INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT

Fiscal Year 2018-19

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, 2018** through **June 30, 2019**.

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 **$183,653.** 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: 2220 Tulare Street, Suite 1000 Fresno, CA 93721 Date: 9/20/18	**DAVE JONES** Insurance Commissioner George Mueller Name: **George Mueller** Title: Deputy Commissioner Date: 10-22-18

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

10/25/18

Date

CALIFORNIA DEPARTMENT OF INSURANCE
FRAUD DIVISION

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM

REQUEST FOR APPLICATION
FISCAL YEAR 2018-2019

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GRANT APPLICATION CHECKLIST and SEQUENCE
FISCAL YEAR 2018-2019

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)**	☒	☐
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, 2018 to June 30, 2019

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: Edith Treviso

Address: Office of the District Attorney

2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (559) 600-2120

(1) New Funds Being Requested: $ 382,730

(2) Estimated Carryover Funds: $ 40,000

Traci Fritzler
Assistant District Attorney
(3) *Program Director*

Stephen Rusconi,
Business Manager
(4) *Financial Officer*

(5) *District Attorney's Signature*

Name: Lisa A. Smittcamp

Title: District Attorney

County: Fresno

Address: 2220 Tulare Street, Suite 1000

Fresno, CA 93721

Telephone: (559) 600-3141

Date: 6/4/18

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM CONTACT FORM
FISCAL YEAR 2018-2019

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: Edith Treviso

   b. Title: Chief of Financial Crimes

   c. Address: 2220 Tulare Street, Suite 1000

   d. Fresno, CA 93721

   e. E-mail address: ETreviso@FresnoCountyCA.gov

   f. Telephone Number: (559) 600-2120 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: 2220 Tulare Street, Suite 1000

   d. Fresno, CA 93721

   e. E-mail address: SRusconi@FresnoCountyCA.gov

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

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

   a. Name: Edith Treviso

   b. Title: Chief of Financial Crimes

   c. Address: 2220 Tulare Street, Suite 1000

   d. Fresno, CA 93721

   e. E-mail address: ETreviso@FresnoCountyCA.gov

   f. Telephone Number: (559) 600-2120 Fax Number: (559) 600-2144

FORM 4

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2018-2019

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, 2018.

COUNTY PLAN: QUALIFICATIONS
FISCAL YEAR 2018-2019

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 2016-2017 and 2017-2018 fiscal years ONLY. Include information you believe made your program successful. It is not necessary to list every case that was worked during this time.

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 fraud since 2014.

Fiscal Year 2016-2017

The Deputy District Attorney (hereinafter referred to as DDA) who was assigned to the Fraud Unit in February, 2015 was reassigned to another Unit in July, 2016. It was decided at that time to use the 2016-2017 funding for a Senior Investigator, since healthcare fraud cases are very time consuming with voluminous records to be reviewed before a filing decision can be made. When the investigator completed his/her investigation, a DDA would be assigned to review the case for filing. The DDA would then bill his/her hours to the Fraud Unit's budget.

Senior District Attorney Investigator Shelly Sweeton (hereinafter referred to as SDAI) was assigned to the Fraud Unit in November 2016. During Fiscal Year 2016-2017 she had three open investigations. The first one involved the owner of a lingerie company billing for the most expensive mastectomy products on every patient. The referral received stated that the provider was billing for silicone prosthesis that were in fact only foam or fiber-filled. The provider also billed for non-covered products including underwear and swimsuits. The estimated loss as a result of the fraud was between $200,000 and $300,000. SDAI Sweeton contacted several insurance companies requesting all billing from this lingerie company. After a review of the records received, a search warrant for the home and business of the owner was written and served on September 21, 2017. Thirty-six boxes of evidence were

seized. During a review of the records it was discovered that the owner of the company was also billing her insurance company for prosthetics for herself, even though she does not have a medical need for these products. Three additional search warrants were served on two banks and a billing company on October 27, 2017. SDAI Sweeton remained the lead case agent when she left the Fraud Unit and took a position with the California Department of Insurance Central Valley Regional Office (hereinafter referred to as Fraud Division) in July, 2017. This investigation continued into Fiscal Year 2017-2018.

