From: DMHC Licensing eFiling

Subject: APL 22-025 - Health Plan Requirement to File Annual Antifraud Report

Date: Monday, November 1, 2022 3:04 PM

Attachments: APL 22-025 - Health Plan Requirement to File Annual Antifraud Report (11.1.2022).pdf

Dear Health Plan Representative,

The Department of Managed Health Care (Department) issues this All Plan Letter (APL) 22-025 to remind health care service plans of their continuing obligation to comply with the annual antifraud reporting requirements under the Knox-Keene Health Care Service Act of 1975.

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-323-0435
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: November 1, 2022

TO: All Health Care Service Plans

FROM: Sonia Fernandes, Deputy Director
Office of Enforcement

SUBJECT: APL 22-025 Health Plan Requirement to File Annual Antifraud Report

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The Department of Managed Health Care (Department) issues this All Plan Letter (APL) to remind health care service plans ("plans") of their continuing obligation to comply with the annual antifraud reporting requirements under the Knox-Keene Health Care Service Act of 1975, as amended[1] ("Knox-Keene Act"). The Department has determined that several plans have either failed to file any annual antifraud reports or have inconsistently filed these reports with the Department. Additionally, reports filed with the Department have lacked the required information.

Pursuant to Health and Safety Code section 1348, subdivision (a), every plan licensed to do business in this state is required to establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud.[2]

Section 1348, subdivision (c), requires every plan that establishes an antifraud plan pursuant to section 1348, subdivision (a), to provide to the director an annual written report which, at a minimum, includes the following information:

1. Describes the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency.

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[1] Health and Safety Code section 1340, et seq. References herein to "section" are to sections of the California Health and Safety Code.

[2] Health and Safety Code section 1348, subdivision (a).

2. Number of cases prosecuted to the extent known by the plan.[3]

The annual report may also include recommendations by the plan to improve efforts to combat health care fraud.[4]

Plans subject to the provisions of section 1348, subdivision (c), must file the annual report with the director to maintain compliance.[5]

While the Department recognizes Medicare plans[6] have a separate annual antifraud filing requirement under Center for Medicare & Medicaid Services' (CMS) program requirements[7], Medicare plans are not exempt from their obligation to comply with the other requirements of the Knox-Keene Act that bar unfair business practices by solicitors and representatives marketing Medicare products.[8] For this reason and based on the Department's authority over Medicare antifraud activities under section 1361.1, Medicare plans are directed to annually file an attestation with the Department affirming that they have complied with federal CMS antifraud requirements.

For the 2022 calendar year, plans are advised to file their antifraud reports, or in the alternative, submit an attestation confirming compliance with CMS antifraud requirements, no later than December 31, 2022.

A plan's failure to comply with the above requirements may result in disciplinary proceedings against the plan pursuant to Section 1386, including, but not limited to, administrative penalties.

Please direct questions regarding this APL to Amir Javideyan, Attorney III at Amir.Javideyan@dmhc.ca.gov or (916) 255-2371.

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[3] Health and Safety Code section 1348, subdivision (c).

[4] *Id.*

[5] *Id.*

[6] Plans offering Medicare Parts A, B, C, D, and Medicare supplemental coverage.

[7] 42 C.F.R. § 422.503(b)(4)(vi). Fraud, waste, and abuse prevention measures were incorporated into required Part C and D compliance plans effective January 1, 2009 (72 Fed.Reg. 68700, 68702.). For plan years beginning January 1, 2011, amendments explicitly clarified what constitutes an "effective" compliance program. (72 Fed.Reg. 19678, 19688.).

[8] Health & Safety Code section 1361.1.