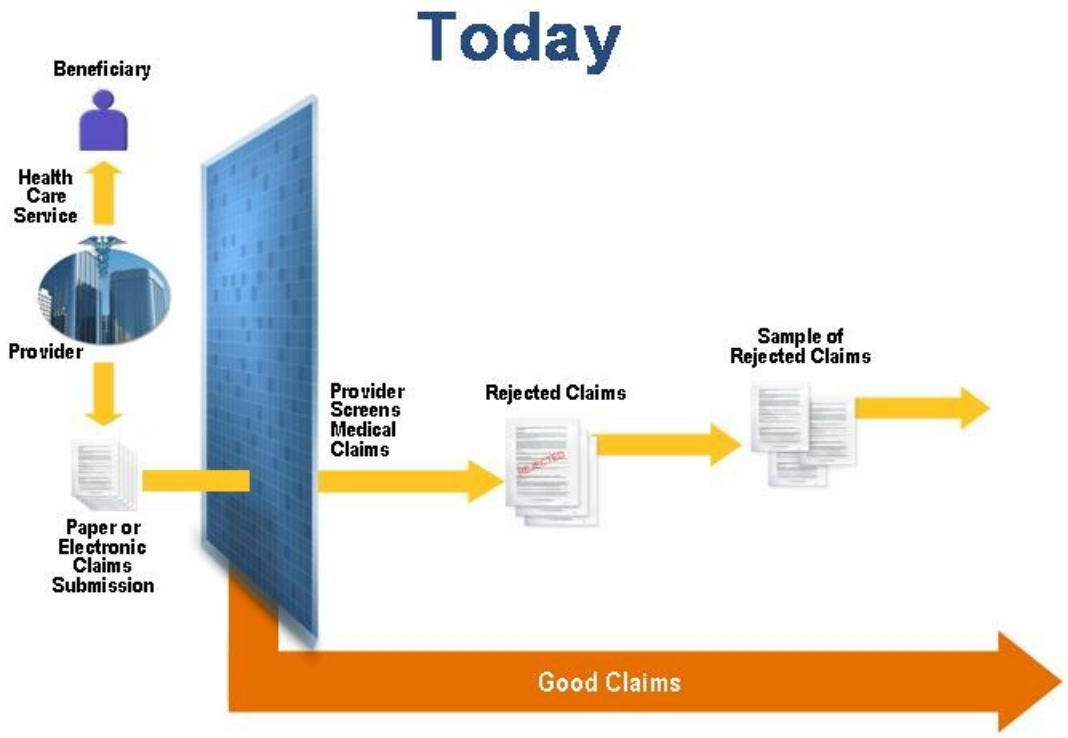

Figure 8. Today's claims processing system includes minimal fraud control

The following are the key elements of current DHS anti-fraud efforts:

- *Enrollments/Re-enrollment*

  To prevent fraudulent providers from enrolling and remaining enrolled in Medi-Cal, DHS tightened the enrollment process by developing new regulations, applications, provider agreeements and internal security prootcols to assure the integrity of the

provider enrollment process. One of the key elements of the enrolllment and re-enrollment efforts is a background check and an on-site review of providers by DHS' Audits and Investigations (A&I).

•*Moratoriums*

Because of the high risk for fraud, DHS has placed moratoriums on new enrollments of Durable Medical Equipment (DME), non-chain laboratories and non-chain, non-pharmacist owned pharmacies in Los Andgeles and Adult Day Health Care Centers (ADHC).

•*Administrative Sanctions*

Administrative sanctions include withhold of payments, temporary suspension from Medi-Cal, Special Claims Review, and prior authorization for services, etc. The sanction are placed on a provider as a result of field reviews and preliminary investigations.

•*Field Audit Reviews*

A&I, in concert with EDS Provider Review Unit, monitor provider payments for abnormal changes, such as large percentage increase from the previous week. The prupose is to detect fraudulent schemes, suspicious providers and stop inappropirate payments as quickly as possible. From this analysis, A&I field staff conduct on-site pre-checkwrite reviews of the suspicious providers, which may result in administractive sanctions or stopping the payment on a check. In 2004, legislation was passed which delayed the Medi-Cal check-writes by one week to allow more time to review providers prior to the checks being issued.

•*Procedure Code Limitation (PCL)*

Medi-Cal and non-Medi-Cal providers that are suspected of abusing certain procedure codes are denied reimbursement when billing with those codes.

•*Random Claims Samples*

Every week 200 FFS claims are randomly selected for review prior to payment. This was increased from 100 to 200 in June 2006.

