INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT

Fiscal Year 2021-22

Disability and Healthcare Insurance Fraud Program

The Insurance Commissioner of the State of California hereby makes award of funds to **Fresno County**, Office of the District Attorney, in the amount and for the purpose and duration set forth in this grant award.

This grant award consists of this agreement and the application for the grant which is made a part hereof. By acceptance of the grant award, the grant award recipient agrees to administer the grant project in accordance with all applicable statutes, regulations and Request-for-Applications (RFA).

Duration of Grant: The grant award is for the program period, **July 1, 2021** through **June 30, 2022**.

Purpose of Grant: This grant award is made pursuant to the provisions of California Insurance Code Section 1872.85 and shall be used solely for the purposes of enhanced investigation and prosecution of disability and healthcare insurance fraud cases.

Amount of Grant: The grant award agreed to herein is in the amount of **$180,365.** This amount has been determined by the Insurance Commissioner. However, the actual total award amount for the county is contingent on the collection and the authorization for expenditure pursuant to the Government Code Section 13000 et seq. The grant award shall be distributed pursuant to Section 1872.85 of the Insurance Code.

Official Authorized to Sign for Applicant/Grant Recipient Lisa Smittcamp Name: Lisa A. Smittcamp Title: District Attorney Address: 2100 Tulare Street Fresno, CA 93721 Date: 9/16/2021	**RICARDO LARA** Insurance Commissioner George Mueller Name: **George Mueller** Title: Deputy Commissioner Date: 10/12/2021

I hereby certify upon my own personal knowledge that budgeted funds are available for the period and purposes of this expenditure.

Crista Hill
Crista Hill, Budget Officer, CDI

10/17/21
Date

CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM

REQUEST FOR APPLICATION
FISCAL YEAR 2021-2022

SECTION II
APPLICATION AND INSTRUCTIONS

APPLICATION TABLE OF CONTENTS

Each Application must include a Table of Contents.

TABLE OF CONTENTS
FISCAL YEAR 2021-2022

TABLE OF CONTENTS

GRANT APPLICATION CHECKLIST and SEQUENCE
FISCAL YEAR 2021-2022

THE APPLICATION MUST INCLUDE THE FOLLOWING:

	YES	NO
1. **GRANT APPLICATION TRANSMITTAL (FORM 02)** completed and signed by the district attorney?	☒	☐
2. **PROGRAM CONTACT FORM (FORM 03)** completed?	☒	☐
3. Original or certified copy of the **BOARD RESOLUTION (FORM 04)** included? If NOT, the cover letter must indicate the submission date.	☐	☒
4. **TABLE OF CONTENTS**	☒	☐
5. The County Plan includes:		
a) **COUNTY PLAN QUALIFICATIONS (FORM 05)**	☒	☐
b) **STAFF QUALIFICATIONS (FORM 06(A))**	☒	☐
c) **ORGANIZATIONAL CHART (FORM 06(B))**	☒	☐
d) **PROGRAM REPORT (DAR OR FORM 07)**	☒	☐
e) **COUNTY PLAN PROBLEM STATEMENT (FORM 08)**	☒	☐
f) **COUNTY PLAN PROGRAM STRATEGY (FORM 09(a))**	☒	☐
g) **TRAINING AND OUTREACH (FORM 09(b))**	☒	☐
6. Projected **BUDGET (FORMS 10-12)** included?	☒	☐
a) **LINE-ITEM TOTALS VERIFIED?**	☒	☐
b) **PROGRAM BUDGET TOTAL (FORM 12)** matches amount requested on FORM 02?	☒	☐
7. **EQUIPMENT LOG (FORM 13)** completed and signed?	☒	☐
8. **JOINT PLAN (Attachment A)** completed and signed?	☒	☐
9. **CONFIDENTIAL CASE DESCRIPTIONS (Attachment B)** Is all content readable? A partial narrative is not acceptable.	☒	☐
10. **ELECTRONIC VERSION** (CD/DVD) included?	☒	☐

FORM 02

GRANT APPLICATION TRANSMITTAL

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM

Grant Period: July 1, 2021 to June 30, 2022

Is this a multi-county grant application request? No
If Yes, list all counties: _____

Office of the District Attorney, County of Fresno,
hereby makes application for funds under the Disability and Healthcare Insurance Fraud Program pursuant to Section 1872.85 of the California Insurance Code.

Contact: Scott Hoedt

Address: 2100 Tulare St.

Fresno, California 93721

Telephone: (559) 600-4380

(1) New Funds Being Requested: **$ 321,051.00**

(2) Estimated Carryover Funds: $ **0.00**

Traci Fritzler,	Stephen Rusconi,
Assistant District Attorney	Business Manager
(3) *Program Director*	(4) *Financial Officer*

Lisa Smittcamp
(5) *District Attorney's Signature*

Date: 5/19/2021

Name: Lisa A. Smittcamp

Title: District Attorney

County: Fresno

Address: 2100 Tulare Street

Fresno, California 93721

Telephone: (559) 600-3141

FORM 03

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM CONTACT FORM
FISCAL YEAR 2020-2021

1. Provide contact information for the person with day-to-day operational responsibility for the program, who can be contacted for questions regarding the program.

