LHPC
Local Health Plans *of* California

COMBATING MEDICAID FRAUD, WASTE, AND ABUSE

OUR COMMITMENT

- Local plans are committed to ensuring that Medicaid, known in California as Medi-Cal, remains sustainable for the beneficiaries who depend on it.
- Medi-Cal managed care plans are a critical guardrail against fraud, waste, and abuse, ensuring appropriate delivery of covered benefits, timely access to quality care, and proper payments through provider oversight. Local plans strengthen this protection by operating transparently as fiscally accountable public entities.
- As local not-for-profit plans, we are especially responsible stewards, acutely aware of the value of each dollar and deeply committed to ensuring its appropriate use. Plans are actively engaged in monitoring and preventing fraud through provider and utilization checks.

PLANS ARE ACTIVELY ENGAGED IN ROBUST FRAUD, WASTE AND ABUSE (FWA) MONITORING

Local Plans have established systems and processes that prevent, identify and address fraud, waste and abuse. From halting attempts to defraud the program to developing systems to fix administrative errors, local plans work to protect the integrity of Medi-Cal.

Medicaid Managed Care Plans are **subject to audits, sanctions and reporting obligations** to ensure program integrity.

PROVIDER MONITORING, REPORTING AND RECOUPMENT

- Initial onboarding and credentialing ensures providers are qualified.
- Monthly checks of federal and state databases verify providers haven't been flagged for FWA.
- Embedded processes monitor provider FWA, such as pre-payment systems safeguards, post-payment claims review, prior authorization, and grievance monitoring.
- Required provider training on proper billing practices to prevent against upcoding, kickbacks, etc.
- Dedicated units to identify and investigate suspected FWA, report bad actors to appropriate agencies and recoup improper payments.

UTILIZATION MONITORING

- Regular monitoring of utilization trends to identify and prevent FWA.
- Confirming there is no duplication of services.
- System safeguards to ensure Medicaid is the payor of last resort.

ELIGIBILITY VALIDATION

Although local plans do not process eligibility, they inform the Department of Health Care Services (DHCS) when there are changes to a member's eligibility or contact information.

For example, plans will notify the state if they receive information about a member's change in circumstance impacting eligibility, such as change of address, changes to income, insurance status or death.

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CONSIDERATIONS FOR FEDERAL POLICY DEVELOPMENT

MAINTAINING APPROPRIATE COVERAGE

CMS and state policies **should not create unreasonable barriers** to maintaining health coverage for eligible members.

Eligibility verification policies need to **account for real-world challenges** to protect against wrongful disenrollment.

COST SAVINGS AND ADMINISTRATIVE EFFICIENCY

Eligibility determinations **must not be overly burdensome or prescriptive**. Implementing overly complex systems could significantly increase administrative costs, offsetting any savings.

Enhancing systems used by states to match eligibility data with federal databases will improve fraud detection without creating an undue administrative burden.

PROTECTING AGAINST DUPLICATE ENROLLMENT

Local plans support efforts to identify and protect against duplicate enrollment.

- **Proactively monitor** for members that may have moved out of state or out of the service area.
- **Work with the state** to identify members who gained coverage under another program.
- **Support current requirement for valid California address** on Medi-Cal applications, which is verified by data sources like the Franchise Tax Board.
- **Endorse current policy** of freezing Medi-Cal enrollment when duplicate enrollment is found.

LOCAL PLANS UPHOLD THE INTEGRITY OF MEDI-CAL

IDENTIFYING SUSPICIOUS ACTIVITY

A local plan identified an out-of-area pharmacy and prescriber that were filling a significant volume of over-the-counter drugs. The outcome of member interviews revealed that the members were not cared for by the prescribing provider and did not receive the prescription. The plan reported the prescriber and pharmacy to DHCS and CMS, and collaborated with the DOJ on its investigation.

CLINICAL REVIEW OF PRESCRIPTIONS

A local plan investigated a physician who was an outlier prescriber of an expensive eye injection, which averages $40,000 per patient. Clinical review of patients' medical records determined that the eye injection was not medically appropriate and that less expensive treatments should have been tried first. The plan reported the misuse to DHCS and CMS and updated its coverage policy for the eye injection.

LOCAL PLAN BEST PRACTICES

Deploy software that identifies patterns in large claims data sets, design and conduct ad hoc audits of outliers.

Regularly audit claims samples and randomly contact members to verify service delivery.

Host anonymous tip phone lines for reporting information on questionable activity.

Utilization management and prior authorization protects against waste and abuse, by ensuring the medical necessity for a member's requested services.