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Pursuant to the provisions of Joint Rule 59, the following Assembly Journal for the 2025–26 Regular Session was printed while the Assembly was in Final Recess.

SPECIAL COMMITTEE MEETINGS

By unanimous consent, the following committees were permitted to meet:

Utilities and Energy, on Tuesday, October 20, 2026, at 12:30 p.m., at 1021 O Street, Room 1100;

Utilities and Energy, on Wednesday, October 28, 2026, at 1:30 p.m., at 1021 O Street, Room 1100;

Select Committee on Growing and Retaining the Creative Economy in California, on Thursday, October 29, 2026, at 11 a.m., at Wolf Theater in the Television Academy Saban Media Center, 5220 Lankershim Blvd., North Hollywood 91601;

Joint Legislative Audit Committee, on Thursday, October 29, 2026, at 5 p.m., at Santa Clarita Valley International School, 28080 Hasley Canyon Rd. #200, Castaic 91384;

Joint Legislative Committee on Climate Change Policies, on Tuesday, October 20, 2026, at 10:30 a.m., at the Collins Conference Room of the James West Alumni Center at UCLA, 325 Westwood Plaza, Los Angeles 90095.

REPORTS

The following letters of transmittal were presented by the Chief Clerk and ordered printed in the Journal:

California State Auditor

2025-603
October 13, 2026

*The Honorable Speaker of the Assembly
The Honorable Members of the Assembly
of the Legislature of California
State Capitol, Room 319
Sacramento, California*

Members of the Assembly: State law authorizes my office to establish a high-risk government agency audit program for the purpose of identifying, auditing, and issuing reports on state issues that have major challenges associated with their economy, efficiency, or effectiveness. Since 2013, the State's deteriorating water infrastructure has been a recurring item on our state high-risk list. Accordingly, my office conducted an audit of the oversight of dams and levees by the Department of Water Resources (Water Resources), Governor's Office of Emergency Services (Cal OES), and the Central Valley Flood Protection Board. Overall, we found that poorly maintained dams and levees continue to pose a risk to public safety.

Existing law does not require dam owners to identify and set aside the financial reserves necessary to maintain their dams in satisfactory condition. Consequently, some owners of dams that require repairs or improvements to meet state safety standards have delayed those activities because they do not have the financial resources. Such delays increase the risk that these dams may fail, which could endanger hundreds of thousands of people and billions of dollars of property. Water Resources expects that its reevaluation of conditions of risky dams will lead to an increase in the number of dams in poor or unsatisfactory condition. Moreover, Water Resources does not have the authority to take meaningful action to minimize the risk that a dam poses until the dam reaches a state of imminent failure. Cal OES has not collaborated with Water Resources to ensure that owners of dams complete their required emergency action plans, which help protect life and property if dams fail.

We also found that Water Resources has not followed state law requiring it to take over the maintenance of levees when levees' local maintaining agencies do not meet their contractual obligations. Water Resources determined that the maintenance work would draw resources away from its statewide flood-risk reduction efforts. However, the lack of maintenance increases the chance that levees may fail, which would endanger hundreds of thousands of people in the surrounding communities and could cause billions of dollars in property damage.

Respectfully submitted,

GRANT PARKS
California State Auditor

Above report referred to the Committee on Emergency Management.

California State Auditor2025-605
October 15, 2026

*The Honorable Speaker of the Assembly
The Honorable Members of the Assembly
of the Legislature of California
State Capitol, Room 319
Sacramento, California*

Members of the Assembly: The Department of Health Care Services (Health Care Services) is the federally designated single state agency responsible for administering the California Medical Assistance Program (Medi-Cal), the State's Medicaid program. In accordance with the State's high-risk government agency audit program authorized by Government Code section 8546.5, my office presents this report that provides an additional rationale for designating Health Care Services as a high-risk agency; specifically, Health Care Services' insufficient oversight of payments to Medi-Cal providers.

We first designated Health Care Services as *high risk* in 2007 because of challenges associated with its organizational restructuring and concerns about its ability to meet the Legislature's expectations of increased accountability and program effectiveness. In the intervening years, we have continued to monitor Health Care Services' progress toward addressing its high-risk status, and in December 2025, we retained Health Care Services on our high-risk list because of problems we identified with its Medi-Cal eligibility determinations. In this report, we detail our assessment that results in our updating the state high-risk list because we have determined that Health Care Services is at substantial risk of making inappropriate payments to Medi-Cal providers. Curtailing inappropriate payments to providers would allow the Medi-Cal program to redirect funds to benefit both beneficiaries and those who provide health care to the State's most vulnerable residents.

It is important to note that this report represents only our assessment of Health Care Services' oversight of provider payments for Medi-Cal services as high risk, thus warranting another reason for Health Care Services' inclusion on the state high-risk list. Making this assessment allows my office—as resources permit—to self-initiate a subsequent high-risk audit to more deeply explore the root causes of and potential solutions for curtailing inappropriate payments to Medi-Cal providers. This report is not the result of an audit under our state high-risk audit program and therefore does not include any specific recommendations.