The second investigation involved billing for services not rendered. The reporting party became suspicious when a claimant said that the clinic treated her for services not rendered. Clinic bills and records were reviewed with the patient and it showed that many services billed for were not received. Additional billings from the provider were ordered for comparison. This investigation continued into Fiscal Year 2017-2018.

A third investigation was opened based on data analytics that showed a physician billing for a patient on every day of the year. This investigation also continued into Fiscal Year 2017-2018.

An additional investigation was opened and investigated by the FBI. It involved a physician billing for services when he was out of the country. The services were actually provided by mid-level practitioners but billed at the higher physician's rate. The Fraud Unit assisted the FBI with their investigation.

A pharmacy fraud case referred by Department of Healthcare Services (hereinafter referred to as DHCS) was filed during Fiscal Year 2016-17. It involved a nurse practitioner forging prescriptions for a patient in exchange for getting expensive pain medication for herself under the patient's private insurance. The case is currently in court pending preliminary hearing. The assigned DA billed his time to the Fraud Unit budget. He has experience in healthcare fraud and has worked in the auto fraud and workers' compensation fraud units for the past eleven years.

Fiscal Year 2017-2018

During Fiscal Year 2017-2018, the investigation involving the owner of the lingerie company continued. As discussed above, search warrants were served on her home, business, two banks and a billing company. Because of the volume of records seized, the review has been time-consuming. Detective Sweeton has located and interviewed three companies in which the owner was doing business for custom prosthesis from 2014-2017. She is comparing these records to the billings for custom prosthesis during the same time frame. SDAI Okasaki (assigned to the Fraud Unit in January, 2018 as will be discussed below) assisted with the interviews and review of the records. It is anticipated that the investigation will be completed during Fiscal Year 2019.

The second investigation which began in 2016 was closed in August, 2017. The investigation revealed that the physician legitimately billed for treating a patient every day of the year. The patient was autistic, had seizures and needed constant therapy. The parents verified that the physician was present each day and were very satisfied with his services.

The FBI returned the investigation involving the physician billing for services while he was out of the country back to the Fraud Unit in January, 2018. Additional follow-up is being conducted by SDAI Okasaki. The provider submitted 462 insurance claims to Anthem Blue Cross during a period of time when he was out of the country. Patients are being interviewed to determine if the exam was conducted with the physician present.

In the pharmacy fraud case discussed above, the Fraud Unit obtained a conviction against the patient. The case is still pending in court against the nurse practitioner.

An additional investigation involving a chiropractor billing for using unauthorized equipment was opened during Fiscal Year 2017-2018. The allegation was that the chiropractor was using a retrofitted jigsaw in lieu of a Pettibon Tendon Ligament Muscle Stimulator. There is no FDA approval for such a self-made device. Investigation revealed that the jigsaw resembles the Pettibon Stimulator and works in much the same way. It was determined that it would be more appropriate for the Department of Chiropractic Examiners to conduct an administrative investigation into the use of this retrofitted device. The Fraud Unit referred this investigation to them.

2. Specify any unfunded contributions (i.e., financial, equipment, personnel, and technology) and support 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 2017-18. 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, was 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 provided at no cost.

3. 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.

As discussed above, the decision was made to use the 2016-2017 funding for a SDAI. SDAI Shelly Sweeton was assigned to the Fraud Unit in November 2016.

She began her law enforcement career in 1988. She worked for the Grover Beach Police Department from 1988 to January 2001. She was an investigator for the Santa Barbara County District Attorney's Office from 2001 to August 2007.

After joining the Fresno County District Attorney's Office in 2007, Ms. Sweeton was assigned to the Sexual Assault Unit for 5 years, the Homicide Unit for 3 years and Auto Fraud for one year before coming to the Fraud Unit. SDAI Sweeton opened several significant investigations while assigned to the Fraud Unit.

On July 31, 2017 SDAI Sweeton took a position with the Fraud Division. SDAI Jesse Perez was immediately assigned to the Fraud Unit to replace Ms. Sweeton. SDAI Perez worked at the Fresno County Sheriff's Department for five years before joining the Fresno County District Attorney's Office in 2000. He worked in the Homicide, Sexual Assault and Welfare Fraud Units, before being assigned to the Fraud Unit on July 31, 2017.