•*Beneficiary Identification Card (BIC) Re-issuance*

The BIC replacement project consists of two components: (1) replacing BICs for Los Angeles County beneficiaries whose cards were possibly subject to identity theft, and (2), replacing all BICs, statewide, with new cards that contain a psuedo Social Security Number (SSN). Providers use the new psuedo numbers and correct issue dates to have their claims adjudicated.

•*Research and Development*

In cooperation with external partners, EDS and Medstat, A&I has developed state-of-the-art fraud detection systems for case development and identification of new fraud

schemes. These systems are key in focusing on anti-fraud efforts. EDS recently contracted for the services of Fair Issacs Company (FICO) (a leader in detecting credit card fraud) to analyze paid claims data and identify potentially fraudulent or abusive claiming activities of providers. The initial results of the FICO analysis will be generated in January 2007. The analysis will focus on claims paid during the immediately preceding week for timely results.

- *Medicare Data Match Agreement*
  California has a data match agreement with CMS to share Medicare/Medi-Cal data. This project is 100 percent federally funded and allows both programs to identify fraudulent providers and fraud schemes that might otherwise go undetected.

- *Criminal Fraud Referrals*
  A& I Fraud Investigators work closely with DOJ, the FBI, and the U.S. Attorney and have an investigator assigned to the Health Authority Law Enforcement Team (HALT) in Los Angeles.

- *Medi-Cal Managed Care (MMCD)*
  MMCD has developed anti-fraud activities that were non-existent several years ago. These include efforts to assess and evaluate the effectiveness of the contracted health plans in providing timely access to primary care and other necessary services, in increasing utilization and quality of clinical preventative services and care while promoting education and best outcomes possible to the vulnerable Medi-Cal population served. MMCD has also developed centralized anti-fraud and abuse functions, which coordinates and addresses fraud and abuse issues within Medi-Cal managed care as well as at the health plan level.

Comparison of Current System against a Model Fraud Control Strategy

The above listed current fraud control activities can be compared against the characteristics of a model fraud control strategy as outlined by Malcolm Sparrow in, "License to Steal: How Fraud Bleeds America's Health Care System[19]." Table 3 provides a snapshot of how these current activities stack up to Malcolm Sparrow's model fraud control strategy.

[19] Malcolm K. Sparrow, License to Steal: How Fraud Bleeds America's Health Care System (Boulder: Westview Press, 2000), pp. 206.

Model Fraud Control Strategy	Accomplished in Current System?	How Accomplished
Commitment to routine, systematic measurement	Limited	•Random claims sampling of 200 fee-for-services claims per week •Annual Medi-Cal Payment Error Study •Virtually no systematic analysis of provider claims by category or region to look for anomalies or emerging fraud trends •Virtually no analysis of beneficiary data
Resource allocation for controls based upon an assessment of the seriousness of the problem	Limited	•Resource allocation has grown, but is still not at a level that matches the scale of the problem •Medi-Cal payments are funded from program dollars, but fraud prevention unit funding is spread across other state agencies. Therefore, funding decisions for fraud control are not currently based solely on ROI in terms of program dollars saved.
Clear designation of responsibility for fraud control	Partial	•While fraud control responsibilities of individual units are clearly identified, there is limited ability to address fraud from a holistic perspective •Different fraud control organizations cooperate with each other, but are loosely connected and thus each have their own agendas
Adoption of a problem-solving approach to fraud control	No	•Most fraud control efforts clearly land in the category of prevention or the category of enforcement •Little is done to attack categories of fraud in a broad-based, cross-functional manner
Deliberate focus on early detection of new types of fraud	No	•There is virtually no ability to analyze data to look for patterns that could be identified as potential emerging fraud

Model Fraud Control Strategy	Accomplished in Current System?	How Accomplished
Prepayment, fraud-specific controls	Limited	•New processes include monitoring of provider payments for abnormal changes and enable pre-checkwrite reviews of suspicious providers •Claims are adjudicated on a claim-by-claim basis as opposed to by episode of care, making fraud detection more difficult •Data access methods are rigid, making it difficult to execute ad hoc queries that would enable experts to sort and analyze claims by non-standard methods such as by beneficiary, or looking for groups of providers with similar claim histories, etc.
Some risk of review for every claim	No	•Although random sampling is done, the samples are small (200 weekly – not statistically significant) and only come from the batch of rejected claims. Therefore, claims which fall within the normal price ranges for approved services have absolutely no risk of review.