Key Observations:

- Health Care Services has a history of weaknesses in overseeing providers, including prior audit findings related to Medi-Cal payments to providers with indicators of fraudulent activity.
- One of Health Care Services' risk assessment tools identified approximately 28,000 providers as being in the top 10 percent of risk scores for inappropriate billing because they submit an unreasonably high number of claims, serve a large number of beneficiaries, or take other actions that can indicate fraud; however, Health Care Services has not researched or investigated 26,000 of these providers—who accounted for at least \$12 billion in Medi-Cal services in fiscal year 2024–25. Although not all of these

providers may have engaged in fraud, waste, or abuse, the amount underscores the opportunities for enhanced scrutiny by Health Care Services.

- Managed care plans' investigations and Health Care Services' follow-up efforts have not always been sufficient to stop providers from inappropriate billing for Medi-Cal services. Health Care Services has been slow to or failed to follow up on certain providers when there are indications of potential wrongdoing.
- For example, Health Care Services closed an investigative referral it received from a managed care plan in 2023, even though the plan concluded that some payments were inappropriate and that the provider was nonresponsive during the managed care plan's investigation. The provider went on to bill more than \$5.5 million in Medi-Cal services in fiscal year 2024–25 before Health Care Services eventually referred the provider to the California Department of Justice (DOJ) for possible criminal investigation and prosecution in April 2026. As of July 2026, DOJ had not filed charges for this provider.
- Two providers collectively billed for nearly \$1.6 million in Medi-Cal services in fiscal year 2024–25, despite having become ineligible to participate in the Medi-Cal program before or during fiscal year 2021–22.
- Transportation providers overcharged almost \$31 million in Medi-Cal services in fiscal year 2024–25 by charging mileage at a rate intended for nonemergency ambulance trips, even though the claims were for services involving other vehicle types, such as taxicabs and wheelchair vans.

The State High-Risk Government Agency Audit Program

California Government Code section 8546.5 authorizes the California State Auditor to develop a state high-risk government agency audit program for the purpose of identifying, auditing, and issuing reports on any state agency or statewide issue that the office identifies as being at high risk. In accordance with this statutory authority, our office adopted regulations in 2016 that provide the criteria and procedures we use to determine high-risk agencies and statewide issues. Specifically, my office may determine that a state agency or statewide issue is high risk if, in our professional judgment, the agency or issue is at risk of suffering from or producing waste, fraud, abuse, and mismanagement or has major challenges associated with its economy, efficiency, or effectiveness. Further, these regulations allow us to amend the state high-risk list to add state agencies or statewide issues that meet the criteria for being designated as high risk or to update descriptions for current agencies and issues to better reflect results of more recent assessments.¹

¹ The high-risk list is published in Report 2025-601, *State High-Risk Audit Program: The California State Auditor's Updated Assessment of Issues and Agencies That Pose a High Risk to the State*, December 2025.

Our office added Health Care Services to the high-risk list in 2007, and we retained Health Care Services as a high-risk agency on the most recent high-risk list because of problems with its Medi-Cal eligibility determinations. The high-risk assessment this report details updates the description for why Health Care Services is a high-risk agency, and it includes our conclusion that Health Care Services' insufficient oversight of payments to Medi-Cal providers allows for a high likelihood of fraud, waste, or abuse that poses a serious detriment to the State; that Health Care Services is not taking adequate corrective actions to prevent that risk; and that future audits by my office—and Health Care Services' implementation of the resulting recommendations—may significantly reduce the risk of inappropriate payments to Medi-Cal providers. After we designate a state agency or statewide issue as high risk, state law permits my office to issue audit reports with recommendations for improvement. As described previously, this report is not the result of an audit under our state high-risk audit program, rather it is a justification for the State Auditor to commit resources for future, in depth audits of Medi-Cal's payment practices for providers.

**Fraud, Waste, and Abuse Increase Medi-Cal Costs for Both
Fee-for-service and Managed Care Delivery Models**

As the State's Medicaid program, Medi-Cal offers no-cost and low-cost health coverage to *beneficiaries*, people who live in California and meet certain eligibility criteria, such as income requirements. Although local county offices manage most Medi-Cal cases—including determining whether individuals are eligible to receive Medi-Cal benefits—Health Care Services is ultimately responsible for overseeing the program. As of July 2025, Medi-Cal insured more than 14 million Californians, or more than one-third of the State's population. With approximately \$220 billion allocated for it in the State's fiscal year 2026–27 budget, Medi-Cal is currently one of California's most costly programs, and the program's budget has more than doubled during the last 10 years.

Medi-Cal provides health care to beneficiaries through two primary delivery models: fee-for-service and managed care. Under the fee-for-service delivery model, Medi-Cal directly reimburses providers for each individual service they provide to beneficiaries. Fee-for-service is primarily a temporary coverage category that typically covers beneficiaries when they first qualify for Medi-Cal services. However, fee-for-service coverage is also available for beneficiaries who qualify for an exemption from managed care because, for example, they have certain complex medical conditions. Health Care Services sets maximum allowable rates that providers participating in the fee-for-service model can charge to Medi-Cal for covered services. Providers submit claims for payment to Health Care Services' contracted claims processing partners, which evaluate the claims and either pay or deny them.