SDAI Jesse Perez worked in the Fraud Unit until December 31, 2017 when he took a medical leave of absence. On January 1, 2018, SDAI Henry Okazaki was assigned as his replacement. SDAI Okazaki has been in law enforcement since 1998. He was a police officer with the Fresno Police Department until 2014, when he joined the Fresno County District Attorney's Office. He spent almost three years in the Welfare Fraud Unit, and worked on the Felony Trial Team and the Subpoena Services Unit as well.

The Fresno County District Attorney's Office is committed to maintaining consistent personnel in the Fraud Unit, which can be seen by the immediate reassignment of a SDAI to replace a vacancy. It is important to have continuity of personnel to work ongoing cases, create and maintain relationships with law enforcement and the Fraud Division, and to build the knowledge necessary to be successful.

4. 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 FBI 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. DHCS investigators and DDAs from the Workers' Compensation Fraud Unit also attend the working group. The working group serves networking and educational purposes. It allows the members to foster working relationships with federal law enforcement. The case discussion educates all members of the trends in healthcare fraud at the federal and local levels.

California Department of Healthcare Services

The Fraud Unit has developed a working relationship and case referral system with the investigator from DHCS. A provider fraud case recently filed involving a registered nurse and medical technician discussed above was referred by DHCS.

Fresno Police Department

In Fiscal Year 2014-2015, the Fraud Unit met with financial crimes detectives to discuss the grant and facilitate case referrals. Subsequently, the Fraud Unit received two referrals. The Fraud Unit has maintained contact with the Fresno PD 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. The SDAI has assisted Kern County reviewing medical records seized from a search warrant.

5. Were any frozen assets distributed in the current reporting period? (Assets may have been frozen in previous years.) If yes, please describe. If no, state none.

None.

COUNTY PLAN: STAFFING
FISCAL YEAR 2018-2019

COUNTY OF FRESNO

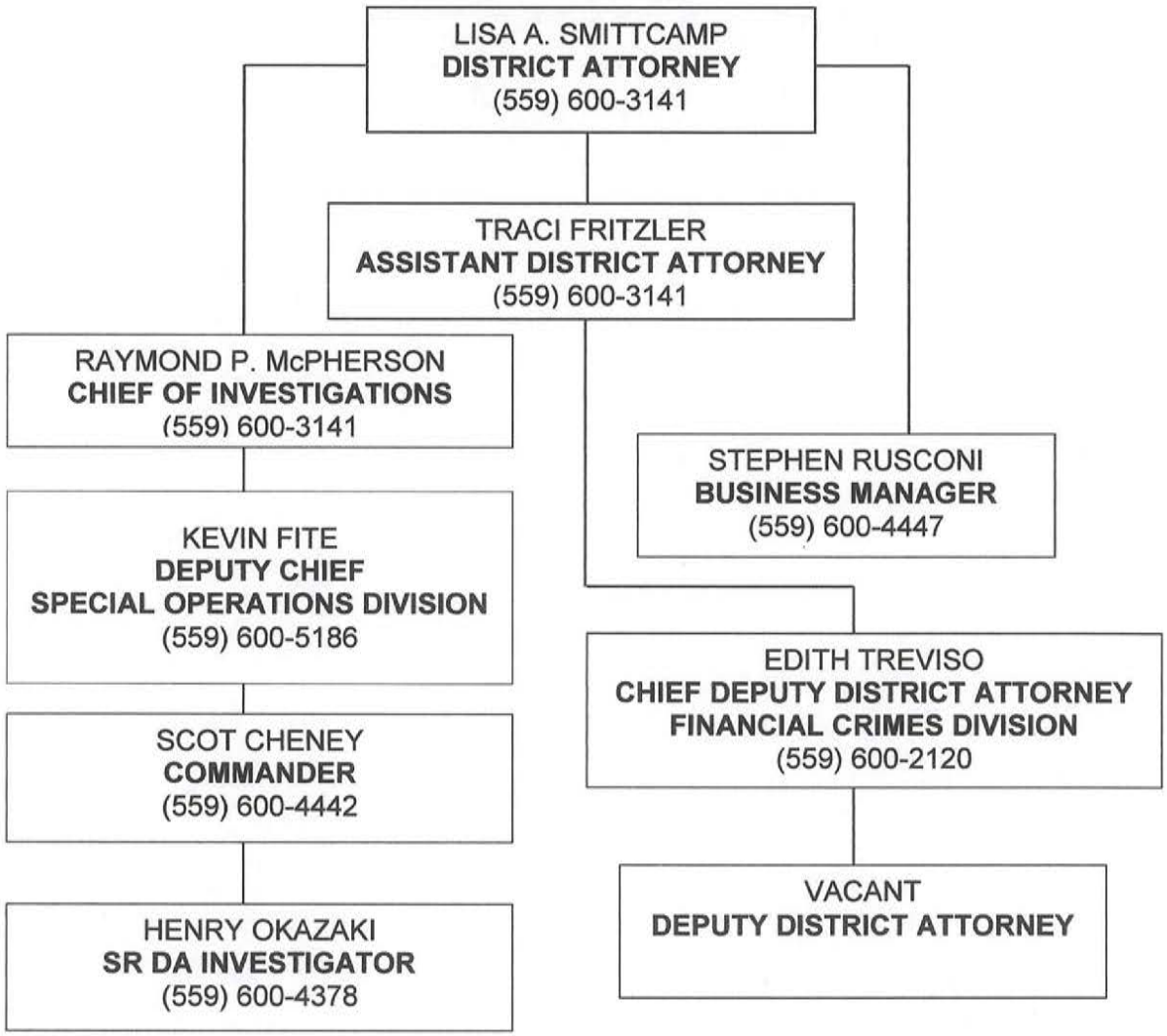
Prosecutors	% Time	Time With Program Start Date/End Date
None—when a case is filed the DDA bills his/her time to the Fraud Unit budget		

