INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

GRANT AWARD AGREEMENT

Fiscal Year 2021-22

Workers' Compensation Insurance Fraud Program

The Insurance Commissioner of the State of California hereby makes an 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 and made a part hereof. By acceptance of the grant award, the grant award recipient agrees to administer the grant program in accordance with all applicable statutes, regulations, and Request-for-Application (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 1872.83 and shall be used solely for the purposes of enhanced investigation and prosecution of workers' compensation insurance fraud cases.

Amount of Grant: The grant award agreed to herein is in the amount of **$1,348,743.** This amount has been determined by the Insurance Commissioner with the advice and consent of the Fraud Assessment Commission based on the estimated funds collected pursuant to Section 62.6 of the Labor Code. However, the actual total award amount for the county is contingent on the collection of assessments and the authorization for expenditure pursuant to Government Code Section 13000 et seq. The grant award shall be distributed pursuant to Section 1872.83 of the Insurance Code and the California Code of Regulations Subchapter 9, Article 3, Sections 2698.53, 2698.54, and 2698.57.

Official Authorized to Sign for Applicant/Grant Recipient	**RICARDO LARA** Insurance Commissioner
Lisa Smittcamp	George Mueller
Name: Lisa A. Smittcamp Title: District Attorney Address: 2100 Tulare Street Fresno, CA 93721 Date: 9/17/2021	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

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM

REQUEST FOR APPLICATION
FISCAL YEAR 2021-2022

SECTION II
APPLICATION AND INSTRUCTIONS

APPLICATION TABLE OF CONTENTS

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FISCAL YEAR 2021-2022

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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 the 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

WORKERS' COMPENSATION 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 Workers' Compensation Insurance Fraud Program pursuant to Section 1872.83 of the California Insurance Code.

Contact: Lynette Gonzales, Deputy District Attorney

Address: 2100 Tulare St.

Fresno, California 93721

Telephone: (559) 600-4414

(1) New Funds Being Requested: $ 1,348,743

(2) Estimated Carryover Funds: $ 46,000

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

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

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

Date: 4/14/2021

Name: Lisa A. Smittcamp

Title: District Attorney

County: Fresno

Address: 2100 Tulare St.

Fresno, California 93721

Telephone: (559) 600-3141

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: Lynette Gonzales

    b. Title: Deputy District Attorney

    c. Address: 2100 Tulare St.

    Fresno, California 93721

    d. E-mail address: **lgonzales@fresnocountyca.gov**

    e. Telephone Number: (559) 600-4414 Fax Number: (559) 600-2144

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

    a. Name: Stephen Rusconi

    b. Title: District Attorney Business Manager

    c. Address: 2100 Tulare St.

    Fresno, California 93721

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

    e. Telephone Number: (559) 600-4447 Fax Number: (559) 600-4441

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

    a. Name: Lynette Gonzales

    b. Title: Deputy District Attorney

    c. Address: 2100 Tulare St.

    Fresno, California 93721

    d. E-mail address: **lgonzales@fresnocountyca.gov**

    e. Telephone Number: (559) 600-4414 Fax Number: (559) 600-2144

FORM 04

BOARD OF SUPERVISORS RESOLUTION
FISCAL YEAR 2021-2022

Please be advised that a 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 workers' compensation insurance fraud cases during the last two (2) fiscal years, as specified in the California Code of Regulations, Title 10, Section 2698.55.

- The outcomes reported in FORM 05 shall represent activities funded by this grant program.
- If a case is being reported in more than one insurance fraud grant program, clearly identify the component(s) that apply to this program.
- Information concerning investigations should be general and are subject to disclosure under a PRA request or subpoena. Investigation details that are confidential should be provided only in Attachment B, Part 1, FORM 05.

1. What areas of your workers' compensation 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.
- It is not necessary to list every case that was worked during this time. A description of your significant cases for this period will suffice.

IMPORTANT: If you are including any task force cases in your caseload, name the task force and your county personnel's specific involvement / role in the case(s). Provide confidential case information in Attachment B under the *Activity This Fiscal Year and Current Status* column, specifically naming the task force and your county personnel's specific involvement / role in the case.

FISCAL YEAR 2019-2020

In Fiscal Year 2019-2020, the District Attorney's Workers' Compensation Fraud Unit (Fraud Unit) filed five (5) claimant fraud cases and fifteen (15) uninsured employer fraud cases. The successes of the Fraud Unit are largely due to the creation of a specialized unit dedicated to vertical prosecution of workers' compensation fraud cases. Vertical prosecution is when the same deputy district attorney manages a case from the filing of criminal charges through the disposition of the case either by plea or jury trial. The unique nature of worker's compensation fraud requires an in-depth understanding of the regulatory and administrative branches of the workers'

compensation system. As such, the Fresno Office of the District Attorney is committed to continuity of attorneys and investigators. However, staffing needs can necessitate reassignment.

The Fraud Unit is an active member of the Central Valley Workers' Compensation Fraud Task Force (hereinafter "Task Force") which is a partnership between the California Department of Insurance (CDI) and the District Attorney's Offices in Fresno, Tulare, Kings, Kern, Merced, Madera and San Luis Obispo counties, along with the Franchise Tax Board (FTB) and the Employment Development Department (EDD). An existing Memorandum of Understand (MOU) governs Task Force Operations.

Cases Initiated

Claimant Fraud

In a claimant fraud case, the claimant was picking broccoli when he fell and injured his back. After he reported the injury, claimant reported additional injuries even though he was not working. The employer, a farmer, offered modified work of which claimant refused. *Subrosa* surveillance captured the claimant walking, squatting for prolonged periods, and carrying a box over his shoulder. The PQME reviewed the video and found claimant's representation of his limitations inconsistent with what he observed on the video.

The Fraud Unit filed a claimant fraud case involving a parole officer. The officer sustained an injury in a single car accident on her way to work. Shortly after she returned to work she sustained a second vehicle accident. She now reported injuries to her head, back and wrist. Throughout the course of her treatment, she complained that her migraines and wrist pain worsened. During her PQME evaluation, she claimed she could not work due to the extreme pain in her wrist. During her deposition, she again claimed that she had not worked since the date of injury. It was later learned that she was soliciting business as a tattoo artist within ten (10) days of being injured. As of this writing, the claimant retained counsel and the case is being litigated in court.

A case was filed against a claimant who worked as a janitor. Here, the applicant reported that he tripped over a hose and fell backwards injuring his back and shoulder. Applicant would appear at his medical appointments wearing a back brace and using a cane. However, *subrosa* video captured him taking the trash out without discomfort or the use of a cane, shopping at Costco and Dollar Tree, bending and carrying a case of water without support and even playing soccer with his son – sprinting and using both feet to kick and juggle a soccer ball. This claimant has also retained private counsel and the case is currently being litigated.

In another case, the applicant was injured when a hand-truck fell out of his work vehicle and hit him in the head. He claimed injuries to his head, neck, back, left arm and face. Applicant reported he could only lift light objects, could not sit or stand for prolonged periods and had immense pain if walking up ten (10) stairs. *Subrosa* video captured the applicant at the gym using a stair stepper and lifting heavy

weights over his head. The AME viewed the video and estimated the weight applicant was lifting to be approximately 270-280 lbs. and inconsistent with the limitations he reported to him and testified to at deposition. This case is also in active litigation.