For managed care, Health Care Services contracts with health plans to provide comprehensive health care coverage through a network of providers. Medi-Cal delivers care to 95 percent of beneficiaries through managed care plans, and to compensate the plans, Health Care Services pays a *capitation rate*—a fixed, predetermined amount—to the managed care plan each month for each enrolled beneficiary, regardless of whether the beneficiary seeks Medi-Cal services during the month. Managed care plans pay providers for Medi-Cal services and bear the financial risk if a beneficiary uses more Medi-Cal services than the capitation payment covers.

Fraud, waste, and abuse in Medi-Cal provider payments increase costs to Health Care Services for both service delivery models. In the fee-for-service model, the Medi-Cal program directly overpays providers when claims are inappropriate or fraudulent. In managed care plans, inappropriate payments to providers serve to increase Health Care Services' future costs for managed care. Because Health Care Services bases the capitation rates that it pays to managed care plans in part on previous service use and cost information, undetected inappropriate payments in managed care inflate the future capitation rates that Health Care Services pays. Although Health Care Services has developed a mechanism for excluding known overpayments from its capitation rate development process, this mechanism does not safeguard the State against undetected inappropriate payments driving up Health Care Services' future capitation rates.

Health Care Services Has a Problematic History of Overseeing Medi-Cal Providers

Health Care Services has faced a history of concern from both state and federal governmental entities related to its oversight of Medi-Cal providers. My office, as well as the federal Department of Health and Human Services' Office of Inspector General (HHS-OIG) and the Centers for Medicare and Medicaid Services (CMS), have found a variety of problems over the last 15 years. These problems include payments to ineligible providers and a lack of ongoing provider oversight within the managed care system, such as through audits or data mining, making it vulnerable to ongoing fraudulent or abusive practices by providers. Although some of these issues have been resolved, recent program reviews by federal entities have continued to express concerns over the State's fraud prevention and investigative activities.

Several of the federal observations demonstrate that Health Care Services has not always prioritized correcting known issues or preventing fraud. Specifically, CMS' November 2012 and March 2016 program integrity reviews identified multiple repeat findings, including concerns related to Health Care Services not doing enough to ensure that ineligible providers do not participate in Medi-Cal, an issue that we also reported on in 2022 and that we discuss later in this assessment. In 2017, CMS twice requested that Health Care Services complete corrective action plan updates for addressing all recommendations that CMS reported in 2016, but Health Care Services did not respond to either request.

In another example, HHS-OIG's *California Medicaid Fraud Control Unit: 2023 Inspection* report, published in May 2025, noted concerns with the low number of fraud referrals that Health Care Services and managed care plans submitted to DOJ for possible criminal investigation and prosecution, which echoed a similar concern that CMS published in its September 2023 *California Focused Program Review Integrity Review: Medicaid Managed Care Oversight* report: the number of investigations managed care plans referred to Health Care Services was low for a program the size of California's. The HHS-OIG report stated that the primary factor influencing the number of fraud referrals that Health Care Services submitted to DOJ was a shift in Health Care Services' leadership priorities, which caused staff to focus their resources on activities other than fraud investigations. That report also discussed DOJ's challenges in using Medi-Cal claims data for its investigations because Health Care Services sometimes took months to process DOJ's data requests. Although HHS-OIG reported in July 2026 that these latest concerns have been largely resolved because DOJ now receives referrals directly from managed care plans and DOJ has obtained direct access to a portion of the Medi-Cal claims data, these issues demonstrate that Health Care Services has not always prioritized preventing fraud.

Our past reports have identified indications of fraud in the Medi-Cal program. In Report 2013-119, *California Department of Health Care Services: Its Failure to Properly Administer the Drug Medi-Cal Treatment Program Created Opportunities for Fraud*, August 2014, we identified nearly \$94 million in payments to providers who had indicators of fraudulent activity. Likewise, in Report 2021-123, *California Hospice Licensure and Oversight: The State's Weak Oversight of Hospice Agencies Has Created Opportunities for Large-Scale Fraud and Abuse*, March 2022, we identified numerous indicators of fraud and abuse by hospice agencies that affected both the federal Medicare program and Medi-Cal. In that report, we also determined that hospice agencies likely overbilled Medi-Cal by at least \$3.1 million in 2019 for fee-for-service payments and that data limitations prevented us from including in our overbilling estimate similar payments for managed care.

Health Care Services acknowledges that the size and complexity of the Medi-Cal program create a significant risk of undetected fraud, waste, and abuse in Medi-Cal billing. Further, Health Care Services identified more than \$2 billion in cumulative overpayments to Medi-Cal providers from fiscal years 2020–21 through 2024–25, \$300 million of which Health Care Services states that it has not yet recovered from the providers. According to Health Care Services, recovery of overpayments occurs on a flow basis with dollars being collected over multiple years. Further, new overpayments are identified each fiscal year, which adds to the cumulative amount of overpayments for collection. According to Health Care Services, recently identified overpayments may have lower rates of collection compared to older debts because not enough time has elapsed for collection, which may skew the overall appearance of its progress toward collecting overpayments. However, Health Care Services acknowledged that in some cases, overpayments remain outstanding because the provider is out of business or not working and, therefore, no longer has the means to pay back what it owes.