COUNTY OF FRESNO

Investigators	% Time	Time With Program Start Date/End Date
Shelly Sweeton	100%	11/1/16 – 7/31/17
Jesse Perez	100%	7/31/17 – 12/31/17
Henry Okazaki	100%	1/1/18 – present

COUNTY PLAN: ORGANIZATIONAL CHART
FISCAL YEAR 2018-2019

ORGANIZATIONAL CHART



COUNTY PLAN: DISTRICT ATTORNEY PROGRAM REPORT
FISCAL YEAR 2018-2019

DAR (FORM 07) is submitted online

STATISTICAL INFORMATION WILL BE CAPTURED

FROM JULY 1, 2017 TO MAY 31, 2018

COUNTY PLAN: PROBLEM STATEMENT
FISCAL YEAR 2018-2019

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.

The current conditions in Fresno County create an environment in which disability and healthcare fraud can thrive. The drought, which has been present for several years, an uncertain economy, and unique population characteristics of Fresno County, make it a fertile environment for its consumers to become victims of disability and healthcare insurance fraud.

Fresno County is part of Central California's Farm Belt. Its economy is robust and agriculturally focused. In 2012, Fresno County ranked number one in the nation in agricultural sales at $4.9 billion.[1] The effects of five consecutive years of drought are still being felt by the farming industry in Fresno County. In April 2016, the U.S. Bureau of Reclamation announced a five percent water allocation to Westside farmers.[2] As a result, approximately 200,000 acres of land were not farmed.[3] In 2014, at least 410,000 acres were lost to fallowing, $800 million lost in farm revenues, and $447 million spent in additional pumping costs in the Central Valley.[4] It is estimated that the 2014 drought caused a statewide loss of $2.2 billion and 17,100 seasonal and part-time jobs.[5] This water shortage ultimately lost income for individual households.

The unemployment rate in Fresno County is higher than the national and state rates. In March 2017 the unemployment rate in Fresno County was 10.3% compared to the state unemployment rate of 4.9% and national rate of 5.1%. Although the unemployment rate in Fresno County dropped slightly in January 2018, it is still over two percentage points higher than the national average.[6]

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[1] "2012 Census of Agriculture County Profile, Fresno County," U.S. Department of Agriculture National Agricultural Statistics Service (USDA-NASS)
[2] "Valley's Westside farmers seethe over tiny water allocation from feds," The Fresno Bee (April 1, 2016), http://www.fresnobee.com/news/state/california/water-and-drought/article69443782.html (Accessed 5/11/16)
[3] Ibid.
[4] "Economic Analysis of the 2014 Drought for California Agriculture," R. Howitt, J. Medellin-Azaura, D. MacEwan, J. Lund, D. Sumner, UC Davis Center for Watershed Sciences (July 2014), p. 15
[5] Ibid, p. ii
[6] "Fresno Metropolitan Statistical Area (MSA), Fresno County," (April 15, 2016) State of California Employment Development Department
http://www.labormarketinfo.edd.ca.gov/file/lfmonth/frsn$pds.pdf (Accessed 5/13/16)