    a. Name: Scott Hoedt

    b. Title: Chief Deputy District Attorney of Financial Crimes

    c. Address: 2100 Tulare Street

    Fresno, CA 93721

    d. E-mail address: shoedt@fresnocountyca.gov

    e. Telephone Number: (559) 600-4380 Fax Number: (559) 600-2144

2. Provide contact information for the District Attorney's Financial Officer.

    a. Name: Stephen Rusconi

    b. Title: Business Manager

    c. Address: 2100 Tulare Street

    Fresno, CA 93721

    d. E-mail address: srusconi@fresnocountyca.gov

    e. Telephone Number: (559) 600-4447 Fax Number: (559) 600-4100

3. Provide contact information for questions regarding data collection/reporting.

    a. Name: Scott Hoedt

    b. Title: Chief Deputy District Attorney of Financial Crimes

    c. Address: 2100 Tulare Street

    Fresno, CA 93721

    d. E-mail address: shoedt@fresnocountyca.gov

    e. Telephone Number: (559) 600-4380 Fax Number: (559) 600-2144

FORM 04

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2021-2022

The Resolution from the Board of Supervisors authorizing Fresno County to enter into a Grant Award Agreement with the California Department of Insurance will be forwarded no later than December 31, 2021.

COUNTY PLAN: QUALIFICATIONS
FISCAL YEAR 2021-2022

QUESTIONS

Answer the following questions to describe your experience in investigating and prosecuting disability and healthcare insurance fraud cases during the last two (2) fiscal years as specified in the California Code of Regulations, Title 10, Section 2698.97.1.

1. **What areas of your disability and healthcare insurance fraud operation were successful and why?**

    - **Detail your program's successes for the 2019-2020 and 2020-2021 fiscal years ONLY. Include information you believe made your program successful.**

The Fresno County District Attorney's Office Disability and Healthcare Fraud Unit (hereinafter referred to as Fraud Unit) has received funds to prosecute disability and healthcare insurance fraud since 2014.

Fiscal Year 2019-2020

During Fiscal Year 2019-2020 the Fraud Unit filed a new case involving a schoolteacher who made a false representation regarding her medical condition on her application for disability insurance. This case ultimately resolved in FY 2020-2021 with a dismissal after the defendant completed her community service.

The investigation involving the auto accident from FY 2018-2019 was closed due to jurisdictional issues and subsequently forwarded to Arizona law enforcement.

The investigation regarding the doctor allegedly overbilling CPT Code 94200 from FY 2018-2019 was closed for insufficient evidence.

The detox provider investigation from FY 2018-2019 was closed because of federal prosecution.

Another investigation initiated in FY 2019-2020 involving a pharmacy flagged by an audit and a complaint by a member who received a prescription not requested or ordered by his physician was closed due to concurrent federal civil investigation.

An investigation concerning a health clinic where it was alleged that a non-medical provider, a law firm, was directing medical care of claimants involved in an auto collision was transferred as the case did not meet the grant criteria.

An investigation initiated involved a fraudulent misrepresentation on a disability insurance application. This case was closed after investigation due to insufficient evidence.

Fiscal Year 2020-2021

During FY 2020-2021, the Fraud Unit continued its prosecution of the owner of a lingerie company who was billing insurance companies for silicone prostheses when the items provided were only foam or fiber filled. The criminal complaint filed in this case contains sixty-seven (67) counts of billing fraud under Penal Code § 550(a)(5) with the fraud exceeding $100,000.00 and is proceeding in the Fresno County Superior Court.

The Fraud Unit opened several investigations during fiscal year 2020-2021.

An investigation was opened to look into a medical professional who misrepresented her medical history when she applied for short-term disability benefits through her employer. This investigation is complete, and the case will soon be submitted for filing review.

An investigation was opened where an individual submitted a significant number of fraudulent disability claims for himself and his wife. The insured was unable to verify dates of service and in some instances, the alleged employer listed on the claim forms did not exist. The total suspected loss is $41,894.00.

In another case, a claimant obtained disability benefits while away from work and failed to notify the insurer when he returned, continuing to claim benefits.

Another investigation concerns an individual who made false representations to the insurer regarding his physical abilities and the level of care needed. After *subrosa* was conducted, it was learned that the claimant had physical capabilities far beyond what he represented. The loss to the insurer is approximately $240,880.00.

Several other investigations from FY 2019-2020 carried over into this fiscal year and continue to be investigated by the Fraud Unit.

The investigation into a chiropractor who is believed to be engaging in billing fraud is ongoing. In this case, a nurse practitioner who was fired from her job learned that her nursing credentials were being used by her former employer without her permission to justify medical billings to a private insurer.

The billing fraud investigation into owners of a sleep diagnostic company for unauthorized testing, is also ongoing. Here, a patient received neurological testing during a sleep study. When the patient contacted the sleep lab, she was told not to contact the doctor who allegedly ordered the testing. It was learned that the doctor never actually ordered the neurological test that was billed to the insurance company.

Another investigation involving a company that specializes in sleep studies is also ongoing. Here, billing records for member patients did not match up with patient claims data. This discrepancy caused a referral and subsequent investigation.

The investigation into a radiology company suspected of double billing also carried over from last fiscal year. This investigation began when the patient noticed her insurance company was billed twice for the same procedure. The insurance company performed an audit that uncovered suspicious billing totaling $791,051.05.

2. List the governmental agencies you have worked with to develop potential disability and healthcare insurance fraud cases.

Federal Bureau of Investigation and United States Attorney's Office

In Fiscal Year 2015-2016, the Fraud Unit established a working relationship with the Federal Bureau of Investigation and the United States Attorney's Office. There are monthly meetings of the Healthcare Fraud Working Group at the Eastern District United States Attorney's Office. California Department of Health Care Services investigators and Deputy District Attorneys (DDAs) from the Workers' Compensation Fraud Unit also attend the working group. The working group serves a networking and educational purpose and allows members to foster working relationships with federal law enforcement. The case discussions educate all the attendees of the trends in healthcare fraud at the federal and local levels.