Health Care Services Is Responsible for Detecting, Evaluating, and Investigating Potential Fraud, Waste, and Abuse in the Medi-Cal Program

As the department responsible for Medi-Cal program integrity and oversight, Health Care Services receives and logs in its case tracking system a monthly average of nearly 2,000 complaints, reports, and allegations of suspected fraud, waste, or abuse—collectively known as referrals. Referrals can include specific allegations of fraud or indicators of potential fraud, both of which may warrant further research. Referrals can be complaints that beneficiaries, providers, or other members of the public submit to Health Care Services, but other entities, such as managed care plans or Health Care Services' own audits or data analytics groups, may also forward or create referrals.

Health Care Services does not need to investigate every referral. To determine which referrals to investigate, Health Care Services performs initial research, during which staff evaluate and rank each referral according to program risk, taking into consideration factors such as the egregiousness of the suspected fraud and sufficiency of the evidence. Based on this review, Health Care Services may close a referral without investigating if it determines, for example, that the referral does not warrant an investigation; that the managed care plan took sufficient action to address the provider's suspected fraud, waste, and abuse; or that the referral is lower risk and Health Care Services wants to prioritize investigating other referrals that are more likely to result in a credible allegation of fraud.

After it opens an active investigation, Health Care Services can temporarily suspend a provider. However, Health Care Services noted that unless the case involves beneficiary harm or egregious fraud, it typically waits until it refers a case to DOJ before it limits payments to providers because such actions may impede beneficiary access to care and have a large negative impact on providers—such as possibly resulting in the end of their businesses—when cases may end up being closed without prosecution or a conviction.

Investigations that Health Care Services opts to perform can culminate in several different outcomes. Health Care Services may impose a variety of remedies, such as initiating recovery of payments that it made for inappropriate billing or sending an educational letter to the provider. If investigators in Health Care Services' Audits and Investigations Division establish a credible allegation of fraud, it refers the case to DOJ and is supposed to suspend payments to the provider, unless it has good cause to believe that suspending payments could jeopardize the investigation. In some instances, Health Care Services closes the investigation because it lacks evidence of wrongdoing.

We observed that the risk of inappropriate payments can continue even after Health Care Services refers a provider to DOJ for possible criminal investigation and prosecution. Specifically, in early 2026, Health Care Services referred a provider to DOJ for overprescribing medication. According to Health Care Services, it should have suspended the provider from participating in the Medi-Cal program, but it did not do so due to its own internal oversight. Health Care Services confirmed that during the ensuing five-month period, this provider issued an additional \$200,000 worth of Medi-Cal prescriptions for beneficiaries. The acting deputy director and assistant deputy director of Health Care Services' Audits and Investigations Division acknowledged that our inquiry into this provider triggered a review that allowed it to identify the oversight and begin processing the suspension.

Despite Identifying Providers With High Risk Scores, Health Care Services Has Not Followed Up on More Than 26,000 of Them

Health Care Services has developed multiple risk assessment tools for measuring the risk that providers are inappropriately billing for Medi-Cal services.² Each risk assessment tool focuses on risk indicators specific to a particular aspect of the Medi-Cal program and can identify providers with billing activity or patterns that may indicate potentially fraudulent, wasteful, or abusive activity. Health Care Services explained that the risk scores from these tools—in conjunction with other analytic tools and information—support audits and guide program integrity investigations. However, despite Health Care Services having proactively developed such tools and identified indicators of potential wrongdoing, it has yet to create a referral for, or investigate, most providers its largest risk assessment tool identifies as having the highest risk scores. This risk assessment tool assigns each provider a risk score based on factors such as unusual provider behavior or billing patterns.

However, a former acting chief of Health Care Services' Data Analytics and Case Development Branch explained that a high risk score does not necessarily indicate fraud. She said that a sudden increase in a provider's billing activity compared to its historical billing trends could be an indicator of fraud, waste, or abuse, but atypical billing activity could also be the result of business changes, such as the implementation of a new program, a change in provider ownership, or other legitimate changes in provider activity. She further noted that because Health Care Services does not have direct control over the data that the managed care plans submit, those data are sometimes incomplete, missing, or inaccurate, which may affect the sensitivity and reliability of the risk assessment tools. Although the risk assessment tools evaluate providers for indicators of potentially fraudulent activity, Health Care Services must still perform additional research to determine whether providers that receive high risk scores are committing fraud, waste, or abuse.

² We provide only limited information about Health Care Services' risk assessment tools to protect the integrity of the tools and avoid disclosure of sensitive operational details.

Federal best practices published by HHS-OIG provide examples of various analyses that entities like Health Care Services may use to identify providers for further follow-up. These analyses include evaluating the amount of time providers spent per beneficiary visit, the number of beneficiaries providers saw per day, and whether providers billed for an improbable number of visits in a single day. The goal of these analyses is to identify providers whose billing may pose a risk and who thus warrant further scrutiny.