Premium Fraud

In 2019, the Fraud Unit filed a case against a contractor who was caught falsifying timesheets showing employees earning a higher than actual rate to obtain lower premiums from three (3) separate insurers. It was learned through investigation, that he also failed to report accurate wages to EDD. In March of 2021, defendant pled guilty to insurance fraud under Insurance Code Section 11760(a) and agreed to pay restitution in the amount of $91,949.08. Sentencing is set in May of 2021.

Provider Fraud

The Fraud Unit filed two (2) provider fraud cases involving medical professionals.

One case involved a psychologist who submitted multiple fraudulent insurance claims for legal medical evaluations she was not authorized to conduct. The evaluations totaled more than $90,000.00.

In a second case, a physician, who had the requisite certification but had allowed it to lapse, continued to conduct legal medical evaluations costing insurers over $16,000.00.

Ongoing Case Activity

At the close of FY 2019-2020, the Fraud Unit collected $39,899 in restitution.

The Fraud Unit also secured one (1) premium fraud conviction, four (4) claimant fraud convictions, and four (4) convictions in uninsured employer cases.

The defendant from the premium fraud case was sentenced to five (5) years felony probation, ninety (90) days custody, and a restitution order in the amount of $131,802.17.

FISCAL YEAR 2020-2021

Cases Initiated

The Fraud Unit filed eight (8) claimant fraud cases, one (1) premium fraud case and four (4) uninsured employer fraud cases.

Claimant Fraud

In December of 2020, the Fraud Unit filed a case against the employee of a contractor who allegedly injured his back and right leg after tripping on pallets at work. Through *subrosa* investigation, it was revealed that the employee was

working while receiving temporary total disability (TTD) benefits. At his deposition, the employee denied working for longer than a week, when in fact he had been working for almost eight (8) months. The fraudulent loss on the claim was in excess of $18,000.

In November of 2020, the Fraud Unit filed a case against a farm labor employee who had initiated his workers' compensation claim in December of 2012, as a result of an injury to his lower back sustained while picking up brush. As a result of the employee's subjective complaints indicating a lack of improvement, the insurer initiated *subrosa* in 2016. The surveillance revealed that the employee was engaging in activities inconsistent with his subjective complaints and demonstrated pain behavior. Upon reviewing the *subrosa* evidence, the QME reduced the employee's whole person impairment (WPI) rating from 13% to 8%.

An employee of a farming company sustained a back injury when he was struck by a forklift operated by a co-worker. Applicant complained of widespread pain throughout his entire back and body, and while off work, received TTD payments. Modified work was offered and although he returned to work, he remained only for a short time claiming his pain was too unbearable to work. *Subrosa* video captured claimant exceeding his physical limitations on multiple occasions. The QME confirmed that the activity seen on the video was inconsistent with the representations made by claimant and to which he testified to at his deposition. This matter is currently being litigated.

Another case was filed against a claimant who, while working in a citrus orchard, sustained an injury to her shoulder when another worker fell off a ladder and landed on her. She received treatment over a period of time but showed no improvement. Doctors routinely noted concerns regarding symptom magnification and exaggeration in their reports and thus, *subrosa* was ordered. The surveillance revealed significant inconsistencies in what she reported to her daily activities. A PQME determined that the complaints were out of proportion to his objective observations in the *subrosa* and that she had fully recovered from her injury as much as five (5) months earlier. The case was referred to the Fraud Unit and is progressing in criminal court.

Another case was filed against an applicant who, while working at a packing company, sustained an injury when she tripped on a step stool in the course of her duties. She was immediately treated for her injury and placed on modified work, but the employer could not accommodate the work restrictions and she was placed on TTD. The applicant was treated for a significant period of time, but her injury did not improve. She reported significant physical restrictions both to medical staff and at her deposition. *Subrosa*, however, contradicted her statements and the QME reported that the applicant had misrepresented her condition to him. The benefits the applicant received that she should not have received totaled $67,863.51.

A case was filed against a farm laborer who, while working in the fields, was struck in the arm with a garden hoe by a co-worker. She sustained no visible injury and refused medical treatment until police arrived to document the incident. The employer became suspicious when suddenly her symptoms increased significantly

and she now claimed injuries to her neck, arm and shoulder. Claimant was treated at an urgent care, obtained physical therapy and was provided work restrictions. Employer provided modified work which claimant refused. Claimant continued to state her symptoms were not improving and she now experienced back pain. A potential material misrepresentation was discovered when the claimant appeared to exceed her stated limitations in *subrosa* video. After reviewing the *subrosa* video, the QME stated that the claimant's representations were inconsistent with her physical abilities seen on video and the case was referred to the Fraud Unit for prosecution. An arrest warrant is pending in this matter.

The Fraud Unit is currently investigating two (2) claimant fraud cases.

Premium Fraud

The Fraud Unit also filed a case against a roofing company who underreported payroll over a period of five (5) years. A data mining project raised flags concerning underreporting to the attention of the insured. The fraudulent loss of premiums totaled $985,091. Due to court backlog, this case is awaiting a court case number. As such, it could not be included in the District Attorney Report (DAR), Part 2, and for statistical purposes, is counted in Attachment B.

Employer Fraud

In August 2020, the Fraud Unit filed a case against an employer who refused to provide workers' compensation insurance to an employee who was injured on the job in December 2016. The employer also failed to report the injury to the insurer and paid the employee to stay home. The employer admitted to the SIU that he failed to report the injury or provide the insurance information because he did not want his insurance rates to go up. The fraudulent loss on the claim is in excess of $2,000.

Provider Fraud

The Task Force is currently investigating a case where medical and non-medical persons are suspected of conspiring to engage in the corporate practice of medicine, self-referring and billing for services not rendered. More information is provided in Attachment B, Part 2C.

The Task Force also closed one investigation of provider fraud for insufficient evidence.

Ongoing Case Activity

Convictions

In March of 2021, a defendant pled guilty to a violation of Insurance Code Section 11760(a) and was ordered to pay restitution in the amount of $91,949.08. Sentencing is set in May of 2021.

Also, in March, another defendant pled guilty to a violation of Insurance Code Section 1874.1(a)(1) and Penal Code Section 118 (perjury). The defendant also agreed to pay restitution in the amount of $40,119.00. Sentencing is set in May of 2021.

Open Investigations

At the close of FY 2018-2019, the Task force opened a voucher fraud investigation. In 2019-2020, the investigation of that case continued. The investigation is ongoing and continues to grow. To date, eleven (11) FD1s have been received and included in the ongoing investigation. The complaints continue to allege the same behavior involving the enrollment of students using cappers and attorneys and billing for services that are not provided. In some instances, students are enrolled despite not meeting the minimum qualifications to receive the benefit.

The Fraud Unit opened four (4) investigations during FY 2020-2021. Three (3) of these investigations involve claimant fraud and one (1) is a premium fraud investigation that is a spin-off from a Department of Industrial Relations (DIR), Division of Labor Standards Enforcement (DLSE), Bureau of Field Enforcement (BOFE) referral.

Also, during FY 2020-2021, the Task Force opened eight (8) premium fraud investigations all involving a form of underreporting or misclassification.

Two (2) provider fraud cases are currently under investigation by the Task Force and one (1) provider fraud investigation was closed due to insufficient evidence.

The Task Force currently has one (1) COVID related claimant case under investigation.

2. **List the governmental agencies and task forces you have worked with to develop potential workers' compensation insurance fraud cases**.