California Department of Health Care Services (DHCS)

The Fraud Unit has developed a good working relationship with investigators from DHCS. The Fraud Unit deconflicts with DHCS to avoid duplication of investigative efforts.

Fresno Police Department

The Fraud Unit has met with financial crimes detectives to discuss the grant and facilitate case referrals. The Fraud Unit has maintained contact with the Fresno Police Department financial crimes unit.

Kern County District Attorney's Office

The Fraud Unit coordinates resources with the Kern County District Attorney's Office Healthcare Fraud Unit. On the bigger investigations, it is more efficient for counties to assist each other in an effort to streamline investigations. Several years ago, the Fraud Unit assisted Kern County in reviewing medical records seized from a search warrant.

3. **Specify any unfunded contributions and support (i.e., financial, equipment, personnel, and technology) your county provided to the disability and healthcare insurance fraud program.**

The Fresno County District Attorney's Office contributed unfunded supervisorial and accounting support to the Fraud Unit during Fiscal Year 2019-2020. A Chief Deputy District Attorney supervised the DDA assigned to the cases being reviewed and in court. A Bureau of Investigations Commander supervised the work performed by the SDAI.

A Senior Budget Analyst who maintains control of the grant monies and assists with the preparation of the budget is also provided at no cost to the Fraud Unit budget. The analyst also maintains a record of all monies spent on behalf of the program. Legal assistants who perform secretarial duties and capture the statistics for the Fraud Unit are also provided at no cost.

4. **Detail and explain the turnover or continuity of personnel assigned to your disability and healthcare insurance fraud program. Include any rotational policies your county may have.**

SDAI Brandon Cooper, who was assigned to the Fraud Unit in early 2019, left employment with the Fresno County District Attorney's Office on September 4, 2020.

SDAI Janette Cantu transitioned into the unit on October 5, 2020. SDAI Cantu has been a District Attorney Investigator for fifteen (15) years. She has worked in Welfare Fraud, Felony Trials, Domestic Violence, and Sexual Assault Units. She developed experience in white collar crime after working in both the Welfare Fraud and Public Aid Assistance Units.

5. **Were any frozen assets <u>distributed</u> in the current reporting period? (Assets may have been frozen in previous years.)**

None

FORM 06(a)