Although its largest risk assessment tool considers these types of risks indicators, we found that Health Care Services did not follow up on the majority of providers with the highest risk scores. To evaluate Health Care Services' use of the risk assessment tool's results, we analyzed the approximately 28,000 providers with risk scores in the highest 10 percent per Health Care Services' own metrics for fiscal year 2024–25. Among those, we identified more than 26,000 providers for which Health Care Services had not initiated any referrals or investigations as of March 2026, despite these providers collectively accounting for at least \$12 billion in Medi-Cal services for fiscal year 2024–25.³ While it is likely that not all \$12 billion is related to fraud, waste, or abuse, even a small percentage represents a significant amount of money. For example, even 1 percent of this amount equates to \$120 million. In addition, a 2023 report by CMS estimated that the percentage of Medi-Cal payments that were inappropriate was approximately 8 percent. Although this estimate did not account for a variety of risks related to improper managed care payments, should this estimate hold true for the 26,000 providers, it would equate to nearly \$1 billion in inappropriate payments. This amount is roughly equivalent to the amount of state funds California's enacted budget for fiscal year 2026–27 allocated for DOJ or the Department of Water Resources.

³ We used only fiscal year 2024–25 data in our assessment, and the data do not include some types of Medi-Cal claims, such as dental claims.

Moreover, we identified examples within this population that warrant further scrutiny. Five of the providers that Health Care Services' largest risk assessment tool designated as being in the top 3 percent of risk scores, and we agree with Health Care Services' assessment that these providers' high volume of claims appear to indicate potential risk. These providers used a Medi-Cal billing procedure code intended for office visits requiring a low level of medical decision-making and commonly lasting between 20 and 29 minutes. If we presume an eight-hour workday, we would expect that each provider would generally see two to three beneficiaries per hour, although the length of the actual office visits may vary. However, on days when these providers used this procedure code, they claimed to have seen more than three beneficiaries per hour during nearly 80 percent of their workdays, and that number does not account for other services they may have provided during those same hours or services during which they were supervising another provider, such as a physician assistant or nurse practitioner, who was treating the beneficiary. In fact, Providers A through D claimed to have seen an average of more than seven beneficiaries per hour, equating to the providers having spent an average of fewer than nine minutes with each beneficiary, which is significantly less than the 20 to 29 minutes that appointments for this billing code commonly last.⁴

Health Care Services states that this risk assessment tool is intended to cast a wide net to find potential anomalies and is only one of multiple factors when evaluating the risk for fraud, waste, and abuse. However, the thousands of providers the tool assigned a high risk score, whom Health Care Services has not initiated any referrals or investigations represent a missed opportunity for the department to scrutinize providers with indicators of potential risk. While all 26,000 providers may not require an investigation, many likely do warrant further scrutiny.

⁴ To preserve the integrity of future and ongoing investigations, we are not publicly disclosing the names of the providers we use as examples of potential fraud, waste, and abuse. Instead, we have assigned each of these providers a letter that we use throughout the report.

**Health Care Services Has Missed Opportunities
to Prevent Future Questionable Payments**

Health Care Services receives a monthly average of nearly 2,000 referrals of suspected fraud, waste, or abuse. When it receives referrals, Health Care Services reviews and evaluates them to determine the next action it takes, which may include conducting more research, sending educational letters to providers, opening a case for investigation, or forwarding the referral to another agency. If it determines that the referral warrants an investigation, Health Care Services ranks the case based on risk factors and assigns it to one of its about 140 investigative staff. We found that Health Care Services investigates less than 15 percent of referrals. Health Care Services asserts that although not all referrals warrant an investigation, its limited resources prevent it from pursuing more fraud investigations than it currently conducts, which we discuss in the next section.

Health Care Services is not the only entity that can investigate suspected provider fraud: managed care plans also perform such inquiries. Managed care plans are contractually required to report any suspected fraud, waste, and abuse to Health Care Services within 10 business days, at which time Health Care Services creates a referral for the provider in its case tracking system. However, the efforts of both Health Care Services and the managed care plan are sometimes insufficient to address inappropriate Medi-Cal billing. We observed instances in which providers continued billing for and receiving millions of dollars for questionable Medi-Cal services after Health Care Services closed a referral for a provider whom the managed care plan investigated and identified inappropriate payments.

Provider F, a hospice provider, was the most financially significant of the three examples. Health Care Services received a referral during the first half of fiscal year 2023–24 stating that the managed care plan was investigating Provider F for submitting claims for services that it allegedly did not provide. According to Health Care Services' notes, the managed care plan made multiple attempts to follow up with Provider F during the investigation, but Provider F did not respond. Consequently, the managed care plan concluded that Provider F had inappropriately billed for the services and issued an overpayment letter to Provider F because of its noncompliance. Health Care Services noted that the managed care plan was able to recover about \$41,000—or a little more than half—of the \$78,000 that Provider F received for the services it allegedly did not provide.

Despite the managed care plan's finding and Provider F's nonresponsiveness, Health Care Services closed the referral in its case tracking system during the second half of fiscal year 2023–24, rather than following up. The former acting chief of Health Care Services' Data Analytics and Case Development Branch explained that it closed the referral for Provider F because the managed care plan was sending the provider an overpayment letter, Provider F did not trigger any alerts in its fraud and abuse detection system, and Provider F had no additional referrals on file. Nonetheless, given the earlier indicators of inappropriate billing, Provider F's nonresponsiveness during the managed care plan's investigation, and the fact that Health Care Services is ultimately responsible for overseeing the Medi-Cal program, we expected that Health Care Services would have immediately escalated follow-up procedures, such as conducting its own investigation to see if it could establish a credible allegation of fraud and suspend payments to Provider F to prevent future questionable payments.

