

DMHC ANTIFRAUD REQUIREMENTS

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SB 956

- A 1997 report by the Senate Insurance Committee for a hearing on health care fraud cited that the U.S. Government Accounting Office estimated that \$1 of every \$10 spent on public insurance programs is lost to fraud.

HMO MODEL AND FRAUD

- The DOI reported that health care fraud in California costs insurers, the state and ultimately policyholders an estimated \$10 billion annually.
- Capitation environment alters but does not eliminate fraud.

H & S 1348 (a)

- Requires DMHC licensees to establish an antifraud plan to organize and implement an antifraud strategy.
- To reduce costs through the timely detection, investigation and prosecution of suspected fraud.

ELEMENTS OF THE PLAN

1. Designation of or contract with individuals with specific investigative expertise.

- Provide a Resume' or Curriculum Vitae of this individual.
- Certifications such as NHCAA Accredited Health Care Fraud Investigator.
- If contracted, also provide a copy of the contract.

TRAINING

2. Training of plan personnel and contractors concerning the detection of health care fraud.

Also, include this information in your annual reports and please be specific (eg: "The SIU director attended the NHCAA Annual Training Conference")

PROCEDURES

3. Managing incidences of suspected fraud. (How are they received? How are they processed/investigated?)
4. Referring cases of suspected fraud to the appropriate prosecutorial agency.

H & S 1348(b)

- Required the licensees to submit the antifraud plans to the Department by **July 1, 1999**.
- Required this antifraud plan to contain the name and telephone number to whom inquiries regarding the antifraud plan may be directed.
(J-8)

AMENDMENTS-J-7

- Requires the plans to submit an amendment pursuant to H & S 1352 with any changes to the antifraud plan.

CHANGES

- Change in contract for investigative services.
- Change in SIU Director or other designee.
- Change in procedures for investigating and/or referring incidences of suspected fraud.

H & S 1348(c)

- Requires the plans to file an annual antifraud report describing the plan's efforts to deter, detect, and investigate fraud to include:
 - Number of fraud cases referred to law enforcement agencies.
 - Number of cases prosecuted to the extent known by the plan.

ANTIFRAUD REPORT

May also include recommendations by the plan to improve efforts to combat fraud.

JANUARY 31st

The Annual Report
deadline date is January
31st each year for
incidences pertaining to
the prior calendar year.

Definition of FRAUD

- “Fraud” includes, but is not limited to, knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit (H & S 1348(e)).

INADEQUATE/INCOMPLETE REPORT

EXHIBIT J-6

ANTI-FRAUD ANNUAL REPORT

(2008)

There were no incidences of fraud discovered by or reported to ██████████ during the calendar year ending December 31, 2008.

██████████ continues to monitor possible fraud as outlined in its anti-fraud plan.

ANNUAL REPORT

What has the plan done
in the past year to
deter, detect,
investigate and refer
fraud and abuse?

QUESTIONS

1. What training has the plan provided to staff regarding fraud and abuse?
2. How many incidences of suspected fraud and/or abuse have been investigated?
3. How many incidences were referred to law enforcement and/or regulatory agencies (eg: Dental Board)?
4. How many prosecutions?

PUBLIC FILINGS

PLEASE BE SURE TO
INCLUDE ONLY
INFORMATION THAT
IS PUBLIC.

CONTACT INFORMATION

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