COUNTY PLAN: STAFFING
FISCAL YEAR 2021-2022

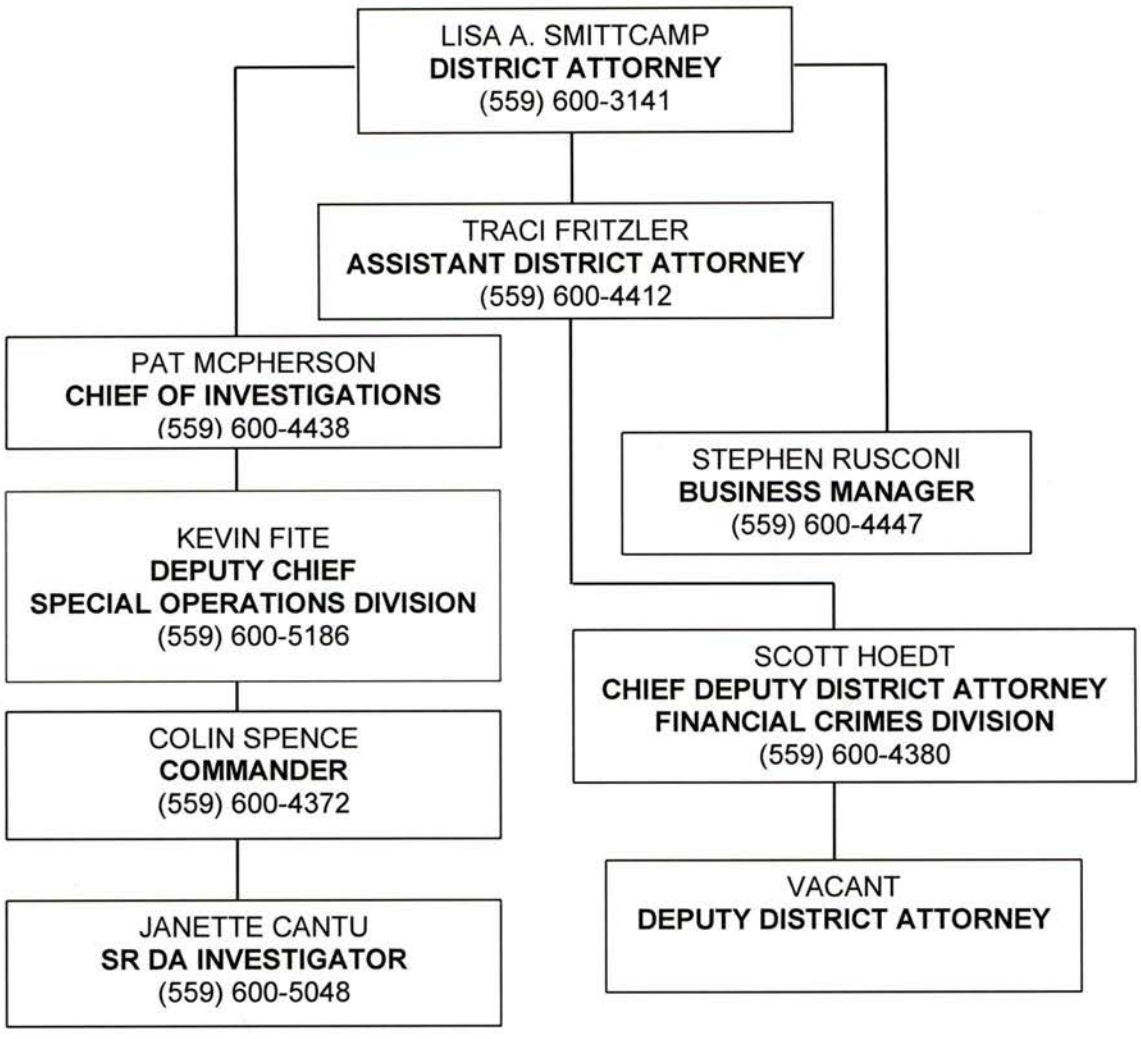
COUNTY OF FRESNO

Name	Role	Start Date	End Date (if applicable)	%Time
Brandon Cooper	SDAI	2/11/2019	7/1/2020	100
Janette Cantu	SDAI	10/5/2020	Present	100

FORM 06(b)

COUNTY PLAN: ORGANIZATIONAL CHART
FISCAL YEAR 2021-2022

ORGANIZATIONAL CHART



COUNTY PLAN: DISTRICT ATTORNEY PROGRAM REPORT
FISCAL YEAR 2021-2022

DAR (FORM 07) is submitted online

STATISTICAL INFORMATION WILL BE CAPTURED

FROM JULY 1, 2020 TO MAY 31, 2021

COUNTY PLAN: PROBLEM STATEMENT
FISCAL YEAR 2021-2022

PROBLEM STATEMENT

Describe the types and magnitude of disability and healthcare insurance fraud (e.g., billing fraud, disability, embezzlement, identity theft, pharmacy, surgery center, unlawful solicitation) relative to the extent of the problem specific to your county.

Use local data or other evidence to support your description.

As of 2021, Fresno County's population is estimated at 1,013,400 and has seen growth of 8.73% since 2010. (U.S. Census Bureau). It is the eleventh (11th) largest county in California. Agriculture is the bedrock of the Central Valley's economy. Valley growers make up California's $50 billion per year agricultural industry and are among the leaders nationwide for the production of almonds, grapes, dairy products and more. (CFDA 2020 Crop Report). Agriculture provides approximately 25% of the region's jobs and it is estimated that one out of three jobs is related to agriculture. (Bureau of Labor Statistics, 2019). In 2019, Fresno County was the leading county in the state in agricultural production. (CFDA 2020 Crop Report).

Because the County generates over 3 billion dollars in agricultural business, it is a prime destination for foreigners looking for work. Approximately 43.35% of Fresno County residents speak languages other than English, the largest group being Spanish which is spoken by 30.15% of the population. Approximately 85% of Spanish speakers speak no English. Patients with language barriers are more likely to consume more health care and those barriers make it difficult for them to take an active role in their medical treatment.[1]

The state's unemployment rate spiked from 4.2% in 2019 to an all-time high of 15.5% the following year due to the pandemic. In a period of two (2) months, the number of those unemployed rose to nearly 2.9 million which surpassed the prior 2.2 million recession peak that took over two (2) years to reach. Fresno County's unemployment rate was 16.7% for the same period.

Further compounding the problem is the lack of education of Fresno County residents. Lack of education precludes gainful employment. The number of college educated persons in Fresno County total only 21.2%, compared to the state average of 33.9%.[2] The median income in Fresno County is approximately

[1] "Implications of Language Barriers for Healthcare: A systematic Review" Oman Medical Journal, Apr. 30, 2020.

[2] **https://www.census.gov/quickfacts/fact/table/CA,US/PST045219** (Accessed 5/3/21).

$34,725 (U.S. Bureau of Labor Statistics), and approximately 20.5% of the County's population lives below the poverty line. (U.S. Census Bureau, 2020). It is well known that poverty is a major contributor to poor health and poor health equally contributes to poverty. This symbiotic relationship, in addition to other factors, creates an atmosphere ripe for fraud on the part of the patient.

In contrast to the patient, whose fraud schemes are largely simplistic, are the professionals in the healthcare industry that seek to turn a profit. According to the U.S. Department of Justice (DOJ), 3.77 billion dollars were lost to healthcare fraud in 2020.[3] The average loss per individual charged by DOJ went from $5.8 million in 2018 to $22.6 million in 2020. The categories of fraud included telemedicine, substance abuse treatment facilities (sober homes), illegal opioid distribution schemes and other miscellaneous types of health care fraud.

During the pandemic, Commissioner Lara directed health insurance companies to increase telehealth access to ensure consumers could obtain medical care while staying safe from exposure. The number of consumers using telehealth prior to the pandemic went from 11% to 46% in 2020.[4] The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) also relaxed HIPAA regulations in order to encourage healthcare providers to offer telehealth services through remote communications that might not otherwise comply with HIPAA. According to a McKinsey report, healthcare providers went from seeing 50 to 175 times the number of patients that were seen prior to the onset of the pandemic by using telehealth.[5] This surge in virtual care visits is expected to result in a rise in fraud involving phantom billings, upcoding, billing for services not rendered, unnecessary prescriptions, diagnostic referrals and durable medical equipment (DME).

An increase in disability fraud is also expected. In Fresno County, the number of persons under the age of 65 with a disability are 9.2% compared to the state's average of 6.7%.[6] Anecdotal evidence suggests that individuals who were infected by COVID-19 are experiencing brain fog, muscle pain and headaches months after testing positive. Should such symptoms become chronic the healthcare and disability arena could be significantly impacted.

