

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA IMPROPERLY CLAIMED AT
LEAST \$23 MILLION OF \$260 MILLION
IN TOTAL MEDICAID REIMBURSEMENT
FOR OPIOID TREATMENT
PROGRAM SERVICES**

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**April 2022
A-09-20-02009**

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

Date: April 2022

Report No. A-09-20-02009



Why OIG Did This Audit

The United States currently faces a nationwide public health emergency due to the opioid crisis. Opioid treatment programs (OTPs) provide medication coupled with counseling services (referred to in this report as “OTP services”) for people diagnosed with an opioid use disorder. This audit is part of OIG’s oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis. Based on our prior audit of a selected OTP in California, we identified that there was a risk of improper Medicaid reimbursement for OTP services. Therefore, we performed this statewide audit of OTP services in California for calendar years 2018 and 2019.

Our objective was to determine whether California claimed Medicaid reimbursement for OTP services that met Federal and State requirements.

How OIG Did This Audit

Our audit covered Medicaid claims for OTP services provided from January 2018 through December 2019 (audit period), with Medicaid reimbursement totaling \$371.6 million (\$259.8 million Federal share).

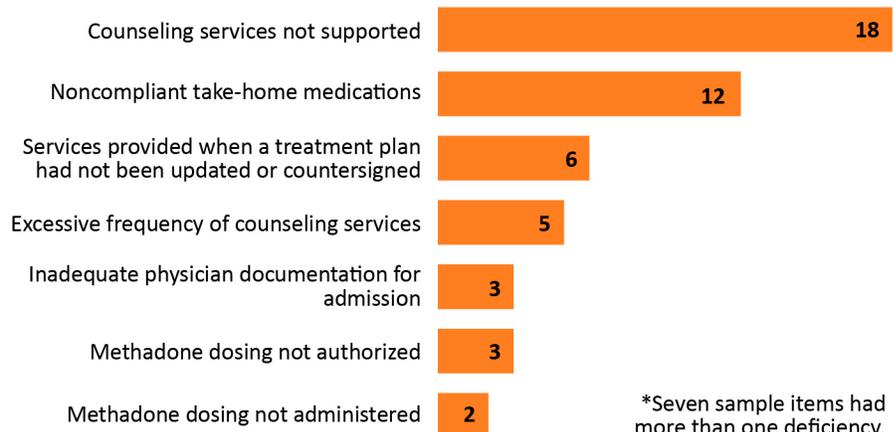
We reviewed a stratified random sample of 130 beneficiary-months to determine compliance with Federal and State requirements. A beneficiary-month (which we refer to as a “sample item”) included all claims for OTP services provided to a beneficiary in a month.

California Improperly Claimed at Least \$23 Million of \$260 Million in Total Medicaid Reimbursement for Opioid Treatment Program Services

What OIG Found

California claimed Medicaid reimbursement for some OTP services that did not meet Federal and State requirements. Of the 130 sample items, 88 had services that were all allowable, but 42 had services that were unallowable.

Deficiency and Number of Sample Items With Unallowable Services*



On the basis of our sample results, we estimated that California claimed at least \$23.1 million in unallowable Federal Medicaid reimbursement for OTP services during our audit period. In addition, we identified deficiencies in three areas that did not result in unallowable services but could impact the quality of care provided to beneficiaries receiving OTP services.

What OIG Recommends and California Comments

We recommend that California refund \$23.1 million to the Federal Government and take specific actions to address the deficiencies that we identified. In addition, we recommend that California take actions to ensure that OTPs comply with Federal and State requirements for providing and claiming reimbursement for OTP services. (The full text of our recommendations is shown in the report.)

California agreed with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations, including reviewing and monitoring corrective action plans and conducting additional postservice postpayment reviews of OTPs.

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INTRODUCTION

WHY WE DID THIS AUDIT

The United States currently faces a nationwide public health emergency due to the opioid crisis. The high potential for misuse of opioids has led to alarming trends across the country, including record numbers of people developing opioid use disorders. In 2020 alone, there were nearly 70,000 opioid-related overdose deaths in the United States. Opioid treatment programs (OTPs) provide medication coupled with counseling services (referred to in this report as “OTP services”) for people diagnosed with an opioid use disorder. As part of the Office of Inspector General’s (OIG’s) oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis, we decided to audit OTP services in California. Based on our prior audit of a selected OTP in California, we identified that there was a risk of improper Medicaid reimbursement for OTP services.¹ Therefore, we performed this statewide audit of OTP services in California for calendar years (CYs) 2018 and 2019.