Table 3. Comparison against Sparrow's model fraud control strategy

A Modern Technology-based Approach to Fraud Control

The task force believes that by making claims adjudications an integral part of fraud control, much could be done to improve fraud control efforts and come closer to matching Sparrow's Model Fraud Control Strategy. Figure 9 shows how a technology-based approach to detecting and preventing fraud can make claims processing an integral part of the fraud control strategy and provide a more nimble response to emerging fraud patterns.

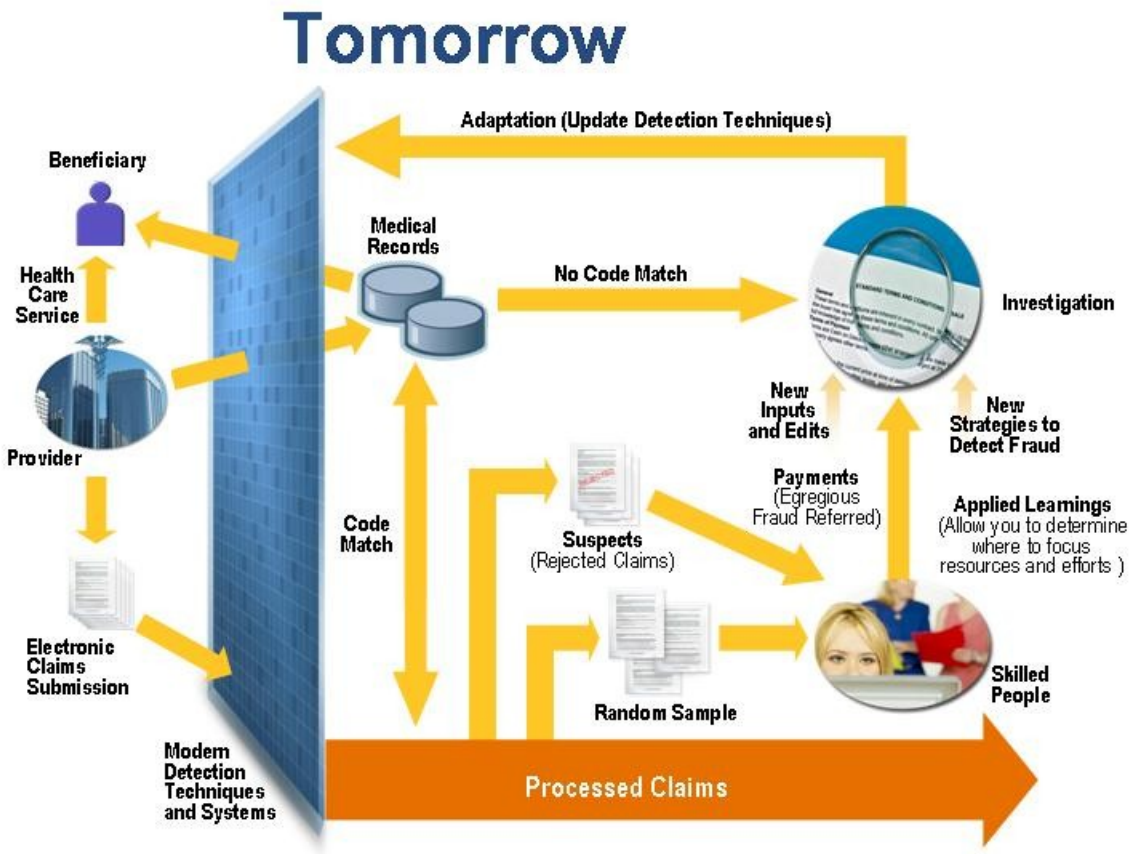

Figure 9. Modern techniques for integrating fraud control into claims processing

Steps for Claims Processing in the Modern Approach

The chronological steps for claims processing in this modern approach as shown in Figure 9 are as follows:

1)Claim code is matched against electronic medical records to verify that service was performed.

2)If no matching medical record is found, send the claim to investigations.

3)If the claim matches the medical records, it is processed in the normal mode.