Fraud in healthcare and involving disabilities are also difficult to detect without the aid of civilians. Tips of fraud are likely to come from consumers who happened to review their Explanation of Benefits and discovered discrepancies in billing. Because Fresno County is a jurisdiction with a large population that is not college educated, who speak English as a second language and experiences a high unemployment rate, our citizens are prime targets of fraud.

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[3] **https://www.justice.gov/criminal-fraud/file/1370171/download** (Accessed 5/4/21).
[4] McKinsey COVID-19 Consumer Survey, April 27, 2020.
[5] McKinsey COVID-19 Consumer Survey, April 13, 2020.
[6] **https://www.census.gov/quickfacts/fact/table/CA,fresnocountycalifornia/PST045219** (Accessed 5/6/21).

PROGRAM STRATEGY

1. **Explain how your county plans to resolve the problem described in your problem statement. Include improvements in your program.**

For Fiscal Year 2021-2022, the Fraud Unit is renewing its request to fund a full time SDAI and funding for one quarter of a DDA. The SDAI will spend the time necessary to investigate healthcare insurance fraud cases and the DDA assigned will be able to work alongside the SDAI to provide continuity to the program by developing strategies for investigation and prosecution. Both the DDA and SDAI continue to participate in the monthly Healthcare Fraud Working Group with the U.S. Attorney's Office of the Eastern District of California and where appropriate, the Fraud Unit will participate in joint healthcare investigations.

The Fraud Unit also continues to coordinate with Kern County's Healthcare and Disability Fraud Program. Sharing resources enhances each county's ability to complete investigations in a timely manner.

The Fraud Unit intends to meet individually with Healthcare SIUs to establish working relationships with SIU investigators and provide education and training. This enhanced communication will serve to increase the suspected fraud referrals to the Fraud Unit.

In an effort to generate more tips/referrals from the public, the Fraud Unit is in the process of creating infographics regarding healthcare and disability fraud to be distributed to and shared on the social media of major healthcare providers in the area as well as other non-governmental organizations (NGOs) social media. These infographics will aim to educate and encourage consumers to examine their EOB's and question any discrepancies they might see. With the help of the public, the Fraud Unit and CDI can better combat criminal activity that seeks to exploit our healthcare system.

2. **What are your plans to meet the announced goals of the Insurance Commissioner? A copy of the goals has been provided for your reference.**
   - **If these goals are not realistic for your county, please state why they are not, and what goals you can achieve. What is your strategic plan to accomplish the goals?**

The Fraud Unit seeks to meet the Insurance Commissioner's goals with a dedicated fulltime SDAI and a DDA who will focus at least 25% of their time on healthcare and disability fraud. This work will not only be comprised of investigation and prosecution of these cases but will also focus on outreach. While the majority of healthcare fraud is committed by a small number of

dishonest healthcare providers, the result hurts everyone in the form of higher premiums, deductibles and co-payments.[7,8] As a result, a concerted effort at outreach to healthcare providers, insurers, employees and the general public, to educate and encourage them to report fraud will serve to meet the Commissioner's goals. The Fraud Unit aims to do this by providing training, developing infographics for use on social media and including a section on Healthcare and Disability Fraud on our District Attorney webpage for public access and fraud reporting.

3. What goals do you have that require more than a single year to accomplish?

The investigation and prosecution of medical provider fraud is a complex and lengthy process. While the onset of the pandemic is sure to result in a surge of healthcare and disability fraud, the magnitude may not be known for at least a year or more. It is the goal of the Fraud Unit to become well versed in the types of healthcare and disability fraud that we might see as a direct result of the pandemic, like telemedicine or telehealth. As discussed above, its use during the pandemic has exploded and it is anticipated that even after the pandemic subsides, telemedicine will still be available to consumers in some way. As of this writing, there are several bills pending in Congress that seek to make telehealth a more permanent option in healthcare and similar bills have been introduced in California.[9,10] Being adept in identifying common fraud schemes that involve telehealth will enable the Fraud Unit to share its expertise with allied law enforcement agencies and the insurance industry.

4. Describe the county's efforts and the district attorney's plan to obtain restitution and fines imposed by the court to the Disability and Healthcare Fraud Account.

The Fraud Unit maintains an internal database of all restitution orders on criminal convictions. Payments are made directly to the Fraud Unit, are documented and then forwarded to the victim(s). When a defendant misses a payment, staff sends a notification letter to him/her to remind them of the obligation. In the event the letter is unsuccessful in gaining compliance, staff notifies the Probation Department and defense attorney and sets a hearing for a probation violation.

In addition to requesting that restitution be made a condition of probation when probation is granted, the Fraud Unit requests the Court issue an Order for Victim Restitution, CR-110, and an Abstract of Judgement – Restitution, CR-111 and provides copies to the victim. This allows a victim to enforce the criminal restitution

[7] **https://home.treasury.gov/system/files/136/2018NMLRA_12-18.pdf** (Accessed 5/6/21).
[8] **https://www.gao.gov/assets/gao-16-216.pdf** (Accessed 5/6/21).
[9] H.R. 7663, 116th Cong. § 4 (2020) "Protecting Access to Post-COVID-19 Telehealth Act of 2020;"
S. 4375 116th Cong. § 2 (2020) "Telehealth Modernization Act;"
H.R. 8156, 116th Cong. § 2 (2020) "Ensuring Telehealth Expansion Act;"
H.R. 7992, 116th Cong. § 2 (2020) "Telehealth Act."
[10] A.B. 32 (2020).

order as a civil judgment should he/she fail to make restitution after the term of probation has expired.