The combined factors of the extended drought and high unemployment contribute to an uncertain economic future for many Fresno County residents. This uncertainty will force some residents to take risks in order to make ends meet. Individuals filing a disability or healthcare claim may seize the opportunity to obtain more money and security through misrepresentations and fraud. Medical providers and industry professionals with a decreasing client base may turn to billing fraud to make ends meet.

Additionally, two population characteristics in Fresno County suggest that its citizens could be more susceptible to fraud than citizens of other counties: 1) approximately 43.7% of the population speaks a language other than English in the home and 2) the number of college educated adults over 25 with a bachelor's degree or higher is 19.5%, compared to the state average of 30.7%. [7]

These population characteristics play a role in billing fraud cases, where fraud is committed by sophisticated professionals behind closed doors. It is difficult for law enforcement to detect this type of fraud without civilian assistance. Oftentimes, the fraud is discovered by a consumer who reviews billing invoices and discovers the discrepancy. With a large population who are not college educated and speak English as a second language, Fresno County is a jurisdiction where providers can take advantage. Believing their clientele are less likely to report or question fraudulent behavior, unscrupulous providers will commit billing fraud with a sense of impunity.

Provider and medical fraud schemes often originate in Southern California and make their way to Fresno County. In these cases, skillful fraudsters send accomplices to Fresno County to carry out their fraudulent schemes while remaining undetected in Southern California. Frequently, the injured people in these cases are Spanish speaking and unable to take an active role in their treatment or question billing practices.

Healthcare spending will continue to increase in the future. America's total health spending is approximately $2.7 trillion or 17% of Gross Domestic Product (GDP). [8] The Affordable Care Act has produced a significant impact on the expenses of health insurance. Private health insurance coverage is more prevalent than government coverage at 65.5% and 37.3% respectively. By 2024, it is estimated that health care spending will account for 19.6% of GDP.[9] The Affordable Care Act and the aging baby boomer population have led to an influx of capital into the healthcare industry. This increase in capital has attracted fraudsters and created incentives for medical industry professionals to commit insurance fraud. A 2012 study published in the Journal of the American Medicine Association (JAMA),

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[7] "State and County Quick Facts, Fresno County, California" (2009-2013) U.S. Census Bureau , http://quickfacts.census.gov/qfd/states/06/06019.html (Accessed 5/14/15)

[8] "The $272 Billion Swindle," The Economist (May 2014), http://www.economist.com/news/united-states/21603078-why-thieves-love-americas-health-care-system-272-billion-swindle (Accessed 5/14/15)

[9] "National Health Care Expenditure Projections 2014 – 2024," Centers for Medicare and Medicaid Services (2014), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (Accessed 5/16/16)

estimated between $82 billion and $272 billion in 2011 was lost due to health care fraud or spent in law enforcement efforts to catch the fraudsters.[10] It is vital that local law enforcement agencies obtain the industry knowledge and professional connections necessary to prosecute healthcare insurance fraud effectively. Over half of Californians, close to 14 million, obtain health care coverage through private carriers in group or individual plans.[11]

By investigating and prosecuting fraud in the private health insurance realm, local law enforcement can ensure that the premiums paid by millions of Californians will be kept at fair and reasonable amounts.

[10] "Eliminating Waste in US Health Care," DM. Berwick & AD. Hackbarth, The Journal of the American Medical Association (April 11, 2012)

[11] "The Private Insurance Market in California 2013," California Health Care Foundation (February 2015), http://www.chcf.org/publications/2015/02/data-viz-health-plans (Accessed 5/14/15)

COUNTY PLAN: PROGRAM STRATEGY
FISCAL YEAR 2018-2019

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 2018-2019, the Fraud Unit is requesting funding for a full time SDAI and a half time DDA. The SDAI will spend the necessary time to investigate healthcare insurance fraud cases. As discussed above there are 3 open investigations. Once these investigations are completed, the DDA can prosecute the cases. During Fiscal Year 2017-2018 there was not a DDA assigned to the Fraud Unit. The case that was filed was handled by a DDA who billed his time to the Fraud Unit budget. Rather than have cases filed by different DDAs, it will provide more continuity to the program to have a dedicated DDA who can work with the SDAI during the investigation to develop a strategy for the case, and learn the nuances of healthcare fraud together.