California Department of Industrial Relations (DIR), Division of Workers' Compensation (DWC)

The Department of Industrial Relations, Division of Workers' Compensation, provides guidance, education, and information about the Workers' Compensation system of laws, rules, and court decisions. DWC provides information and documentation related to Qualified Medical Evaluators and Qualified Medical Evaluations. DWC also refers medical provider fraud cases to the Fraud Unit.

California Department of Industrial Relations (DIR), Division of Labor Standards Enforcement (DLSE), Bureau of Field Enforcement (BOFE).

The Bureau of Field Enforcement is responsible for investigation and enforcement of statutes covering workers' compensation insurance coverage, cash pay and unlicensed contractors and has the authority to issue stop orders penalties for said violations. BOFE refers uninsured employers to the Fraud Unit for prosecution and has provided other information leading to more complex workers' compensation fraud investigations.

Central Valley Workers' Compensation Fraud Task Force

The Fraud Unit has been a member of the Central Valley Premium Fraud Consortium since its inception in 2005. The counties in the Central Valley (Fresno, Tulare, Kings, Kern, Merced, and Madera) and the Fraud Division assist each other in investigating and prosecuting premium fraud cases. The Consortium was converted into a Task Force on August 2, 2017. A Memorandum of Understanding (MOU) established an agreement to operate an interagency workers' compensation anti-fraud partnership between the California Department of Insurance (CDI) and the District Attorney's Offices in Fresno, Tulare, Kings, Kern, Merced, Madera and San Luis Obispo counties along with the Franchise Tax Board (FTB) and the Employment Development Department (EDD). This MOU governs the Central Valley Workers Compensation Fraud Task Force (Task Force) operations.

The mission of the Task Force is to successfully investigate and prosecute all areas of workers' compensation fraud in the participating counties, focusing our combined resources on complex medical fraud cases. The Task Force also works on premium and applicant fraud cases as directed by the Insurance Commissioner's goals and objectives. The approach of the Task Force is to include all areas of workers' compensation fraud but is committed to focusing on cases that have the highest impact in our respective communities and those that cross county lines.

Employment Development Department (EDD)

EDD is a member of the Task Force and provides valuable information regarding employer payroll. EDD investigators also assist the Fraud Unit in analyzing Unemployment Insurance Code violations.

Contractors State License Board (CSLB)

CSLB's Statewide Investigative Fraud Team (SWIFT) routinely conducts undercover sting operations in Fresno County in an effort to deter uninsured contractors. Fraud Unit investigators often participate in these stings and staff attorneys prosecute the cases. CSLB investigators also refer cases to the Fraud

Unit when they identify an uninsured contractor out in the field. CSLB periodically conducts enforcement actions in Fresno County and also refers those uninsured employers to the Fraud Unit.

Department of Labor (DOL)

The Department of Labor refers uninsured employers, wage theft, and premium fraud cases to the Fraud Unit for prosecution.

Workers' Compensation Appeals Board (WCAB)

The Workers' Compensation Appeals Board refers claimants to the Fraud Unit when there is a question of employer fraud. Transcripts from the hearings are often used to prove cases that are filed.

United States Postal Service (USPS)

Staff has also worked with investigators from the United States Postal Service, Office of Inspector General on cases involving postal employees committing workers' compensation insurance fraud.

Fresno Unified School District (FUSD)

The Fraud Unit works with the claim adjusters at FUSD on claimant fraud cases. FUSD is self-insured and adjusts their workers' compensation fraud cases in-house. The Fraud Unit has provided training to FUSD on numerous occasions.

County of Fresno

The Fraud Unit also works directly with Risk Management Department at the Countyof Fresno. Claimant fraud referrals are forwarded to the Fraud Unit.

City of Parlier

The City of Parlier refers claimant cases to the Fraud Unit and has also contacted the unit for guidance on potential claimant fraud by city employees.

U.S. Immigration and Customs Enforcement/Homeland Security Investigations

Many of the suspects investigated by the Fraud Unit are foreign-born nationals. The Homeland Security Investigations, Enforcement Removal Operations and Citizenship Immigration Services has assisted the Fraud Unit to determine the identities of claimant fraud suspects.

Federal Bureau of Investigations (FBI)

The Fraud Unit and the Special Agent in the Fresno office of the FBI who investigates medical fraud have partnered with CDI's Fraud Division to investigate large scale organized provider fraud.

Drug Enforcement Administration (DEA)

The Fraud Unit investigators and DEA diversion investigators collaborate on cases involving the diversion of prescription medications by medical professionals (i.e. patients or doctors misusing or selling controlled substances). The DEA provides the controlled substance prescription information that might lead to evidence of criminal activity by medical providers or claimants.

Franchise Tax Board (FTB)

Suspects willing to commit premium and medical fraud are often willing to defraud other entities, including the State of California. When the Fraud Unit suspects an individual or business entity is committing tax evasion, it will make a referral to the Franchise Tax Board.

California Department of Corrections and Rehabilitation (CDCR)

Investigators from the Department of Corrections and Rehabilitation, Office of Internal Affairs and the Fraud Unit partner on claimant fraud cases when the claimant is a Department of Corrections employee working in Fresno County.

Fresno Police Department

The Fresno Police Department has contacted the Fraud Unit for training in workers' compensation investigations regarding potential claimant fraud by employees.

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

The Fresno County District Attorney's Office has assigned a Budget Analyst, Chief Deputy District Attorney, and a Commander of the Bureau of Investigations to oversee the Fraud Unit. The Bureau of Investigations also provides additional staff for the service of search and arrest warrants for purposes of officer safety.

The Fraud Unit is committed to maintaining its current staffing level which includes two senior DA investigators to be housed at CDI's Central Valley Regional Office as part of the Task Force.

The Fraud Unit is physically located in the same location as other grantees of the California Department of Insurance. This allows Investigators and prosecutors to roundtable and share information and ideas as to how to effectively investigate and prosecute our cases.

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

The Fresno County District Attorney's Office does not have a rotational policy. Generally, turnover is minimal, and the office is committed to maintaining continuity of staff to develop the expertise necessary in this area of law. However, in the last two (2) years, retirements and staffing needs required reassignments. The Fraud Unit prioritizes training from all sources, including that offered by CDI's Central Valley Regional Office, training provided by other District Attorney Offices, and self-study to bring all Fraud Unit staff up to speed quickly.

Scott Hoedt is currently the Chief of the Fraud Unit and came on board in November of 2019. He replaced Gerald (Jerry) Stanley who replaced long-time Chief Edith Treviso when she retired in 2018. Chief Hoedt oversees the Fraud Unit as well as the other units that receive Department of Insurance grants.

Deputy District Attorney Katherine Plante was assigned to the Fraud Unit on April 6, 2020. Prior to coming to the District Attorney's office in 2016, she worked twelve (12) years in private practice. Her practice areas included insurance coverage litigation and management liability insurance on the insured side. Her background and experience in the insurance industry has enhanced her expertise in the workers' compensation fraud arena.

Deputy District Attorney Lynette Gonzales was assigned to the Fraud Unit on October 13, 2020. She has been a Deputy District Attorney for fourteen (14) years and is a skilled litigator. Ms. Gonzales is credited with working to establish the office's first Animal Cruelty Unit and successfully securing the State's first criminal conviction for farm labor trafficking. Prior to coming to the District Attorney's office, she served as a law clerk in the U.S. District Court for the Eastern District of California.

Deputy District Attorney Gonzales replaces Deputy District Attorney Melanie Taylor, who retired in October of 2020.