4)All claims are subject to a series of automated tests to ensure that the claim is for a valid provider ID, a valid beneficiary, and involved an approved Medi-Cal service that was priced appropriately. Claims that do not pass these standard tests are treated

as "Suspect" and are manually reviewed by a team of skilled investigators to determine if there is 1) potential fraud, 2) a need for more information from the provider, or 3) an obvious error that can be corrected so that the claim can be reprocessed.
5)A random sample of a statistically significant number of claims is chosen from the stream of claims being processed. These claims are subject to some additional tests and are manually reviewed by skilled investigators specifically trained to look for fraud and to spot emerging fraud trends.
6)Claims in these random samples which have the appearance of potential fraud are sent to an additional investigative review team for a full audit. Payment to the provider is held off during the investigation.
7)Claims that pass all of the automated standard tests and random review tests (if applicable) are accepted as genuine claims and are scheduled for automatic payment to the provider.

Centralized Electronic Medical Records

One of the key differences between the modern approach of Figure 9 and today's approach that was shown in Figure 8 is the use of electronic medical records – a system characteristic that has far-reaching impact. Industry experts and government officials have been calling for electronic medical records as a means to both improve the quality of patient care and offer increased protection against fraud. As shown in Figure 9, the electronic medical records are updated by providers when their service is delivered or their procedure performed.

Beneficiaries can also view their own medical records, providing a means to verify that the services which the provider has indicated that they performed were indeed received by the beneficiary. If the beneficiary sees that something in their medical records file is inaccurate, they can immediately inform officials of the problem so that the error gets corrected or addressed through an investigation. If fraud has been committed, the fraud behind the error will likely be uncovered during the investigation.

Figure 9 also shows that medical records are matched against the claim codes of the claims being processed. When providers update the beneficiary's medical record after performing a service, they must enter a code that identifies the type of service or procedure performed. That same code for the procedure must also be represented on their claim submission in order for the claim to be paid. This is the first step in processing a claim so that mismatches between the claim and the beneficiary's medical records can immediately be spotted as potential fraud. If a mismatch is found, the claim is immediately sent to be investigated.

Beneficiary-based Data

Another significant differentiator of the modern approach shown in Figure 9 is that the electronic medical records contain beneficiary information and this data can be sorted based on beneficiary ID and case history. This means that claims investigators can review a claim by querying the medical history of the beneficiary to see if the claim makes sense in the context of the patient's history. If the claim indicates that a blood test was

performed for the beneficiary, but there was no prior illness that would warrant a blood test, then there is good cause for suspicion.

In the current Medi-Cal system (Figure 8), claims are processed on a claim-by-claim basis and there is no way to relate claims to the beneficiary's medical history. This makes it easier for providers to submit false claims and get away with it. The modern system would employ relational technology to enable all medical records and all claims to be sorted by provider, beneficiary, date of service and other factors. This flexibility gives claims examiners and audit investigators greater visibility into their situation, enabling faster and more accurate results in identifying fraud.

In order to fully investigate a claim, however, the examiners or investigators would need the approval of the beneficiary in order to gain access to their medical history without breaching the beneficiary's privacy. This would mean contacting the beneficiary which would also provide the opportunity to ask the beneficiary to confirm that the services in the claim were indeed performed.

Another major benefit of beneficiary-based data is that it can provide a complete patient history to doctors, enabling the population of Medi-Cal beneficiaries who tend to change doctors and providers somewhat frequently to benefit from the fact that their doctors may see their current condition within the context of their medical history. Any provider could review a patient's medical history with the patient's approval. This could help avoid redundant tests and lab expenses as well as contraindicated services, medications, etc. It would also enable higher quality care for Medi-Cal beneficiaries since providers would have better information on which to make their diagnoses.

Applied Learning

The approach highlighted in Figure 9 also shows that the internal learning process about fraud control and prevention is different in the modern approach. Learning can be greatly accelerated in this approach because auditors and investigators are dealing with real-time data and are seeing new trends as they develop.

In the current system, audits are conducted on claims data that may be several months old and providers have already been reimbursed for those claims. It takes time for auditors to analyze and identify fraud trends, so if they start with old data, they can't possibly be responsive to the fast-changing habits of nimble fraud perpetrators.

By doing their analysis on real-time claims data, auditors can get a much faster jump on the problem. Their ability to identify trends can also be accelerated by search tools and statistical analysis solutions that enable auditors to look at many sets of claims data from many different angles. And lastly, detailed investigations of random claims constantly bring new ideas about the types of fraud that are emerging. When new types of fraud are discovered, auditors can quickly adjust their searches and claims edits to look for those types of fraud throughout the system. This enables the Medi-Cal system to respond before large sums of money have been paid to fraudulent providers. If a big case or large

scam is uncovered, auditors can immediately focus more resources on the big problem, diverting resources from looking for types of fraud that are no longer as prevalent.