The DDA and SDAI will continue to attend the monthly meetings of the Healthcare Fraud Working Group at the US Attorney's Office. The Fraud Unit can assist in joint healthcare investigations where appropriate. The SDAI assisted the FBI with their investigation discussed above by securing records from the insurance companies that were needed to prove the fraud. Once that portion of the investigation was completed, the case was turned over to the Fraud Unit for completion.

During Fiscal Year 2018-2019, the Fraud Unit will coordinate with Kern County who also has a Healthcare and Disability Fraud Program. Sharing resources will enhance each county's ability to finish investigations in a timely manner.

The Fraud Unit will also make efforts to meet individually with Healthcare SIUs. Building individual working relationships with SIU investigators will educate industry professionals on the type of cases the Fraud Unit investigates and prosecutes. This communication will increase suspected fraud case referrals to the Fraud Unit.

Healthcare provider fraud is unique and complex. Health care industry terminology, procedures, and trade practices are not known to the standard experienced criminal investigator or prosecuting attorney. It is a specialized area of criminal prosecution. The law enforcement connections and relationships made in this last fiscal year will be carried forward by the Fraud Unit. The SDAI and DDA will continue to work with CDI investigators to identify and develop cases from fraud referrals.

2. What are your plans to meet the announced goals of the Insurance Commissioner? A copy 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 will meet the Insurance Commissioner's goals by having a full time investigator, who can devote needed resources to the investigation of medical provider fraud cases which have the highest impact on the healthcare system. As discussed above these investigations are labor intensive. With a half time DDA, the investigator and prosecutor can work together from the beginning of the investigation to develop the case.

The Fraud Unit will continue to coordinate with other agencies who are working to combat healthcare fraud in Fresno County. The Fraud Unit will meet with individual SIUs to build connections necessary for the successful referral, investigation, and prosecution of healthcare insurance fraud cases. The Fraud Unit will also continue its participation in the working group discussed above, as well as the Fraud Division SIU roundtables. It is important for the Fraud Unit to have a network of resources that can assist staff in identifying and investigating complex billing fraud schemes.

The Fraud Unit will conduct outreach meetings with healthcare professional organizations, including pharmacy associations, and local police agencies to discuss fraud trends. Through outreach with various medical professionals, the Fraud Unit will learn more about the industry and learn how to identify fraudulent conduct in specific practice areas.

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

The investigation and prosecution of medical provider fraud cases will take longer than one year to accomplish. These cases often require multiple search warrants for business records and forensic review of evidence seized. Some cases may require surveillance or an undercover operation. The Fraud Unit will work with the Fraud Division to find ways to streamline the larger investigations. Please see Attachment "A" for the Joint Plan. For example, the Fraud Unit will determine if search warrants are absolutely necessary to investigate a case or if the case can be investigated and proven by the use of governmental agency records and witnesses. If any case takes longer than one year to investigate, the Fraud Unit will move forward into the second year to follow the case to its conclusion.

4. Training and Outreach

List the **training received** by each county staff member in the disability and healthcare fraud unit **during Fiscal Years 2016-2017 and 2017-2018**.

In Fiscal Year 2016-2017 SDAI Shelly Sweeton received the following training:

- April 2017: NIFCIA Monterey
- May 2017: Strategy for Medical Fraud Investigations
- May 2017: Healthcare and Provider Fraud

In Fiscal Year 2017-2018 SDAI Jesse Perez attended the following training:

- CDAA Fraud Symposium

In October 2017 SDAI Henry Okazaki attended the following training:

- April 2018: NICFIA Monterey

Describe what kind of training/outreach **you provided in Fiscal Year 2017-2018** to local Special Investigative Units, as well as, public and private sectors to enhance the investigation and prosecution of disability and healthcare insurance fraud. Also describe any coordination with the Fraud Division, insurers, or other entities.