Senior Investigator Michael Ortiz was assigned to the Fraud Unit on March 9, 2020. Mr. Ortiz has over thirty-two (32) years of experience in law enforcement which includes eight (8) years with the California Highway Patrol and over twenty (20) years with the California Department of Justice, Bureau of Investigations. He has extensive experience in complex investigations involving narcotics, money laundering and financial crimes.

Senior Investigator Meng Vang was assigned to the Fraud Unit on October 5, 2020. He has been with the District Attorney's office for approximately one (1) year. Prior to this, he was a police officer for five (5) years. In that time, he investigated

numerous financial crimes cases, including identity theft, counterfeit money, forged checks and other fraud cases.

Sr. Investigator Vang replaces Sr. Investigator Kelly Mayfield who was rotated out of the unit on October 5, 2020.

Senior Investigator Yvette Galutira was assigned to the Fraud Unit on October 5, 2020. Prior to this assignment, she served in the Public Aid Unit and In-Home Supportive Services Fraud Units. Ms. Galutira was a police officer for twelve (12) years where she developed expertise in investigating identity theft and check and credit card fraud cases.

Sr. Investigator Galutira replaced Sr. Investigator Margie Juarez, who also rotated out of the unit on October 5, 2020.

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

   None.

FORM 06(a)

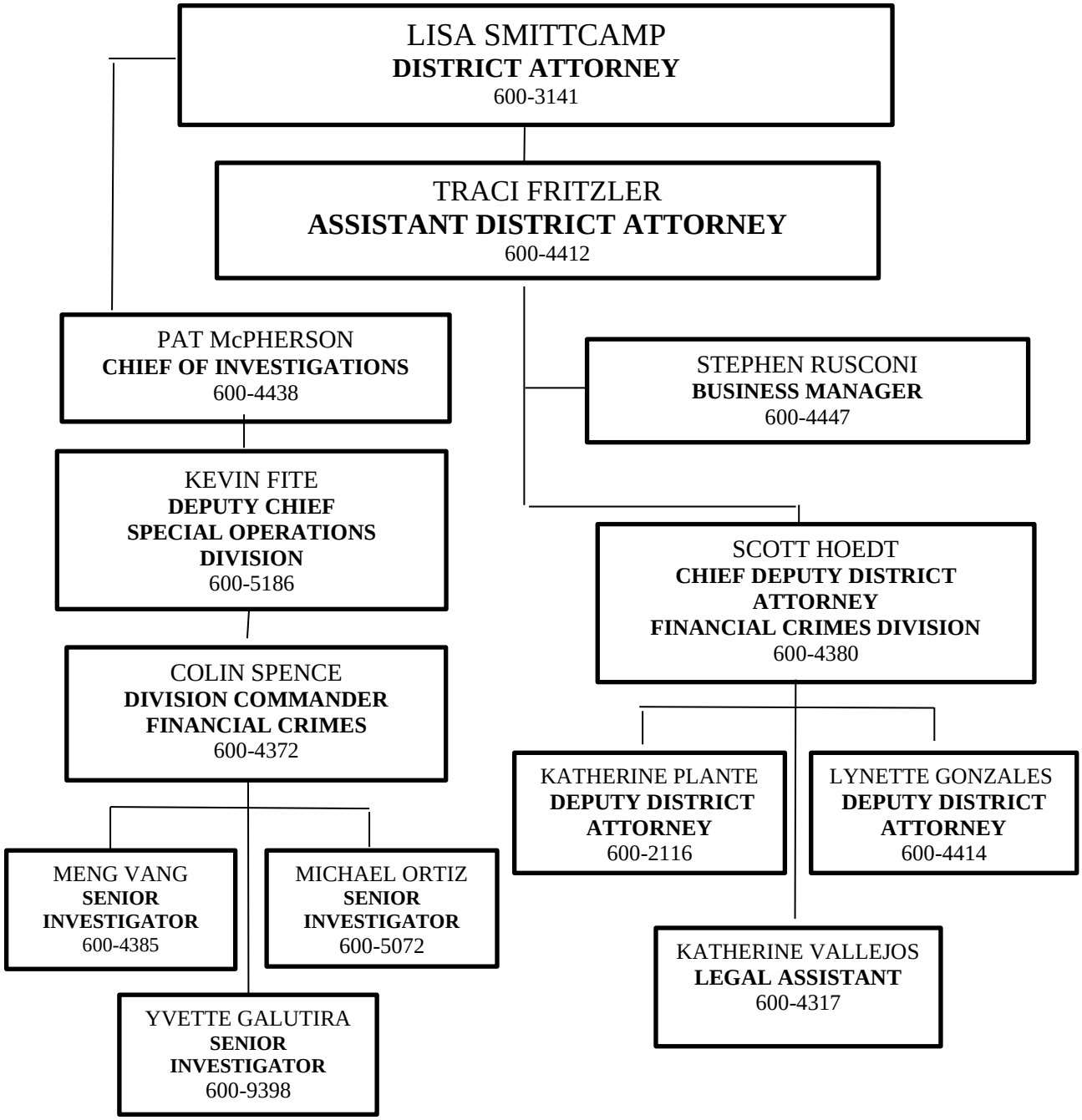
COUNTY PLAN: STAFFING
Fiscal Year 2021-2022

COUNTY OF FRESNO

Name	Role	Start Date	End Date (if applicable)	%Time
Katherine Plante	Deputy District Attorney	3/9/2020	Present	100%
Lynette Gonzales	Deputy District Attorney	10/12/2020	Present	100%
Melanie Taylor	Deputy District Attorney	4/1/2019	10/9/2020	100%
Michael Ortiz	Senior Investigator	3/9/2020	Present	100%
Meng Vang	Senior Investigator	10/5/2020	Present	100%
Yvette Galutira	Senior Investigator	10/5/2020	Present	100%
Kelly Mayfield	Senior Investigator	12/1/2018	10/5/2020	100%
Margie Juarez	Senior Investigator	5/1/2019	10/5/2020	100%
Kathy Vallejos	Senior Legal Assistant	10/7/2019	Present	100%

COUNTY PLAN: ORGANIZATIONAL CHART
FISCAL YEAR 2021-2022

ORGANIZATIONAL CHART



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

FISCAL YEAR 2021-2022

DAR (FORM 07) submitted online

STATISTICAL INFORMATION WILL BE CAPTURED

FROM JULY 1, 2020 TO APRIL 15, 2021

COUNTY PLAN: PROBLEM STATEMENT
FISCAL YEAR 2021-2022

PROBLEM STATEMENT

Describe the types and magnitude of workers' compensation insurance fraud (e.g., claimant, single/multiple medical/legal provider, premium/employer fraud, insider fraud, insurer fraud) 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).

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. During that time, the agriculture industry lost over 94,000 jobs. (EDD Data Trends, May 2020). The level of unemployment, however, not only stems from the pandemic but also the seasonal nature of agriculture and food processing.

Currently, the County is experiencing double-digit unemployment. At the end of 2020, Fresno County's unemployment rate was at 10.4%, up from 8.5% in November. The average unemployment rate for 2020 in Fresno county is approximately 11.3%, higher than the state's average at 10.1%. (U.S. Bureau of Labor Statistics). The median income in Fresno county approximately $34,725 (U.S. Bureau of Labor Statistics), and approximately 37.9% of the County's population lives below the poverty line. (U.S. Census Bureau, 2020).