Provide the amount of restitution ordered and collected for the past five fiscal years. If this information is not available, provide an explanation.

Fiscal Year	Restitution Ordered	Restitution Collected
2020-21	$0	$0
2019-20	$0	$0
2018-19	$0	$0
2017-18	$0	$0
2016-17	$0	$0
TOTAL	$0	$0

Use this space to provide a brief explanation why the restitution ordered and collected information is not available (if applicable).

N/A

5. **Identify the performance objectives that the county would consider attainable and would have a significant impact in reducing disability and healthcare insurance fraud. Project a count you expect to actively investigate. Do not include cases that are open and assigned but have little or no expectation of being worked.**

Projection for FY 2021-2022:

a. __7__ new investigations will be opened and worked during FY 2021-2022

b. __3__ new prosecutions will be initiated during FY 2021-2022

Prior year's projection from FY 2020-2021 submitted RFA:

c. __7__ new investigations will be initiated during FY 2020-2021

d. __3__ new prosecutions will be initiated during FY 2020-2021

6. **If you are asking for an increase over the amount of grant funds awarded last fiscal year, please provide a brief description of how you plan to utilize the additional funds.**

$ 321,051 FY 2021-2022 Grant REQUEST	$ 178,982 FY 2020-2021 Grant AWARD	$ 142,069 FY 2021-2022 Increase Requested

Utilization Plan:

The Fraud Unit seeks to use the additional funds to assign a dedicated DDA who will devote twenty-five (25) percent of his/her time to reviewing and prosecuting disability and healthcare fraud cases.

FORM 09(b)

COUNTY PLAN: TRAINING AND OUTREACH
FISCAL YEAR 2021-2022

TRAINING AND OUTREACH RECEIVED (Part 1)

- List the **insurance fraud training received** by each county staff member in the disability and healthcare fraud unit **during Fiscal Years 2019-2020 and 2020-2021**.

Name	Training Date	Provider	Location	Topic	Hrs Credit
Janette Cantu	10/14/2020	CDAA	Virtual	Annual Fraud Symposium	18
Janette Cantu	10/21/2020	CDI	Virtual	Workers' Compensation Healthcare Overview	2
Janette Cantu	02/24/2021	Golden Gate WC Consortium	Virtual	Illegal Operation of Telehealth Entities; FD-1s	5
Janette Cantu	04/14/2021-04/15/2021	Anti-Fraud Alliance	Virtual	Pursuing Provider Fraud Schemes Across Pain Management Continuum/Combatting Inappropriate use of MRIs, Injections and EMGs	9
Lynette Gonzales	02/24/2021	Golden Gate WC Consortium	Virtual	Illegal Operation of Telehealth Entities; FD-1s	5
Lynette Gonzales	04/14/2021-04/15/2021	Anti-Fraud Alliance	Virtual	Pursuing Provider Fraud Schemes Across Pain Management Continuum/Combatting Inappropriate use of MRIs, Injections and EMGs	9

TRAINING AND OUTREACH PROVIDED (Part 2)

Date Conducted	Location	Conducted By	Purpose & Content	Target Audience	Method	# of Attendees/Contacts[11]

Training and Outreach Narrative

The SDAI and CDI regularly attend the Healthcare Fraud Working Group hosted by the U.S. Attorney's Office. This group discusses ongoing trends and investigations in the healthcare fraud area and coordinates investigative efforts. The DDA that is working with the SDAI also attends these meetings.

- Describe what kind of training/outreach **you plan to provide in Fiscal Year 2021-2022**.

The Fraud Unit specifically seeks to maximize public awareness by targeting both potential offenders and victims. To this end, the Fraud Unit will provide training and outreach to community members and organizations by way of webinars and workshops regarding healthcare and disability fraud. The Fraud Unit will offer its services to the local health industries and allied agencies. Consistent with the "Joint Plan," the Fraud Unit will endeavor to provide this service jointly, where feasible. In addition, the Fraud Unit intends to add a section concerning disability and healthcare fraud to its webpage, along with the option of submitting a tip and answering frequently asked questions.

[11] For hotline numbers or website links, list the number of calls or specific count of page hits.

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2021-2022

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits		COST
(1.0 FTE) SENIOR DISTRICT ATTORNEY INVESTIGATOR:		
Annual salary: *(102,757)*	102,757	102,757
Benefits:		
Retirement: *(102,757 x .9539)*	98,020	
OASDI: *(102,757 x .0765)*	7,861	
Health Ins-Annual:	9,755	
Unemployment: Annual:	143	
Workers Comp: Annual:	1,310	
Admin Fee- Annual:	132	117,221
(.25 FTE) DEPUTY DISTRICT ATTORNEY:		
Annual salary: *(136,622 x 25%)*	34,156	34,156
Benefits:		
Retirement: *(136,622 x .6527)x 25%*	22,293	
OASDI: *(136,622 x .0765) x 25%*	2,613	
Health Ins-Annual: *(9,755 x 25%)*	2,439	
Unemployment: Annual:	36	
Workers Comp: Annual:	327	
Admin Fee- Annual:	33	27,741
SUMMARY:		
Salaries	136,913	
Benefits	144,962	
TOTAL	**$281,875**	
A. PERSONNEL SERVICES TOTAL		**$281,875**

FORM 11

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: OPERATING EXPENSES
FISCAL YEAR 2021-2022