In the meantime, Provider F went on to bill more than \$5.5 million for Medi-Cal services in fiscal year 2024–25. It was not until the end of fiscal year 2024–25—or more than one year after it closed the initial referral—that Health Care Services created another referral for Provider F, citing a variety of fraud indicators that included a sudden increase in billing. Health Care Services investigated and determined that Provider F was fraudulently billing managed care plans for Medi-Cal services—including billing for individuals who asserted that they were not receiving hospice care. In April 2026, Health Care Services referred the case to DOJ for criminal investigation and prosecution; as of July 2026, DOJ had yet to file charges against Provider F.

Although Health Care Services has a process for excluding known overpayments from its rate development process when establishing future capitation rates for managed care plans, the examples we present demonstrate the risk that Health Care Services is letting some questionable costs continue, even after it has become aware of wrongdoing by providers. Further, although Health Care Services ultimately referred Provider F and Provider G to DOJ for possible criminal investigation and prosecution for fraud, it has not performed further follow up on Provider H, despite a history of overbilling and continued questionable claims. To the extent that any of Provider H's claims are inappropriate, they could increase the future capitation rates that Health Care Services pays for managed care.

**Limited Resources May Contribute to Health Care
Services Not Identifying Additional Fraud**

Although we would expect Health Care Services to follow up on more of the providers with indicators that point to a high risk of fraud, waste, or abuse to ensure the appropriateness of their claims, Health Care Services asserts that it has limited resources and has not researched or investigated all such providers. Health Care Services explained to us that it considers a variety of factors in prioritizing which referrals to investigate, including the egregiousness of the suspected fraud and the potential for harm to beneficiaries. In one case, Health Care Services' staff recommended a provider for investigation for overbilling for office visits associated with COVID-19 tests, but we observed that the investigation notes indicated no activity for more than two years. The staff notes on the closure date for this referral explain that the allegations were now old, that the case had low materiality, that Health Care Services lacked resources, and that they recommended closing the case and monitoring the provider activity.

Increasing resources for fraud prevention would likely prevent additional fraud and result in savings that exceed the additional investment. When we followed up about its investigative staffing levels, Health Care Services provided information showing that these staffing levels have remained relatively stagnant over the last 11 years. While staffing ranged from a low of 112 to a high of 159 during this period, the number of investigative staff in 2016 was about the same as 2026: 137 staff members compared to 141 staff members. However, over this same period, the Medi-Cal budget more than doubled. The number of investigative staff per billion dollars spent on Medi-Cal dropped significantly.

Health Care Services had 1.69 investigative staff for every billion dollars spent on Medi-Cal in 2016. However, the number of investigative staff per billion dollars spent on Medi-Cal dropped by 57 percent to 0.73 by 2026. Health Care Services explained that this decrease coincides with a shift in beneficiaries moving from a fee-for-service to a managed care delivery system—an average of 79 percent of beneficiaries in 2016 were enrolled in a managed care plan compared to 95 percent in 2026. Additionally, Health Care Services contractually requires managed care plans to conduct their own investigations, which provide further monitoring of fraud, waste, and abuse beyond Health Care Services' Audits and Investigations Division. However, investigations by managed care plans have not always been successful in stopping questionable payments, and Health Care Services remains ultimately responsible for ensuring payments are appropriate.

Health Care Services asserts that it seeks to prevent all fraud, waste, and abuse in Medi-Cal and that it saves \$8.60 for every \$1 it spends on its Audits and Investigations Division. Although Health Care Services stated during our assessment that more resources would surely result in more fraud prevention, it believed that it struck the proper balance of investment and return. Given that resources dedicated to fraud prevention deliver savings that far outweigh the initial investment and that Health Care Services believed dedicating additional resources would prevent more fraud, it is unclear why Health Care Services believed its resource level struck the proper balance, especially considering the State's significant public investment in Medi-Cal.

**Health Care Services Allowed Payment of
Medi-Cal Claims to Ineligible Providers**

The HHS-OIG maintains a list of nearly 83,000 individuals and entities that are excluded from receiving payments from federally funded health care programs for various reasons, such as a conviction for Medicaid fraud. Likewise, Health Care Services maintains a list of almost 23,000 providers that are suspended from and ineligible to participate in the Medi-Cal program. Both lists are publicly available on the internet. State law generally requires that Health Care Services suspend providers from the Medi-Cal program when they have a license, certificate, or other approval to provide health care that is revoked or suspended by a federal, California, or another state's approval authority.

Even though Health Care Services has a process for identifying ineligible providers and suspending their eligibility to receive Medi-Cal payments, we found instances of ineligible providers participating in Medi-Cal. When we compared Medi-Cal claims data for fiscal year 2024–25 to the federal and state lists of ineligible providers, we identified two providers that collectively billed for almost \$1.6 million in Medi-Cal services, despite each provider having become ineligible to participate in the Medi-Cal program years earlier. We found that the California Department of Public Health (Public Health) revoked Provider I's hospice license in late 2020, but Health Care Services did not learn of the revocation until nearly five years later while investigating Provider I in fiscal year 2025–26. Because Health Care Services had yet to add Provider I to the State's ineligible list, Provider I billed for nearly \$1.3 million in Medi-Cal services through a managed care plan for fiscal year 2024–25. We did not identify any fee-for-service billings for Provider I during fiscal year 2024–25; Health Care Services asserts that it completed efforts to identify and recoup any fee-for-service payments made after the retroactive effective date of the suspension and confirmed that there were no erroneous fee-for-service billings past October 2020. Health Care Services explained that after learning that Provider I was ineligible to participate in the Medi-Cal program, it notified the provider in August 2025 that it would be added to the State's ineligible list retroactive to 2020, which is why we found Provider I on the State's ineligible list when we performed our analysis in May 2026.