Fresno County is also home to a diverse community. Because Fresno County generates over three (3) billion dollars in agricultural business, it is a prime destination for foreigners looking for work. The majority of the foreign-born

population are from either Latino or Asian countries, the two making up for approximately 95% of the area's immigrant population. Hispanics and Latinos account for half of the population at 53.8% and of those, 68% are foreign-born. Fresno county has the second largest Hmong population in the U.S. with over 22,000 immigrants. Both groups actively work in the agricultural industry.

43.35% of Fresno's 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. Of the Hmong immigrants, approximately 60% do not speak English. This language barrier contributes to a poor understanding of one's legal rights and obligations in the workers' compensation system. (American Community Survey, U.S. Census Bureau).

Fresno county continues to rank in the top twelve (12) counties for suspicious fraud claims (SFC's) and ranked eleventh overall in 2019. (California Department of Insurance 2019 Annual Report). The COVID-19 pandemic presents new opportunities for workers' compensation fraud the likes of which are yet to be seen. Consider simply how the definition of "workplace injury" will change as one's workplace is in his/her home.

Claimant Fraud

Several of the nation's largest farming and packing business are located in Fresno County. Gerawan Farms and Wawona Packing merged in September of 2019 to form the largest stone fruit and table grape grower in the United States, now named Prima Wawona. Prima Wawona employs anywhere from five-thousand (5,000) to twelve-thousand (12,000) employees at peak harvest. Fowler packing, which ranks seventh (7^{th}) in the nation, and Simonian Fruit, which ranks fourteenth (14^{th}) are also present in Fresno County.

Zacky Farms and Foster Farms are also two (2) of the largest employers in the County. Zacky Farms employs approximately eleven hundred (1,100) workers and Foster Farms has over a thousand (1,000) employees at its Fresno facility. Harris Ranch, California's largest beef producer, is located in Coalinga (Fresno County) and has seven hundred (700) total employees.

It is well known that the agriculture industry lends itself to low pay, physically demanding work and transitory workers. A quick survey of past referrals to our Fraud Unit show a high percentage of fraud referrals and cases involve individuals working in the agriculture industry. The Fraud Unit believes that the high number of claimant fraud cases are reflective of the County's economic status.

Compounding an already existing problem in the agriculture industry is the pandemic. The number of fraud referrals are sure to increase as the industry is considered "essential" thereby putting its workers at the highest risk for contracting COVID-19. For others, false claims may feel like a justifiable lifeline when one is facing reduced hours, bankruptcy, the loss of a job, or home. In April of 2020, just one (1) month after the Governor issued the State of Emergency Order, the Department of Industrial Relations reported having received fifteen-hundred (1,500)

COVID-related workers' compensation claims statewide. ("California's Largest Workers' Comp Insurer Just Made it Easier to File COVID-19 Claims," Los Angeles Times, April 22, 2020).

The easing of restrictions and passage of SB1159 might also impact the number of workers' compensation claims filed. Prior to the pandemic, the burden of showing that an illness or injury was industrial related was on the applicant. The passage of SB1159 shifted the burden onto the employer who now must prove that the contraction of COVID-19 is *not* work related. This creates a clear incentive for fraud as a claimant need only make an allegation and bears no burden of proving that he/she contracted COVID-19 at work. By nature, a virus can be transmitted and contracted without the benefit of a witness making it difficult to dispute a claim that the illness is industrial related. COVID-19 vaccine reactions are now also cognizable claims for workers compensation and will make an investigation into the veracity of a claim challenging as most experience and treat reactions at home. A COVID-19 diagnosis can now also be considered an aggravating factor warranting compensation if an employee suffers from an underlying medical condition.

Premium Fraud

Cash pay seems to remain the number one method used by employers to cheat insurance companies out of their premiums. Often, employers do not learn of unpaid premiums until an audit. With smaller employers, audits are often waived, and thus, fraud is typically not discovered until the end of the policy, if at all. The reporting of payroll is now done electronically, making it difficult to determine exactly who is responsible for any misrepresentations made. The decline in the economy has eliminated many auditor positions and thus, years can go by before fraud is detected. This makes locating witnesses difficult for investigators and prosecutors.

While premiums are driven by the number of people employed, business will undoubtedly still feel the financial stress of the pandemic now having to make ends meet with less staff. This might compel some to under report their payroll, staff size or falsify lay-offs in order to have financial stability.

On the flipside are those industries that have expanded their payroll to keep up with demand like big-box stores and supermarkets, trucking, shipping and delivery businesses. These workers are considered "essential" or "high risk." Will premiums increase based on the nature of the work done during a pandemic? They will certainly increase based on the size of the payroll. The Governor's Executive Order expressly allows "insurance carriers to adjust the costs of their policies" and therefore, the cost of workers' compensation coverage will likely increase to account for the payment of benefits on COVID-19 claims covered. Such increases are likely to spur the incidence of fraud.

Uninsured Employer Cases

In an unstable economy, employers try to reduce costs in any way possible and so, in a time of economic stress, it is common for contractors to forego workers'

compensation insurance. Stringent advertising requirements, licensing and renewal fees and having to pass an exam are challenges that can deter even honest contractors from getting properly licensed. Often, an applicant cannot show four (4) years of verifiable experience in the trade he/she is applying for or was paid under the table and cannot secure a licensed contractor to substantiate his/her work.

COVID-19 has forced 90% of Americans indoors. Our homes became our offices, schools, gyms, movie theaters and more. This causes more wear and tear of existing spaces and appliances and has sparked a surge in home improvement. Home Advisor deemed 2020 the "Year of the Home" as spending on home improvement rose to $13,138 in 2020, a $4,000 increase over a year's time.[1] According to the "Family Handyman," 73% of respondents in a home improvement survey said they would hire a professional who promoted COVID safety measure to work in their homes.[2]

The pandemic exacerbated these challenges when licensing exams were cancelled and live-scan locations closed. This caused a backlog and delay of the administration of exams and left many without valid licenses during a time when the industry was booming. (CSLB Industry Bulletin, June 10, 2020, January 27, 2021).

Medical Provider Fraud

Interestingly, occupations in Fresno County with the fastest job growth are in the health industry. (EDD Employment Projections, 2020-2026).

Medical Provider Fraud is a major problem in Fresno County. The fraud schemes of southern California and Kern County are ever present in Fresno. As in the case of claimant/applicant fraud, many injured workers who suffer from language barriers cannot take an active role in their medical treatment. Workers who were interviewed in past cases complained that body parts being treated were never injured.

The impact of COVID-19 may also spur an increase in medical provider fraud. The burden shifting of SB1159 creates a unique opportunity for runners and cappers to solicit injured workers. Medical providers can generate income by making inflated claims, phantom treatments and patients, by submitting false claims, up-charging for real treatments, or providing unnecessary or duplicative services.

The Department of Health and Human Services, Office of the Inspector General estimates that there were 4.5 billion dollars' worth of telehealth related Medicare fraud losses in fiscal year 2020.[3] The Fraud Unit anticipates an increase in workers compensation fraud that corresponds with expanded use of telemedicine.