This rapid learning environment enables much quicker reaction to fraud schemes by enabling constant discovery of new types of fraud and by eliminating costly delays that are inherent in the process when old data is used to perform audits. The learning and adaptation cycle can be reduced from months or years as in today's environment to weeks or days in this modern environment.

Security and Identity Management

In order to preserve confidentiality of beneficiary medical histories, prevent providers from seeing each other's data, and limit access to audits and investigations information, access to electronic medical records must be carefully controlled. Modern identity management technologies provide highly secure access to data and applications while enabling maximum flexibility to adapt to changing requirements. Identity management can also simplify reporting requirements for regulations such HIPPA and Sarbanes-Oxley.

Identity management solutions provide centralized authentication and access controls across a variety of applications, data sources, and user devices. Identity management is usually combined with secure authentication techniques such as requiring a photo ID or thumbprint along with the beneficiary number in order to authenticate users. Whenever a beneficiary receives a service or wants access to their medical records, both means of identification must be available for authentication. If the photo ID is on the BIC card, then there should be a person who verifies the picture matches the patient before inserting the BIC card into a reader that authenticates the user. This approach provides an important security measure to protect the privacy of beneficiary medical history data and helps prevent unauthorized access to medical records.

The greatest benefit of this approach is that it would become very difficult for a provider to falsify medical records and submit corresponding false claims. Providers would be unable to obtain large numbers of valid BIC cards in the way that they currently obtain black market lists of patient IDs. Even if they were able to obtain these cards, the risk of being caught would be much higher than in today's systems because beneficiaries might notice their records were inaccurate. Similarly, audits and investigations teams might notice the abrupt change in the provider's claim history or notice correlations between the claims that make them look suspicious. The higher risk of being caught should act as a good deterrent.

Identity management solutions may also include automated workflow tools that simplify provisioning of user accounts and user access profiles. Such automated solutions can help increase overall security and protect the privacy of beneficiaries and providers by reducing the risk of errors in creating or maintaining user profiles. For example, an electronic enrollment process for a new Medi-Cal beneficiary might automatically

generate a user profile with appropriate access controls whenever a new Beneficiary ID Card (BIC) is issued.

Security must be engineered into the system from its initial design in order to avoid security holes such as those that were recently identified in the federal Medicare and Medicaid patient records[20]. The GAO discovered 47 weaknesses in the computer systems used by the Centers for Medicare and Medicaid Services to send and receive bills and to communicate with health care providers. Their report raised concerns about the privacy of beneficiary medical history records and of provider data. A properly designed security architecture can limit security risks and can help avoid many common security flaws. Security goes well beyond identity management to include secure transmission of data and policies and procedures that protect data whether it is in active use or is archived to tape backups.

Major Benefits of the Modern Approach

The most important benefits to the modern approach include:

- *Improved patient care* – Electronic medical records enable physicians to view and diagnosis current conditions within the context of a medical history regardless of who provided the patient's past health care services.
- *Savings in program costs* – Physicians are able to avoid redundant tests and can more quickly diagnose and treat their patients by having access to the medical history.
- *Significantly reduce false claims* – Increased visibility into medical records that can be searched and matched against claims helps auditors and investigators more accurately and efficiently identify fraud.
- *Virtually eliminate large-scale false claims scams* – The ability for fraudulent providers to submit large batches of false claims that do not relate to real patients is greatly limited because each submitted claim is matched against a medical record. Identity management and security procedures would make it very difficult for a provider to of falsify a patient's medical records in order to make claims match up. Even if they were able to do that, it is likely that auditors and investigators would spot a series of similar claims from the same provider or beneficiaries would notice that their medical records were inaccurate.
- *Efficient management of user profiles* – Identity management solutions can provide administrative savings as well as enhanced security by automating many of the processes for creating and maintaining user access privileges.
- *Potential savings in enrollment processing* – The combined staffing costs of more than $11M for overseeing and processing paper-based applications from fee-for-services providers and Medi-Cal beneficiaries may be significantly reduced through an online enrollment process.
- *Potential savings in processing paper-based forms* – The cost of the OCR operations for EDS to handle paper-based forms could be greatly reduced or eliminated in a system that requires all claims to be submitted electronically.

[20] MSNBC, Medicare and Medicaid Patient Records at Risk, www.msnbc.msn.com/id/15120167/from/ET/, October 3, 2006.