In Fiscal Year 2017-2018, the Fraud Unit established connections with local law enforcement to discuss the investigation of healthcare fraud. Both SDAI Perez and SDAI Okazaki attended the monthly meetings of the Healthcare Fraud Working Group at the U.S. Attorney's Office. This group discusses ongoing trends, investigations, and coordinates investigative efforts. SDAI Perez and Okazaki also attended bimonthly SIU meetings which discussed healthcare fraud trends.

Describe what kind of training/outreach **you plan to provide in Fiscal Year 2018-2019**.

In Fiscal Year 2018-2019, the Fraud Unit will focus on outreach to healthcare and insurance industries. The Fraud Unit will also conduct outreach with medical professionals and organizations. By conducting discussion groups with medical professionals, the Fraud Unit staff will learn upcoming trends and become familiar with standards and vocabulary specific to the medical industry. The Fraud Unit will seek to obtain similar information in other practice areas and utilize that information in the investigation and prosecution of healthcare insurance fraud.

Additionally, the Fraud Unit will form and build relationships with individual healthcare SIUs. These relationships will facilitate case referrals and strengthen the investigation of cases.

In its outreach efforts, the Fraud Unit will coordinate with the Fraud Division. The SDAI is housed at the Fraud Division with the detective who is also assigned to Healthcare and Disability Fraud. This allows for the sharing of expertise as well as the ability to assist with each other's investigations.

5. 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's practice is to collect restitution prior to a plea whenever possible. The collection of restitution prior to plea ensures that restitution is paid to the victims. There is also the option to obtain a restitution order pursuant to Penal Code §1214 which allows victims to enforce the restitution order as a civil judgment if the defendant fails to pay full restitution during the term of probation.

The Fraud Unit maintains a database of all restitution orders on criminal convictions. Payments are made directly to our Unit, which we document and then forward to the victim(s). If a payment is missed, staff immediately sends a notification letter to the defendant(s) reminding him/her of the obligation.

If the letter is unsuccessful, staff contacts the Probation Department and the defendant's attorney and calendars a Probation Violation hearing.

6. Identify the performance objectives that the county would consider attainable and would have a significant impact in reducing disability and healthcare insurance fraud.

   Projection:

   a. ___5___ new investigations will be initiated during FY 2018-2019

   b. ___3___ new prosecutions will be initiated during FY 2018-2019

7. 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.

$ 382,730 FY 2018-2019 Grant REQUEST	$ 183,653 FY 2017-2018 Grant AWARD	$ 199,077 FY 2018-2019 Increase Requested

Utilization Plan:

The Fraud Unit will use the additional funds to assign a dedicated DDA who will devote fifty percent of his/her time to reviewing and prosecuting healthcare fraud cases.

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2018-2019

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits			COST
(1) SENIOR DISTRICT ATTORNEY INVESTIGATOR: This individual devotes 100% of time to this program.			
Annual salary:		$96,665	$96,665
Benefits:			
Retirement: ($96,665 @ .8840)		$85,452	
OASDI: ($96,665 *.0765)		$7,395	
Health Ins- Annual:		$7,647	
Unemployment-Annual:		$60	
Workers Comp-Annual:		$923	
Admin Fee- Annual:		$124	$101,601
(.5) DEPUTY DISTRICT ATTORNEY IV: This individual devotes 50% of time to this program.			
Annual salary: ($129,702 * 50%)		$64,851	$64,851
Benefits:			
Retirement: ($129,702 @ .6583) * 50%		$42,691	
OASDI: ($129,702 *.0765) * 50%		$4,961	
Health Ins-Annual:		$7,647	
Unemployment-Annual:		$60	
Workers Comp-Annual:		$923	
Admin Fee- Annual:		$124	$56,406
Membership Dues:			
California Board Dues	$380		
CDAIA	$25		$405
SUMMARY:			
Salaries	$161,516		
Benefits	$158,007		
Dues	$405		
TOTAL	**$319,928**		
A. PERSONNEL SERVICES TOTAL			**$ 319,928**

FORM 11

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: OPERATING EXPENSES
FISCAL YEAR 2018-2019