[1]< **https://www.homeadvisor.com/research/2020-state-of-home-spending-the-year-of-the-home/**> November 2020.
[2]< **https://www.familyhandyman.com/article/home-improvement-spending-rising/**> December 3, 2020.
[3] < **https://oig.hhs.gov/documents/root/230/2020HealthCareTakedown_FactSheet_9dtIhW4.pdf**>

COUNTY PLAN: PROGRAM STRATEGY
FISCAL YEAR 2021-2022

PROGRAM STRATEGY

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

Claimant Fraud

The Fraud Unit will continue to provide outreach to employers and SIUs on the red flags concerning applicant fraud and the evidence/documentation needed for criminal charges to be filed. Outreach will include a discussion of SB1159, how that has shifted the burden to the employer and how the new law can change the way fraud is committed and give rise to a new set of red flags when claims are COVID-19 related. Equally important is ensuring employers understand the measures they can take to reduce workers' compensation during the time of the pandemic.

The Fraud Unit will continue to encourage referrals and further streamline the referral process. Most recently, the Fraud Unit established a specific email address for the submission of FD1s. This will help maximize the number of FD1s received by our office and allow for prompt review and response to identify and prosecute fraud in its earliest stages. The email inbox will be maintained by the Fraud Unit even where there is a change in staff. The Fraud Unit also hopes to increase its outreach to those communities and businesses where we see an increase in referrals.

Recently, the Fraud Unit met with the Consul at the Mexican Consulate in Fresno to explore opportunities at providing outreach to the population the consulate serves. The Fraud Unit was invited to share infographics on their social media sites and to provide training to their constituents, many of whom are employed in the agriculture industry. The Unit has also reached out to Centro La Familia, to provide outreach to the Spanish speaking communities in Fresno, Kerman, Highway City and Mendota that they serve.

The Fraud Unit hopes to continue our relationships local farmers and packers such as Prima Wawona, Harris Ranch and Foster Farms. These companies have a sufficient employment base to provide many referrals on a regular basis.

Premium Fraud

As a member of the Task Force, the Fraud Unit coordinates with the Fraud Division of the Department of Insurance and other counties in the Central Valley to investigate and prosecute premium fraud. The Task Force prioritizes its resources and focuses on the most serious cases. The Task Force meets quarterly to review potential and ongoing cases. This allows the Task Force to streamline

investigations, shortening the time in which they are conducted and maintaining the integrity of the prosecution.

Partnering with EDD has proven invaluable when attempting to prove premium fraud. Employers often report payroll accurately to EDD. Thus, a discrepancy between what was reported to EDD and what was reported to the insurer can provide valuable evidence of fraud.

The Fraud Unit also works with FTB on all types of workers' compensation fraud investigations. FTB has assisted with bank warrants and will often bring their tax fraud cases to the Fraud Unit for investigation and prosecution when combined with a premium fraud allegation.

EDD and the FTB are currently members of the Task Force.

The Fraud Unit intends to continue to foster new working relationships with agencies in the community to identify and prosecute workers' compensation fraud. For example, the Fraud Unit recently met with the Department of Industrial Relations, Bureau of Field Enforcement to forge a working relationship. The meeting yielded two referrals for potential premium fraud violations stemming from an investigation by the Joint Enforcement Strike Force (JESF), Deputy Labor Commissioner and EDD Investigator. These investigations are in their early stages.

Employer Fraud

The majority of uninsured employer cases are filed with the assistance of CSLB's Statewide Investigative Fraud Teams (SWIFT) and IC (Investigations Center) units. The Fraud Unit and other members of the Task Force participate in undercover stings with CSLB. Fraud Unit investigators will also accompany CSLB investigators in the field to contact uninsured contractors with employees on site. The Fraud Unit maintains regular contact with CSLB and continues to explore options in combatting uninsured employer cases.

Currently, the Fraud Unit and CSLB are planning a sting operation. As home improvement is on the rise due to COVID stay-at-home restrictions, the Fraud Unit is hoping to institute routine compliance checks by mail to ensure contractors are properly insured.

Medical Provider Fraud

Medical provider cases are not only complex, they are lengthy. The Fraud Unit, along with the Task Force, focus on this type of fraud with the goal of completing investigations and filing charges in a timely manner.

Through the Task Force, the Fraud Unit has, for the last three fiscal years, made medical provider fraud investigation a priority. The Task Force filed two (2) medical provider fraud cases in FY 2019-2020. The Task Force has opened an

additional medical provider fraud investigation centered around upcoding and overbilling.

Combatting provider fraud is often difficult due to the lag time between when the fraud occurs and when it is detected. Oftentimes, bad actors will submit the same claims and patients over and over again. However, with the use of data analytics, an insured can quickly and efficiently analyze large amounts of data to identify patterns that might be flags for fraud. The Fraud Unit intends to have greater contact with SIUs to aid in identifying and investigating medical providers that are suspected of ongoing fraudulent activities.

The Fraud Unit also intends to address the issue of provider fraud in its outreach to the public. This will serve not only to educate but inform the public of their role in helping law enforcement curtail fraudulent activity by medical providers.

2. What are your plans to meet the announced goals of the Insurance Commissioner and the Fraud Assessment Commission?

The objectives of Commissioner Lara have been reviewed and the Fresno County District Attorney's Office plans to meet the objectives in the following ways.

Joint Plans and Memorandums of Understanding

In order to maximize the use of resources, the Fraud Unit routinely meets with Department of Insurance investigators and supervisors to develop and refine investigations and litigation of cases filed. This allows for a thoughtful and organized plan of action and the best use of resources without compromising quality for quantity. The Fraud Unit strongly believes that the nature and extent of investigator-prosecutorial collaboration affects not only the quality of the investigations and prosecutions but even the kind of cases that get pursued. In order to enhance more successful investigations and prosecutions, the Fraud Unit intends to provide training to investigators on the legal and ethical issues presented in workers' compensation fraud cases and share with them the vantage point of the prosecutor. The Fraud Unit also hopes to develop public outreach that is conducted but both by the Fraud Unit and the Department of Insurance.

The Fraud Unit also hopes to forge a working relationship with members of the Joint Enforcement Strike Task Force (JESF) and other law enforcement stakeholders to encourage joint investigations and referrals.

Outreach and Public Awareness

Outreach is a critical component to the success of the Fraud Unit. Currently, the Fraud Unit is revamping its webpage on the County website to include information about the various types of workers' compensation fraud in both English and Spanish, provide answers to frequently asked questions (FAQs), and allow for the online reporting of potential fraud directly to the Fraud Unit. The Fraud Unit also intends to update our workers' compensation brochure and ensure that copies are provided to agencies/organizations that provide public services, like Central

California Legal Services (CCLS), California Rural Legal Assistance (CRLA) and the Mexican Consulate.

The Fraud Unit is also in the process of creating infographics to share with other organizations to use on their social media. We intend to use some of these infographics to create posters that can be distributed for posting in businesses and correctional facilities within the county. These infographics will address not only claimant fraud, but premium and provider fraud and will encourage reporting. The Fraud Unit has contacted several community organizations to offer training on workers' compensation fraud. A training for the Special Investigations Unit (SIU) of State Compensation Insurance Fund (SCIF) is currently planned for May of this year.

The Fraud Unit has also begun to participate in the NICB's Central Valley Medical Fraud Task Force Meetings and the Kern County SIU Roundtable meetings as both often discuss workers' compensation fraud issues.

The Fraud Unit intends to follow through with its pre-pandemic plan to speak to the Human Resources class at the Craig School of Business at California State University, Fresno and Central California Legal Services (CCLS).

Strategic Targeting Effort

The Fraud Unit recognizes the need to prioritize its investigations and prosecutions of the fraud with the greatest fiscal impact. To meet this goal, the office has staffed the unit with two (2) full time prosecutors and three (3) full time investigators, two (2) of which are dedicated to the Task Force to investigate medical provider and premium fraud.