VII. Conclusion and Recommendations

Fraud waste and abuse in the Medi-Cal program harms everyone including the citizens of California and the beneficiaries who obtain care through Medi-Cal. While great progress has been made in recent years to curb fraud and abuse, a much broader initiative is required in order to successfully combat the problem. The recommendations outlined below provide a plan for a systematic approach to combating fraud and abuse that is based on information technology solutions that are already being used by the commercial business world.

While the task force recommendations are based on technology solutions, these recommendations can also have a big impact on the efficiency of the state organizations that are involved in combating fraud by helping to streamline business processes. In some cases, it may even make sense to reorganize roles and responsibilities for specific components of the program. For example, when all TAR submissions are handled electronically, it may be more efficient to centralize the review and processing of TAR's rather than continuing to perform these tasks in multiple field offices.

Recommendations of the Task Force

In order to modernize the Medi-Cal payment system and reduce the risk of fraud losses as well as improve patient care, the Task Force offers the following recommendations for consideration:
1)Continuously measure the system;
2)Replace the Medi-Cal claims system; and
3)Empower Medi-Cal providers with network access and identity management.

Recommendation #1 – Continuously Measure the System

Continuous measurement not only enables more accurate tracking of progress, but can also facilitate early detection of new fraud schemes or trends. The task force recommends that measurement be taken to a new level in the Medi-Cal system so that decisions about how to approach Medi-Cal fraud can be based on an accurate assessment of the situation.

Specifically, measurement methods should be expanded to include the following:

- *Random samples of groups of processed claims*
  Random samples of claims should be subject to a series of more detailed testing than the typical claim that goes through claims adjudication. These more detailed tests can be constantly monitored and modified as fraud trends change. The primary focus of random sampling and providing a more detailed analysis of these sets of claims is to identify fraud patterns that might otherwise have been overlooked.

- *Picking transactions at random and auditing them as thoroughly as possible.*
  Only through a thorough audit of specific transactions can we expect to discover how fraud is impacting the Medi-Cal systems. There may be types of fraud that have

entirely escaped the attention of program administrators and the approach of random audits of a statistically significant number of transactions will enable investigators to spot new types of fraud through more complete random investigations that can include contact with patients or, if warranted, an unannounced visits to a provider for an on-site audit of their medical records. We may find out that certain types of fraudulent claims are frequently slipping through the claims adjudication process undetected. These random audits can act as a deterrent to fraud perpetrators. If they know there is a reasonable chance that their claims will be audited and fully investigated, they may be less likely to take the risk of falsifying their documentation. Current systems do little to ferret out falsified claims, so a fraudulent provider can be comfortable submitting thousands of falsified claims without much fear of being caught.

- *Patient interviews*
  Existing systems do not generally contact patients to verify claims. Audit procedures should include patient contact to verify the relationship with the provider, the diagnosis, and the treatment provided. In many cases today, patients cannot even get through to investigators when trying to report potential fraud. If patients are given access to their medical history and notified of claims that are processed on their behalf, then they can be empowered to help identify fraud problems. If a claim appears for services that were not provided, they can notify officials to take action.

While random sampling can prove useful as a tool in monitoring the system's overall health and efficacy in providing timely and accurate services to beneficiaries, the primary objective is to enable the operators and administrators to detect, prevent, and track fraudulent claims from agile perpetrators. Measurement also serves to determine baselines, measure progress, and set new targets with respect to fraud detection and prevention objectives. Ultimately, continuous measurement provides the data necessary to better quantify the problem, make fact-based recommendations and monitor the changes that result.

Recommendation #2 – Replace the Medi-Cal Claims System

Once data from various sampling and measurement techniques is available, we can begin to internalize the learnings back into the system to accelerate the pace identifying new types of fraud. The learning and adaptation cycle can be reduced from months or years as in today's environment to weeks or days in the modern environment. (See section titled, “Applied Learning,” in Chapter V.)

The Medi-Cal system should be put out to bid, and replaced by one that more fully utilizes up-to-date Information Technology to service the overall operation, while providing a better defense against fraud and abuse. The new system should include characteristics such as the following:

- Centralized identity management solution that supports authentication and access controls that can be consistently implemented for all organizations and types of users that need access to specific types of data;

•Modern decision support and data mining tools/techniques that can enable flexible sorting and reporting for data analysis;
•Web-based access that can be independent of device type;
•Security and privacy features that protect sensitive beneficiary and provider data;
•Efficient high-speed processing of transactions; and
•User friendly functionality that can limit the need for training.