According to Health Care Services, there does not yet exist an automatic way for it to receive notification when Public Health revokes a provider's license; rather, Health Care Services depends on Public Health to manually transmit notice of a revocation. Health Care Services recognizes that this process can cause delays, and it explained that it has ongoing workgroups and recurring coordination meetings with Public Health focused on improving cross-agency communication and data flow. Health Care Services stated that as part of these efforts, it is exploring options for an automated notification or data-sharing process so that it can address any future revocations promptly.

The problems we identified involving the second provider were similar. Specifically, the federal Drug Enforcement Administration revoked this provider's certification to administer or prescribe controlled substances in fiscal year 2021–22. Although Health Care Services was aware of the revocation in January 2024 and subsequently added the provider to the State's ineligible list, we observed that the provider billed more than \$300,000 in Medi-Cal services through a managed care plan for fiscal year 2024–25. According to Health Care Services, it relies on the managed care plans to address claims paid to suspended providers. Although we did not identify any fee-for-service billings for this provider during fiscal year 2024–25, Health Care Services asserts that it completed an erroneous payment correction for this provider in April 2026 for any associated fee-for-service payments and recouped an overpayment of nearly \$1,300.

Health Care Services allowing ineligible providers to participate in Medi-Cal is a long-standing problem. In 2012, CMS pointed out gaps in Health Care Services' screening of providers that are ineligible to participate in the Medi-Cal program and—four years later—reported that this issue was unresolved. We also identified payments to ineligible providers in Report 2021-046, *Proposition 56 Tobacco Tax: The Department of Health Care Services Is Not Adequately Monitoring Provider Payments Funded by Tobacco Taxes*, November 2022. In response to that report, Health Care Services implemented changes to its provider suspension process that became effective April 2025. Most recently, the former acting chief of Health Care Services' Data Analytics and Case Development Branch asserted that Health Care Services is also looking into how to receive notification of disciplinary actions from the federal Drug Enforcement Administration. Although these are positive steps, as the single agency responsible for administering the Medi-Cal program, Health Care Services must ensure that it pays only eligible providers.

**We Identified Many Inappropriate Medi-Cal
Payments for Ground Transportation Services**

For situations involving medical emergencies, emergency medical transportation is available for Medi-Cal beneficiaries. Medi-Cal also covers two types of nonemergency ground transportation services to help beneficiaries get to and from Medi-Cal services: nonemergency nonmedical transportation and nonemergency medical transportation. For beneficiaries who do not have another way to get to their Medi-Cal appointment because, for example, they do not have a valid driver's license or money for gas, or they have a physical, cognitive, mental, or developmental limitation, Medi-Cal provides roundtrip, nonmedical transportation service by private or public vehicle, such as a passenger car or taxicab. For beneficiaries to obtain necessary nonemergency medical care when their medical and physical condition make ordinary modes of transportation unsuitable, Medi-Cal covers nonemergency medical transportation by vehicles such as a wheelchair van or nonemergency ambulance.

Medi-Cal has separate mileage rates for nonmedical and medical transportation services. Because the fiscal year 2024–25 rate for nonemergency ambulances for medical transportation was nearly three times more than nonmedical modes of transportation, it makes sense that the State's Medi-Cal regulations require Medi-Cal to provide reimbursement only for the type of nonemergency medical transportation with the lowest cost that is adequate for the beneficiary's medical needs and that is available at the time transportation is needed.

Health Care Services acknowledges that a variety of fraud schemes may occur in ground transportation, including the practices of *phantom trips* and *upcoding*, which respectively refer to providers billing for trips that never occurred or claiming higher rates that are not commensurate with the actual service provided. For this reason, Health Care Services included ground transportation on its list of high-risk service categories and provider types that require a priority focus. In 2024, Health Care Services forwarded to DOJ credible allegations of fraud against two transportation providers. However, as of July 2026, Health Care Services had not forwarded any additional ground transportation providers to DOJ for possible criminal investigation and prosecution.

When we analyzed claims data for fiscal year 2024–25, we identified more than 130 transportation providers who overbilled the mileage rate for nonemergency ground transportation services for Medi-Cal beneficiaries. These transportation providers claimed mileage at a rate intended for nonemergency ambulance trips, even though the claims were for services involving other vehicle types, such as taxicabs and wheelchair vans. In total, these transportation providers received nearly \$31 million more than the allowable rate for fiscal year 2024–25.

Among those transportation providers that we identified with suspicious billing activity was Transportation Provider J, for which Health Care Services already had two referrals on file. Transportation Provider J both overbilled mileage and claimed suspicious trips with the single-passenger vehicle he had registered with the program. For example, we found that Transportation Provider J claimed to have provided almost daily nonmedical transportation of more than 300 miles to a single beneficiary during a five-month period. However, even if the trips were legitimate, we found that Transportation Provider J billed and was reimbursed at the nonemergency ambulance rate of \$3.55 per mile instead of the \$1.30 per mile rate allowed for nonmedical transportation.