The Task Force coordinates efforts with CDI and other Central Valley counties to complete investigations on medical provider fraud and complex applicant and premium fraud cases. The two (2) dedicated Task Force investigators are housed at CDI's Central Valley Regional Office and will not only work Fresno cases, but assist other counties in the Central Valley combat the more complex cases more efficiently and effectively.

The Fraud Unit strives to maintain a balanced caseload by investigating and prosecuting all forms of workers' compensation fraud. Staff will continue to review and pursue referrals and will continue to work with and establish new relationships with SIUs, third-party administrators and self-insureds to ensure that they have the knowledge necessary to make referrals.

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

Complex medical provider and premium fraud cases sometimes take more than a year to investigation. The Fraud Unit and the Task Force continue to collaborate to find ways to streamline larger investigations so as to expedite filing and curtail ongoing fraudulent behavior.

4. Describe the county's efforts and the district attorney's plan to obtain restitution and fines imposed by the court to the Workers' Compensation Fraud Account pursuant to California Insurance Code Section 1872.83(b)(4).

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 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	$ 396,526	$ 87,406
2019-20	$ 143,149	$ 29,898
2018-19	$ 969,940	$ 44,361
2017-18	$ 65,835	$ 45,047
2016-17	$1,020,447	$ 77,419
TOTAL	$2,595,897	$ 284,131

5. **Identify the performance objectives that the county would consider attainable and would have a significant impact in reducing workers' compensation 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. __40__ new investigations will be opened and worked during FY 2021-2022

   b. __25__ new prosecutions will be initiated during FY 2021-2022

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

   c. __40__ new investigations will be initiated during FY 2020-2021

   d. __25__ 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**.

$ 1,348,743 FY 2021-2022 Grant REQUEST	$ 1,387,304 FY 2020-2021 Grant AWARD	$ 0.00 FY 2021-2022 Increase Requested

7. **Local district attorneys have been authorized to utilize Workers' Compensation Insurance Fraud funds for the investigation and prosecution of an employer's willful failure to secure payment of workers' compensation as of January 2003. Describe the county's efforts to address the uninsured employers' problem.**

   The Fraud Unit enjoys a close working relationship with CSLB. The Fraud Unit not only participates in sting operations and regularly meets with investigators to exchange information on developments in the law or regarding the uninsured employer problem in the Fresno area. Generally, the Fraud Unit requires compliance prior to the reduction of a sentence or charges. A joint sting operation is currently planned for summer of 2021.

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 workers' compensation fraud unit **during Fiscal Years 2019-2020 and 2020-2021**.

Name	Training Date	Provider	Location	Topic	Hrs Credit
Manuel Jimenez	10/2019	CDAA	Newport Beach, CA	Fraud Symposium	18
Melanie Taylor	10/2019	CDAA	Newport Beach, CA	Fraud Symposium	18
Kelly Mayfield	10/2019	CDAA	Newport Beach, CA	Fraud Symposium	18
Margie Juarez	10/2019	CDAA	Newport Beach, CA	Fraud Symposium	18
Margie Juarez	07/2019	CDI	Fresno, CA	Claimant Fraud Training	4
Kelly Mayfield	07/2019	CDI	Fresno, CA	Claimant Fraud Training	4
Kelly Mayfield	07/2019	CDI	Fresno, CA	Premium Fraud Training	4
Katherine Plante	10/2020	CDAA	Virtual	Fraud Symposium	9
Katherine Plante	10/2020	CVWCFTF	Virtual	LC 139.3 Schemes & Investigation	1
Lynette Gonzales	10/2020	CVWCFTF	Virtual	LC 139.3 Schemes & Investigation	1

Katherine Plante	02/2021	Golden Gate WC Consortium	Virtual	Illegal Operation of Telehealth Entities; FD1s	5
Lynette Gonzales	02/2021	Golden Gate WC Consortium	Virtual	Illegal Operation of Telehealth Entities; FD1s	5
Meng Vang	02/2021	Golden Gate WC Consortium	Virtual	Illegal Operation of Telehealth Entities; FD1s	5
Meng Vang	10/2020	CDI	Virtual	Basic Investigator Training	16
Meng Vang	10/2020	CDAA	Virtual	Fraud Symposium	24
Mike Ortiz	10/2020	CDAA	Virtual	Fraud Symposium	24
Mike Ortiz	10/2020	CDI	Virtual	Basic Investigator Training	16
Mike Ortiz	02/2021	Golden Gate WC Consortium	Virtual	Illegal Operation of Telehealth Entities; FD1s	5
Yvette Galutira	10/2020	CDAA	Virtual	Fraud Symposium	24
Lynette Gonzales	03/2021	Orange County DA	Virtual	Premium Fraud	1.5
Katherine Plante	03/2021	Orange County DA	Virtual	Premium Fraud	1.5
Yvette Galutira	03/2021	Orange County DA	Virtual	Premium Fraud	1.5
Lynette Gonzales	04/2021	Anti-Fraud Alliance	Virtual	Workers' Compensation Fraud	9

TRAINING AND OUTREACH PROVIDED (Part 2)

Date Conducted	Location	Conducted By	Purpose & Content	Target Audience	Method	# of Attendees/Contacts[4]
10/22/2020	Virtual	Katherine Plante	Sharing of Best Practices	Law Enforcement	Other, Specify in Narrative	12
11/6/2020	Virtual	Katherine Plante, Lynette Gonzales	Training / Educating LEA Partners	Law Enforcement	Other, Specify in Narrative	12
1/5/2021	Virtual	Lynette Gonzales, Katherine Plante	Sharing of Best Practices	Law Enforcement	Other, Specify in Narrative	10
2/10/2021	Virtual	Lynette Gonzales	Public Awareness: Education Component	General Public	Job Fair / Exhibit Booth	100+
2/18/2021	Virtual	Lynette Gonzales	Public Awareness: Education Component	General Public	Other, Specify in Narrative	3
2/23/2021	Virtual	Lynette Gonzales	Sharing of Best Practices	Law Enforcement	Other, Specify in Narrative	3

Training and Outreach Narrative

October 22, 2020 – Outreach to CSLB regarding submission of cases for filing review and streamlining the process.
November 6, 2020 – Informal training to CSLB regarding law and proof issues concerning charges submitted by CSLB.
January 5, 2021 – Quarterly meeting hosted by the U.S. Attorney's Office. Best practices and ongoing investigations are discussed for healthcare related fraud issues.
February 18, 2021 – Outreach meeting with Mexican Consulate to educate on workers' compensation fraud and discuss further training/outreach to their constituents.
February 23, 2021 – Meeting with DIR/BOFE Labor Commissioners to discuss collaboration on workers' compensation investigations and referrals.

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

The Fraud Unit specifically seeks 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 Work-Shops regarding the workers' compensation system and one's rights and responsibilities within that system. The Fraud Unit will offer its services to large industry's Human Resource departments, labor organizations and local business associations as well as non-profit agencies serving the indigent. Consistent with the "Joint Plan," the Fraud Unit will endeavor to provide this service jointly, where feasible.

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

The Fraud Unit intends to supplement its efforts on education and prevention by providing training to its investigators, Task Force investigators and allied law enforcement with an emphasis on potential legal issues and best practices in criminal investigations. This will aid in producing stronger evidence based investigations with the efficient use of limited resources.