Recommendation #3 – Empower Medi-Cal Providers with Network Access and Identity Management

In order to realize a significant gain in overall efficiency in the California Medicaid program, it's critical that "doing business electronically" becomes the standard. The requirement to convert operations from paper based to electronic claims submission and processing gives administrators modern tools and techniques for accurately processing claims and simultaneously greatly improving their ability to detect, prevent, and prosecute fraud and abuse. An electronic network-based process also serves to increase beneficiaries' access to information concerning their own patient experience (medical records). It will therefore be important to provide online access to most, if not all, providers and beneficiaries.

Unfortunately, some California Medicaid providers don't have the means or the technical resources to purchase and support computers to connect into Medi-Cal. A system must be developed to train and provide financial assistance or financial incentives to Medi-Cal providers who need additional support converting their operations to an electronic based claims system.

California should explore innovative ways to fund and support the technology and processes necessary to accomplish the goal of widespread access to Medi-Cal electronic records and electronic claims processing. This will simultaneously improve access to information and offer self-service capability to both beneficiaries and providers.

The task force recommends the following:
•All system menus and views should be written for Web browser access so that any combination of traditional PCs, Internet "thin client" devices, mobile devices, etc. can be deployed as access devices for providers or beneficiaries.
•Develop a formal plan to roll-out network access to all providers in a systematic way.
•Offer both technical assistance and financial incentives for smaller providers to quicken the adoption of electronic submissions and make electronic claims submission a requirement to be an authorized provider within the new system. Providers should be given plenty of notice of the need to move to electronic submissions and appropriate help to do so by the deadline.
•Provide free public access to online medical records for Medi-Cal beneficiaries by funding kiosks that can be made available at public libraries, welfare offices and/or other convenient locations.

Identity management is a cornerstone of this recommendation because it is necessary in order to provide secure access to data records by a wide variety of people using a wide variety of devices. Identity management ensures that only the "right" individuals are given access to the system while facilitating access and limiting the number of passwords needed to protect the organization. Given the HIPAA requirements to protect personal health information along with California Medicaid's concern about fraud and abuse, implementing a state-of-the-art identity management system is particularly important.

Reducing Risk in Large-scale IT Systems Procurement

All systems implementations of the magnitude discussed in this report will be subject to failures and setbacks in the course of the project implementation. It is the nature of large and complex IT projects to include some risks. The State of California must be aware of these risks and must take steps to mitigate them. The state's history with large-scale IT systems implementations has proven that these risks must be carefully managed. Procurements of the IT systems recommended in this report must be handled in a different manner from other types of procurements. Without properly preparing for the implementation, the state may suffer losses due to poor performing systems.

For this reason, the task force recommends the following approach to this IT procurement process to help mitigate risk:

- *Require a services-based component architecture*

  Traditional IT systems were implemented as single monolithic systems. In a large complex project, it is not realistic to expect that everything in the large hierarchical system will work perfectly and as it was intended. In these large monolithic systems, a failure in one part of the system can bring the entire system down. These failures can also be difficult to fix because changes to the failed part of the system often affect other areas. Whenever a substantial change is made, a complete system test is required. By contrast, a modern service oriented architecture (SOA) system is based on many smaller components that operate as independent services. These components are assembled together in a unified system using industry standard interfaces. Individual components can be updated or replaced with minimal or zero impact on other system components. Small failures in these indivual components can thus be readily repaired without creating a major failure in the overall system. A SOA solution greatly reduces project risk by isolating these failures and by simplifying changes to the system.

- *Design the architecture first*

  The state should allocate budget for a system architecture design phase that is executed before the individual components of the system are put out to bid. By first designing the overall architecture, it will be possible to purchase different components of the system from different vendors while enabling these components to work together as a cohesive system. The architectural design will not only define the functionality of the major system components, but will also define the interfaces between system components and the common data types that will be shared throughout the system. For example, the contents of medical records and electronic

claims records will be defined in the system architecture so that these fields can be easily exchanged between system components. By adhering to the defined interfaces and data models established in the architecture phase, the state will have greater flexibility in procuring system components and will have the ability to swap out individual components in the future if the need should arise.

- *Implement modern project management practices for large IT projects*
  Modern project management techniques for large IT projects can bring significant reduction of project risk. The state should hire a knowledgeable IT executive with experience in large-scale IT projects to oversee the procurement and implementation of this project. Structured techniques for project management could then be put in place to help reduce the risk of the project and accelerate its implementation.