As Figure 8 shows, Transportation Provider J's overbilling totaled more than \$105,000 in claims for the beneficiary during the five-month period. When we asked Health Care Services about this overbilling, it followed up with the managed care plan and learned that the managed care plan had erroneously instructed providers to make claims at the nonemergency ambulance rate. Even though Health Care Services was already aware of potential wrongdoing by Transportation Provider J from prior referrals, the fact that neither Health Care Services nor the managed care plan recognized the mistaken billing rate or the extreme mileage demonstrates the opportunity for more proactive research and investigation.

Transportation Provider J also claimed to have provided almost daily trips for multiple other beneficiaries over an extended period. Although Transportation Provider J's program enrollment documents show that he had only one vehicle for transportation, he claimed trips for 35 beneficiaries on a single day, nine of which individually exceeded 340 miles. If these nine trips were legitimate, it would mean that Transportation Provider J traveled more than 3,000 miles on that day for just those nine trips alone, not to mention the miles he would have traveled for the other 26 trips he claimed to have driven. When we brought this example to Health Care Services' attention, a research data specialist from its Audits and Investigations Division explained that it would need to conduct a full investigation to confirm that the trips occurred as reported and that the claims were compliant with Medi-Cal policy. In total, Transportation Provider J claimed more than \$11 million in fiscal year 2024–25. As a result of our inquiry and follow up about Transportation Provider J with Health Care Services, Health Care Services created a referral in its case tracking system for Transportation Provider J in April 2026.

Of the other two referrals of potential fraud or abuse on file for Transportation Provider J, the managed care plan initiated one after receiving a complaint alleging that Transportation Provider J offered payment and gifts to multiple Medi-Cal beneficiaries in exchange for their requesting unnecessary transportation services, for which Transportation Provider J could then bill Medi-Cal. Although the managed care plan informed Health Care Services in 2024 that it was investigating this particular complaint, Health Care Services' case tracking system did not contain any subsequent updates on the investigation until nearly two years later and only after we questioned Health Care Services about Transportation Provider J. When Health Care Services contacted the managed care plan in April 2026 for an update on the investigation, it learned that although the managed care plan suspected Transportation Provider J of potential fraud, waste, or abuse, it could not substantiate misconduct with its available resources and investigation methods. The managed care plan stated that it ended the contract with Provider J in June 2025 for business reasons that were not specifically related to program integrity.

The research data specialist in Health Care Services' Audits and Investigations Division echoed the managed care plan's perspective regarding the difficulty of substantiating wrongdoing by transportation providers. He explained that Health Care Services previously identified and researched certain instances of transportation claims that did not have a corresponding medical office visit or treatment for the beneficiary on the same day. He said that although Health Care Services initiated an investigation into a provider, it closed the case without further action, partly because nonemergency nonmedical transportation policy requirements make it difficult for the department to prove fraud, waste, or abuse. Even though Health Care Services' transportation policy typically allows beneficiary trips for certain nonmedical transport to have no more than eight segments—or four roundtrips—each month, all that the policy requires for a beneficiary to receive additional transportation services is for the transportation provider to submit documentation that the beneficiary asserted that they required the additional transportation to obtain necessary Medi-Cal services.

The Medi-Cal Benefits Policy Branch chief acknowledged that these less-than-robust utilization control policies and minimal documentation requirements can make identifying fraud, waste, and abuse more challenging. He said that Health Care Services is currently updating its transportation policy with additional utilization controls that will allow it to strengthen oversight. He emphasized that the goal of the new policy is to balance beneficiary access to care, provider administrative burden, and program integrity considerations.

**An Audit Could Help Reduce the Risk of Medi-Cal's
Making Inappropriate Payments to Providers**

As this assessment highlights, Health Care Services can improve its process for following up on high-risk Medi-Cal providers, its process for preventing payments to ineligible Medi-Cal providers, and its policy for nonemergency ground transportation services. Because Health Care Services has not taken adequate corrective action to manage these risks, we conclude that it is appropriate for us to update the state high-risk list description for Health Care Services to include the risk of serious detriment that inappropriate Medi-Cal payments to providers pose to the State. This conclusion permits my office to, in future engagements, self-initiate audits of Health Care Services' oversight of payments to Medi-Cal providers and issue recommendations that may significantly reduce the risks of fraud, waste, and abuse.

Perspective From Health Care Services

Health Care Services disagreed with our overall conclusion to include its oversight of payments to Medi-Cal providers as an additional rationale for the department's inclusion on the State high-risk list, but acknowledged that it could do more. Specifically, Health Care Services stated that if it was allocated additional resources it could address additional credible referrals or leads from data analytics.

We prepared this report under the authority vested in the California State Auditor by Government Code section 8546.5 and pursuant to title 2, sections 61000 et seq. of the Code of Regulations.

Respectfully submitted,

GRANT PARKS
California State Auditor

Above report referred to the Committee on Health.

ROBERT RIVAS, Speaker

RUSSELL C. TOMAS, Minute Clerk