The Fraud Unit is currently developing infographics on all areas of workers' compensation fraud that target both offenders and victims to be used on social media sites Facebook and Instagram. We are re-designing our DA webpage to make it user-friendly so it can be a source of information in English and Spanish and will provide an easy mechanism of reporting fraud The Fraud Unit intends to use some of these infographics to create posters that can be provided to organizations and businesses for posting following an outreach contact.

The Unit will continue to participate in quarterly roundtables with allied agencies and SIUs.

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM
BUDGET: PERSONNEL SERVICES
FISCAL YEAR 2021-2022

COUNTY NAME: FRESNO

A. PERSONNEL SERVICES: Salaries and Employee Benefits		COST
(2.0 FTE) DEPUTY DISTRICT ATTORNEY IV:		
Annual salary: *(2 x 132,312)*	264,624	264,624
Benefits:		
Retirement: *2 x (132,312 x .7077)*	187,274	
OASDI: *(132,312 x .0765)*	20,244	
Health Ins-Annual:	17,885	
Unemployment:	161	
Workers Comp:	1683	
Admin Fee- Annual:	224	227,471
(3.0 FTE) SENIOR DEPUTY DISTRICT ATTORNEY INVESTIGATOR:		
Annual salary: *(3x 101,452)*	304,356	304,356
Benefits:		
Retirement: *3x (101,452 x .9539)*	290,325	
OASDI: *3x (101,452 x .0765)*	23,283	
Health Ins-Annual:	26,828	
Unemployment: Annual:	241	
Workers Comp: Annual:	2,524	
Admin Fee- Annual:	336	343,537

(1.0 FTE) LEGAL ASSISTANT:			
Annual salary: *(40,515)*		40,515	40,515
Benefits:			
Retirement: *(40,515* x *.7077)*		28,672	
OASDI: *(40,515 x .0765)*		3,099	
Health Ins-Annual:		8,942	
Unemployment:		80	
Workers Comp:		841	
Admin Fee- Annual:		112	41,746
Membership Dues:			
California Bar Dues *2x 497*	994		994
SUMMARY:			
Salaries	609,495		
Benefits	612,754		
Membership Dues	994		
TOTAL	**$1,223,243**		
A. PERSONNEL SERVICES TOTAL			**1,223,243**

FORM 11

WORKERS' COMPENSATION 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*	3,150
LIABILITY INSURANCE: *rates set by County Risk Management*	600
MAINTENANCE-EQUIPMENT: *repairs and maintenance of office equipment*	2,700
OFFICE EXPENSE: *routine office supplies*	3,500
POSTAGE: *mailing costs*	600
DATA PROCESSING: *computer network access*	21,500
PROFESSIONAL & SPECIALIZED SERVICES: *vital records and audit costs*	6,000
PUBLICATIONS: *attorney publications*	1,500
TRANSPORTATION, TRAVEL, & EDUCATION: *program related in-state travel/training*	10,000
TRANSPORTATION & TRAVEL - FLEET: *vehicle operation and maintenance*	15,000
INDIRECT COSTS: *(10% * Salaries ($609,495))*	60,950
B. OPERATING EXPENSE TOTAL	**125,500**

FORM 12

WORKERS' COMPENSATION INSURANCE FRAUD PROGRAM PROGRAM BUDGET: EQUIPMENT FISCAL YEAR 2021-2022	
COUNTY NAME: FRESNO	
C. EQUIPMENT	***COST***
C. EQUIPMENT TOTAL	**0**
D. PROGRAM BUDGET TOTAL	**1,348,743**

WORKERS' COMPENSATION 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
Chevy Malibu	$31,000	12/15/20	In process		

Rows can be inserted as needed.

☐ **No equipment purchased.**

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

Name: Lynette Gonzales Title: Deputy District Attorney

Signature: Lynette Gonzales Date: 4/15/21

ATTACHMENT A

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 workers' compensation fraud. Given the limited resources available to investigate and prosecute fraud, 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 deconflict upon assignment of investigation 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 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 of 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 during the investigation of a case when so requested by the detective 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 complete 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 a 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.

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 workers' compensation insurance 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.

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

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 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.

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 what 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 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, reasonably 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 letter format or via e-mail outlining the reasons why the case is being declined will be sent to the Central Valley Regional Office.

Certified Minute Orders on all workers' compensation 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 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 communication between offices.

In the event a conflict develops between the agencies using the open lines of communication established, the agencies will seek resolution at the lowest level possible. If a resolution cannot be achieved at this level, the immediate supervisors shall meet 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 Chief Attorney for the Fraud Unit shall meet and confer.

VIII. CENTRAL VALLEY WORKERS' COMPENSATION FRAUD TASK FORCE

The Central Valley Workers' Compensation Fraud Task Force (hereinafter referred to as "Task Force") commenced on August 2, 2017. The Task Force's MOU establishes an agreement to operate an interagency Workers'

Compensation anti-fraud partnership between CDI and the Fresno County District Attorney's Office, the Tulare County District Attorney's Office, the Kings County District Attorney's Office, the Kern County District Attorney's Office, the Merced County District Attorney's Office, the Madera County District Attorney's Office, the California Franchise Tax Board, and the California Employment Development Department. A separate "Memorandum of Understanding" governs the Task Force's operations.

Given the challenges of one investigator working alone in a county to make an impact on workers' compensation fraud in their community, and those that come with working a complex premium fraud or medical provider fraud case that affects multiple counties in the central California region, the idea was formed to work together as a task force to combine our existing resources to fight insurance fraud on a more effective scale with a more robust program through inter-agency cooperation. Smaller agencies and those with new personnel can benefit by shortening their learning curve in working with a task force of experienced personnel as well as ramp up and navigate a larger case much more quickly. Conversely, they can participate (schedule permitting) with larger counties working in unison on complex and large-scale cases and in enforcement operations such as the execution of search warrants and arrest details. When evidence in these types of cases can be collected in a coordinated effort and the cases completed in a tighter frame, the success of the case and its outcome are significantly improved.

The mission of this Task Force is to successfully investigate and prosecute all areas of workers' compensation fraud in the participating counties in the Central Valley focusing our combined resources on complex medical fraud cases. The Task Force will also work on premium fraud and applicant fraud cases as directed by the Insurance Commissioner's goals and objectives. This Task Force approach will include all areas of workers' compensation fraud but will be committed to focusing on those cases which have the highest impact in our communities as well as cases that cross county lines.

IX. EMPLOYERS WHO ARE WILLFULLY UNINSURED

CDI and the Fraud Unit are committed to working together to investigate and prosecute employers in Fresno County who are willingly uninsured. A CDI detective will accompany a District Attorney investigator whenever possible when following up on a tip of an uninsured employer in the county. CDI will be the liaison with the WCIRB in determining if a particular employer carries Workers' Compensation Insurance.

X. OTHER

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

a. Storing evidence
b. Sharing specialized equipment
c. The service of search warrants, arrest warrants and/or subpoenas, and
d. In any other way necessary to accomplish our common goal.

XI. CONCLUSION

The Fraud Unit and CDI agree to work together to investigate and prosecute those who commit insurance fraud in Fresno County by working high impact cases while at the same time maintaining a balanced caseload. 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 workers' compensation insurance fraud in Fresno County.

3/11/2021

Scott Hoedt — Date
Chief Deputy District Attorney
Fresno County District Attorney's Office
Financial Crimes Unit

Christine Diep

3/11/21

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