Reducing Fraud Losses and Improving Quality of Care

The above recommendations are intended to serve the dual purpose of reducing the loss of program dollars to fraud and improving the quality of service provided to Medi-Cal beneficiaries. While the original focus of the task force was to identify methods of reducing fraud losses, the task force believes that addressing fraud could result in even greater benefits in terms of improved patient care. Quality of care can be expected to improve due to the beneficiary-centered approach which enables new uses of medical data. The reduction in fraud losses also leaves more dollars available for patient care.

Specific advantages for beneficiaries include:

- Physicians can more accurately diagnose a patient's condition because they have access to the patient's medical history regardless of whether they've seen the patient before,
- Beneficiaries have greater access to information, thus helping to advocate better care for themselves,
- Electronic requests for prior authorization will expedite approvals so that providers can administer the proper care more quickly, and
- The resulting reduction in fraud losses leaves more dollars available for the care of beneficiaries, enabling Medi-Cal to serve a greater number of beneficiaries and to provide the best possible care.

The recommendations can help reduce fraud losses by:

- Eliminating some of the most common approaches to defrauding Medi-Cal;
- Increasing the efficiency and accuracy of investigators and auditors through better access to information;
- Making it easier to identify emerging fraud trends and react quickly;
- Providing a deterrent to fraud by subjecting all claims to a risk of review;
- Empowering Medi-Cal beneficiaries to join the fight against fraud by verifying the accuracy of their own medical records; and
- Making it harder to fake patient IDs because security systems would require that a patient ID card or biometric ID such as a thumbprint to be available at the time that health care services are rendered.

Next Steps

The task force recommends that the project be initiated immediately by funding a Request for Information (RFI) for a new claims processing system based on the ideas presented in this report. The RFI provides an opportunity to obtain ideas and background information from appropriate vendors so that a Request for Proposal (RFP) can be written and the procurement initiated. A system of this size may take several years to implement so it is important that the initial procurement for the architectural design be started as quickly as possible.

VIII. Acknowledgments

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Malcolm Sparrow
Professor of Practice of Public Management
Program in Criminal Justice Policy and Management
Kennedy School of Government
Harvard University

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Collin Wong-Martinusen
Director, Bureau of Medi-Cal Fraud and Elder Abuse
Office of the Attorney General
State of California Department of Justice

San Martin
Chief of Investigations, Bureau of Medi-Cal Fraud and Elder Abuse
Office of the Attorney General
State of California Department of Justice

Mark Zahner
Chief of Prosecutions, Bureau of Medi-Cal Fraud and Elder Abuse
Office of the Attorney General
State of California Department of Justice

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Frank Armiger – Director, Program Safeguards, CSC
David Botelho – Deputy Director, Audits and Investigations, Department of Health Services
Tim Brynes – Bureau Chief, Florida Office of Medicaid Program Integrity
Eric Cowperthwaite – Information Security Officer, EDS
Nick Dedier – Director, Hawkins Data Center, Office of the Attorney General, California Department of Justice
Diana Ducay – Chief, Office of State Audits and Evaluations, Department of Finance
Hardy Gold – Deputy Attorney General, BMFEA

Kevin Hanlon – Information Technology Manager, Program Safeguard Contract, CSC
David Haxton – Deputy Attorney General, BMFEA
Bruce Heseltine – Program Director, California Benefit Integrity Support Center, EDS
Mike Hilder – Client Deliver Executive - EDS Medi-Cal
Phyllis Kay – General Manager, AdavanceMed, CSC
J. Clark Kelso – State of California, Chief Information Officer
Melisa Mulcahey – Director, EDS Medi-Cal Program Integrity
Kelli O'Neill – Special Agent, BMFEA Computer Forensic Team
David Payne – Client Delivery Executive, Texas Medicaid Access Card Project, EDS
Robert Peirce – Senior Manager, Florida Office of Medicaid Program Integrity
Christy Quinlan – Chief Information Officer, Deputy Director, Department of Health Services
Gene Ralph – Senior Data Analyst, New England Benefit Integrity Support Center , EDS
Carlos Ramos – Assistant Secretary, Information Technology, California Health and Human Services Agency
Anne Roeser – Practice Director, Western Region, GHS, CSC
Stan Rosenstein – Deputy Director, Medical Care Services, Department of Health Services
Judy Schaffer – Program Analyst - EDS Medi-Cal Program Integrity
Sandra Shewry – Director, Department of Health Services
Jerry Stanger – Chief, Department of Health Services Payment Systems Division
Curtis Watkins – Program Manager, Nashville Regional Center, CSC
Irvin White, Jr. – Chief, Department of Health Services, Provider Enrollment Branch