COUNTY NAME: FRESNO

B. OPERATING EXPENSES	*COST*
MOBILE COMMUNICATIONS:	$5,000
LIABILITY INSURANCE:	$300
MAINTENANCE-EQUIPMENT:	$200
OFFICE EXPENSE:	$2,000
POSTAGE:	$500
DATA PROCESSING:	$7,000
PROFESSIONAL & SPECIALIZED SERVICES:	$3,000
PUBLICATIONS:	$150
RENTS & LEASES - BUILDINGS:	$9,000
FACILITY MAINTENANCE:	$500
SMALL TOOLS:	$1,500
TRANSPORTATION, TRAVEL, & EDUCATION:	$7,500
TRANSPORTATION & TRAVEL - FLEET:	$10,000
INDIRECT COSTS: (10% * Salaries ($161,516))	$16,152
B. OPERATING EXPENSE TOTAL	**$ 62,802**

FORM 12

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM PROGRAM BUDGET: EQUIPMENT FISCAL YEAR 2018-2019	
COUNTY NAME: FRESNO	
C. EQUIPMENT	*COST*
C. EQUIPMENT TOTAL	$ 0
D. PROGRAM BUDGET TOTAL	$ 382,730

FORM 13

DISABILITY AND HEALTHCARE INSURANCE FRAUD PROGRAM
PROGRAM BUDGET: EQUIPMENT LOG
PRIOR FISCAL YEAR 2017-2018

COUNTY NAME: FRESNO

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

☒ **No equipment purchased.**

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

Name: EDITH TREVISO Title: CHIEF FINANCIAL CRIMES

Signature: [signature] Date: June 4, 2018

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 request assistance from CDI.

II. RECEIPT AND ASSIGNMENT OF CASES

CDI and the Fraud Unit will deconflict upon assignment of investigations to ensure there is no duplication of investigative efforts.

If it is determined that CDI will conduct the investigation, both the Fraud Unit and CDI will develop a litigation plan. 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, 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. CDI agrees to house the assigned Fraud Unit Investigator, dependent on availability of space, to work with a designated CDI Disability and Healthcare Fraud Investigator. This is designed to maximize resources, foster open communication, and avoid duplication of efforts.

When CDI investigates a case, the detective and prosecutor will meet within 30 days of the case assignment to discuss the litigation plan. The detective will apprise the Fraud Unit of his/her progress on a monthly basis. He/She will contact the DDA at any time in order to review the litigation plan and make changes if needed.

The CDI Captain, or his/her designee, and the Supervising Prosecutor will meet quarterly to discuss any issues or problems with the joint investigation of cases. Changes can be made to the agreement if necessary.

IV. UNDERCOVER OPERATIONS

In the event that an undercover operation occurs during this grant period, both the CDI Captain, or his/her designee and the Chief DDA from the Fraud Unit 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. If it becomes necessary, the Chief DDA will provide written authorization to CDI to conduct surreptitious recordings pursuant to Penal Code Section 633.

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 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 the Fraud Unit prosecutor will determine what additional investigation is needed.

The Fraud Unit will provide CDI with a filing decision in writing within 30 days of the case submission. Certified Court Minute Orders on all convictions in Fresno County will be provided to CDI on a quarterly basis.

VI. TRAINING

CDI and the Fraud Unit will continue to work together to educate the community on ways to combat Disability and Healthcare fraud. Any requests for training received by CDI will be communicated to the Fraud Unit and vice versa.

VII. PROBLEM RESOLUTION

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 the event a conflict develops between detectives and prosecutors, using the open lines of communication established, the detectives and prosecutors will seek an early resolution. If a resolution cannot be achieved at this level, the immediate supervisors shall meet jointly with the detectives/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 Fraud Unit supervisor shall meet and confer.

VIII. OTHER

Both the CDI and the Fraud Unit will assist each other in the following additional 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 and productivity being the overriding principles governing the relationship. Both agencies further agree that the ultimate goal is to reduce the overall occurrence of healthcare fraud in Fresno County. In practical terms, both departments are currently undertaking the above procedures. This document clarifies this coordination and serves as a guide and resource document for future reference.

Edith Treviso

EDITH TREVISO
Chief Deputy District Attorney
Fresno County District Attorney's Office

Date: 5-7-18

Kathleen Rooney

KATHLEEN ROONEY
Assistant Chief
California Department of Insurance
Fraud Division

Date: 4/30/18