COUNTY NAME: FRESNO

B. OPERATING EXPENSES	COST
MOBILE COMMUNICATIONS: *24/7 radio network access*	1,050
LIABILITY INSURANCE: *rates set by County Risk Management*	500
MEMBERSHIPS: *Investigator membership CDAIA*	35
OFFICE EXPENSE: *routine office supplies*	2,000
POSTAGE: *mailing costs*	200
DATA PROCESSING: *computer network access*	8,000
PROFESSIONAL & SPECIALIZED SERVICES: *vital records and audit costs*	1,200
TRANSPORTATION, TRAVEL, & EDUCATION: *program related in-state travel/training*	5,000
TRANSPORTATION & TRAVEL - FLEET: *vehicle operation and maintenance*	7,500
INDIRECT COSTS: *(10% * Salaries ($136,913))*	13,691
B. OPERATING EXPENSE TOTAL	**$39,176**

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM PROGRAM BUDGET: EQUIPMENT FISCAL YEAR 2021-2022	
COUNTY NAME: FRESNO	
C. EQUIPMENT	***COST***
C. EQUIPMENT TOTAL	**$0**
D. PROGRAM BUDGET TOTAL	**$321,051**

FORM 13

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT LOG
PRIOR FISCAL YEAR 2020-2021

COUNTY NAME: FRESNO

Equipment Ordered	Equipment Cost	Date Ordered	Date Received	Serial Number	Equipment Tag Number

Rows can be inserted as needed.

☒ **No equipment purchased.**

I certify this report is accurate and in accordance with the Grant guidelines.

Name: Scott Hoedt Title: Chief Deputy District Attorney

Signature: [signature] Date: 5/19/21

ATTACHMENT "A"

JOINT INVESTIGATIVE PLAN

JOINT INVESTIGATIVE PLAN

I. STATEMENT OF GOALS

The purpose of the Joint Plan is to create a framework by which the Fresno County District Attorney's Office (hereinafter referred to as the "Fraud Unit") and the CDI Central Valley Regional Office (hereinafter referred to as "CDI") will effectively work together to combat disability and healthcare fraud. Given the limited resources available, it is imperative not to duplicate efforts. It is also essential to use the resources of both agencies to their fullest potential. For example, if a case crosses county lines, the Fraud Unit will turn to CDI for assistance.

II. RECEIPT OF ASSIGNMENT OF CASE

CDI and the Fraud Unit will de-conflict upon assignment of investigations to ensure there is no duplication of investigative efforts. If it is determined that CDI will conduct the investigation, the Fraud Unit will assign a prosecutor to the case to serve as a legal resource for CDI detectives. The assigned attorney and CDI detective will develop a litigation plan. This action is consistent with and supports the philosophy of vertical prosecution. They will work together to determine the charges to be filed and interviews to be conducted. During the initial meeting, timelines will be established for the completion of the investigation and priorities will also be set. The Fraud Unit will be apprised of all aspects of CDI's investigation.

III. INVESTIGATIONS

By working together at the outset of a case, and by sharing fraud referrals on a monthly basis, there will be no duplication of effort. Open communication will exist between both offices, which is the key to investigating the cases as expediently and efficiently as possible.

Vertical prosecution shall be used for all cases investigated. Vertical prosecution means the case detective from CDI or the Fraud Unit will communicate with the assigned prosecutor when the case is assigned for investigation. The assigned prosecutor and detective will meet in person or via telephone prior to starting the investigation. They will discuss the viability of the case, the investigative plan, and schedule meetings and case updates throughout the investigation.

a) Pursuant to the above provision, and to maximize the efficient and effective expenditure or resources, it is expected that each party will conduct its investigations independently in most cases. However, it is understood and agreed that either party will provide assistance to the other upon request in any investigation where such assistance is needed. This could include serving search warrants, interviewing witnesses, making arrests, etc.

b) Joint investigation may be undertaken in cases where the parties determine it is beneficial to combine resources to achieve the most efficient and effective result. This will be determined on a case-by-case basis. The Fraud Division detective(s) and the assigned prosecutor shall communicate at regular intervals as necessary, but no less than one time a month, for the duration of a joint investigation and resulting prosecution.

c) It is the intent of this joint investigative plan to avoid duplication of investigative efforts by maintaining regular communication to discuss caseloads and share information concerning current investigations.

d) Ongoing investigations will be discussed at each meeting or more often as the matter dictates. A prosecutor will be assigned to each investigation to assist in any legal issues and to ensure that all elements of the case are present to meet charging requirements. This teamwork will reduce unnecessary investigative work and ensure that an investigation is terminated at the earliest possible time if it becomes apparent that no further amount of work would result in a prosecution.

e) The Chief of the Fraud Unit or his designee will be available to meet with the Fraud Division detective at any time to discuss any aspect of the case.

f) It is the intent of the parties that by maintaining regular communication and adhering to agreed upon plans and procedures, the completed investigation will result in the filing of criminal charges and a successful prosecution. At the same time, however it is understood that not every case that is investigated will result in prosecution. This can happen when the evidence does not develop as expected, material witnesses are no longer available, the case lacks jury appeal, the reasonable likelihood of conviction is minimal, or other unforeseen circumstances develop. The parties will take all possible steps to avoid such situations, as it is not desirable to expend investigative resources on cases that are not prosecuted in court.

g) The CDI Captain, or Captain's designee, and the Supervising Attorney, or the Supervising Attorney's designee, will meet quarterly to discuss any issues or problems with the joint investigation.

Consent to Record Lawful Communications

Pursuant to California Penal Code Section 633, the District Attorney's Office authorizes any sworn peace officer employed by the California Department of Insurance, Fraud Division to surreptitiously record any communication that can be lawfully overheard or recorded in connection with any criminal investigation involving disability and healthcare fraud in the County of Fresno. This authorization shall remain in effect for the 2021-2022 fiscal year. The District Attorney's Office shall have the right to withdraw this authorization by written notice to the Department of Insurance, Fraud Division.

IV. UNDERCOVER OPERATIONS

In the event that an undercover operation occurs during this grant period, both the CDI Captain, or her designee and the Supervising Attorney will meet to develop a litigation plan which will identify the direction of the investigation, address relative investigative issues, define the responsibilities of both agencies and provide a method to resolve disagreements.

Either party may decide to conduct an undercover operation in a particular case using its own personnel and resources. In a situation where the Fraud Division conducts its own independent undercover investigation in Fresno County, the detective will consult the assigned prosecutor on the case consistent with vertical prosecution.

In a case where there will be a "joint" undercover investigation, there will be a joint operational plan prepared prior to the start of the investigation, which outlines and specifies the goals and objectives of the investigation, as well as the duties and responsibilities, including personnel and financial responsibilities, of each of the parties in the investigation.

V. CASE FILING REQUIREMENTS

Cases presented to the Fraud Unit for filing will contain sufficient evidence to prove guilt beyond a reasonable doubt. This will include a verification that witnesses are available and willing to testify, and contain all available documentation needed to prove the fraud. Witnesses will be interviewed pursuant to Proposition 115 whenever feasible.

If interpreters were used, they will be identified and interviewed if possible. It is difficult to state a more definitive list of requirements for filing since each case is different. Ongoing discussions between the detective and prosecutor will determine if any additional investigation is needed. The prosecutor shall notify the case detective as soon as practical if additional follow up investigation is warranted on the case. Every effort shall be made by the parties to complete the investigation as soon as practical.

The assigned prosecutor shall file criminal charges only if all of the following requirements are satisfied:

a) Based upon a complete investigation and a thorough consideration of all pertinent information readily available, the prosecutor is satisfied that the evidence shows the accused is guilty of the crime to be charged;

b) There is sufficient legally admissible evidence of a corpus delicti;

c) There is sufficient legally admissible evidence of the identity of the perpetrator of the crime;

d) The prosecutor has considered the probability of a conviction by an objective fact-finder hearing the admissible evidence and has considered the evidence necessary to satisfy the legal proof of a criminal case; and

e) The admissible evidence is of such convincing force that it would warrant conviction of the crime charged by a reasonable and objective fact-finder after hearing all the evidence available at the time of charging and after hearing the most plausible, reasonable foreseeable defenses that could be raised under the evidence presented.

The Fraud Unit will provide CDI with a filing decision in writing within 30 days of the case submission. If after a complete review of the case the prosecutor decides not to file criminal charges, the prosecutor will contact and consult with the Fraud Division to discuss the reasons for not filing the case. Both parties understand that not every case may result in criminal prosecution. A case may be declined for prosecution when the evidence does not develop as expected, material witnesses are no longer available, the reasonable likelihood of a conviction is minimal, the case lacks jury appeal or other unforeseen circumstances develop. The parties will attempt to avoid such situations, so as not to expend investigative resources on cases that will not result in a criminal prosecution. If a case has been formally submitted for filing and the prosecutor declines to prosecute, a formal rejection notice either in letter format or via e-mail outlining the reasons why the case is being declined will be sent to Central Valley Regional Office.

Certified Court Minute Orders on all Disability and Healthcare Fraud convictions/sentencings in Fresno County will be provided to CDI as soon as possible.

VI. TRAINING

CDI and the Fraud Unit will continue to work together to educate the community on ways to combat fraud. Any requests for training received by CDI will be communicated to the Fraud Unit and vice versa. In this way both offices will conduct outreach together to employers, carriers and the public.

VII. PROBLEM SOLUTION

With CDI and the Fraud Unit working in a "team concept" it will be easier to resolve problems in an expedient manner. This will also reduce any potential breakdown in communications between offices.

In any event a conflict develops between investigators and prosecutors, using the open lines of communication established, the investigators and prosecutors will seek an early resolution. If a resolution cannot be achieved at this level, the immediate supervisors shall meet jointly with the investigators or prosecutors to seek resolution. It is anticipated that most, if not all, conflicts will be resolved by this step. If a conflict

persists, then the Captain of CDI and the Supervisory Attorney for the Fraud Unit shall meet and confer.

VIII. OTHER

Both CDI and the Fraud Unit will assist each other in the following ways:

1) Storing evidence;

2) Sharing specialized equipment;

3) The service of search warrants, arrest warrants, and/or subpoenas; and

4) In any other way necessary to accomplish our common goal of deterring disability and healthcare fraud.

IX. CONCLUSION

The Fraud Unit and CDI agree to work together to investigate and prosecute disability and healthcare fraud in Fresno County by working high impact cases. Both agencies agree that anti-fraud efforts must be conducted in a cost effective and efficient manner with professionalism, productivity and effectiveness being the overriding principles governing the relationship. Both agencies further agree that the ultimate goal is to reduce disability and healthcare fraud in Fresno County.

4/19/2021

Scott Hoedt
Chief Deputy District Attorney
Fresno County District Attorney's Office

Date

Christine Diep

04/19/2021

Christine Diep
Captain
California Department of Insurance – Fraud Division
Central Valley Regional Office

Date