OBJECTIVE

Our objective was to determine whether California’s Department of Health Care Services (the State agency) claimed Medicaid reimbursement for OTP services that met Federal and State requirements.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Opioid Treatment Program Services

Each State’s Medicaid program may cover substance-use-disorder treatment services, including services provided by OTPs.² OTPs provide detoxification and maintenance treatment. During detoxification treatment, a patient receives a narcotic replacement medication, such as

¹ *California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider’s Opioid Treatment Program Services* ([A-09-20-02001](#)), issued Jan. 25, 2021. Appendix B lists OIG reports related to opioid treatment and prescription drug monitoring programs.

² OTPs’ physicians, nurses, and other licensed professional care providers, including addiction counselors, must comply with the credentialing requirements of their respective professions (42 CFR § 8.12(d)).

methadone, in decreasing dosages to ease adverse physical and psychological effects caused by withdrawal from long-term use of an opiate, such as heroin. During maintenance treatment, a patient receives narcotic replacement medication in stable and medically determined doses. A patient may be authorized to receive medication for unsupervised, “take-home” use.³ OTPs must also provide counseling services to each patient as clinically necessary. The purpose of comprehensive maintenance treatment is to reduce or eliminate chronic opiate addiction while the patient is provided a comprehensive range of additional treatment services.

California’s Opioid Treatment Program Services

In California, Medicaid is referred to as “Medi-Cal.” There are two Medi-Cal programs covering OTP services: Drug Medi-Cal (DMC) and DMC Organized Delivery System (DMC-ODS). The State agency administers these programs.

Under the CMS-approved State plan, the DMC program pays for substance-use-disorder treatment services provided to eligible Medi-Cal beneficiaries by DMC-certified providers, including OTPs. OTP services are covered when furnished by OTPs that have a contract with the State agency, or that have a contract with or are operated by their respective counties. OTPs and counties submit claims for OTP services to the State agency for reimbursement. The State agency reimburses OTPs and counties based on statewide rates.

The DMC-ODS program is a demonstration project that offers California counties—through a Medicaid section 1115 waiver—the opportunity to expand access to high-quality care for Medicaid beneficiaries with a substance-use-disorder.^{4,5} Counties may elect to enter into an intergovernmental agreement with the State agency to provide or arrange for the provision of DMC-ODS services through a Prepaid Inpatient Health Plan.⁶ OTPs that provide services through the DMC-ODS program may be county-contracted or county-operated. An OTP submits claims to its respective county, and the county certifies the claims before submitting them to the State agency for reimbursement. The county reimburses the OTP at the lower of the statewide rates or the provider’s usual and customary charge to the general public.

³ We refer to these medications as “take-home medications.” A take-home medication is the supply of a narcotic medication provided for unsupervised use by a patient at home. It may be authorized for a single day or for a span of multiple days in lieu of having the patient ingest the dose under supervision.

⁴ On December 30, 2015, CMS approved an extension of California’s section 1115(a) Medicaid waiver, known as Medi-Cal 2020, through December 31, 2020. Under the waiver, California established the DMC-ODS program.

⁵ The goal of the DMC-ODS program is to demonstrate how organized substance-use-disorder care improves beneficiary health outcomes while decreasing systemwide health care costs. Counties that choose to participate in the DMC-ODS program are required to provide access to a full continuum of substance-use-disorder benefits modeled after the [American Society of Addiction Medicine Criteria](#). Accessed on Feb. 3, 2022.

⁶ A Prepaid Inpatient Health Plan is an entity that provides medical services to enrollees under contract with the State agency.

California counties and OTPs that have a contract with the State agency submit claims electronically to the Short-Doyle Medi-Cal system for adjudication.⁷ This claims adjudication system validates the file format of the claims and uses certain business rules or system edits when adjudicating the claims.⁸ For example, the number of units billed for methadone must equal the number of days in the service date range.

OTP services covered by the State plan under the DMC program are available to all beneficiaries in all counties. Beneficiaries who reside in counties that opt into the DMC-ODS program receive additional services that are not covered by the State plan. Table 1 summarizes the OTP services covered under the DMC and DMC-ODS programs.

Table 1: OTP Services Covered Under the DMC and DMC-ODS Programs

OTP Services Covered Under the DMC Program	OTP Services Covered Under the DMC-ODS Program
<ul style="list-style-type: none"> • Intake (i.e., admission process) • Individual and group counseling • Patient education • Medical psychotherapy • Medication services (methadone only) • Collateral services • Crisis intervention services • Treatment planning and discharge services* 	<ul style="list-style-type: none"> • All services covered under the DMC program • Additional medication services (buprenorphine, disulfiram, and naloxone)[†] • Recovery services • Withdrawal management

* Treatment planning is the preparation of a treatment plan that includes a patient’s short-term goals, tasks that the patient must perform to complete those goals, and services that the patient needs. The treatment plan must identify the frequency with which these services are to be provided.

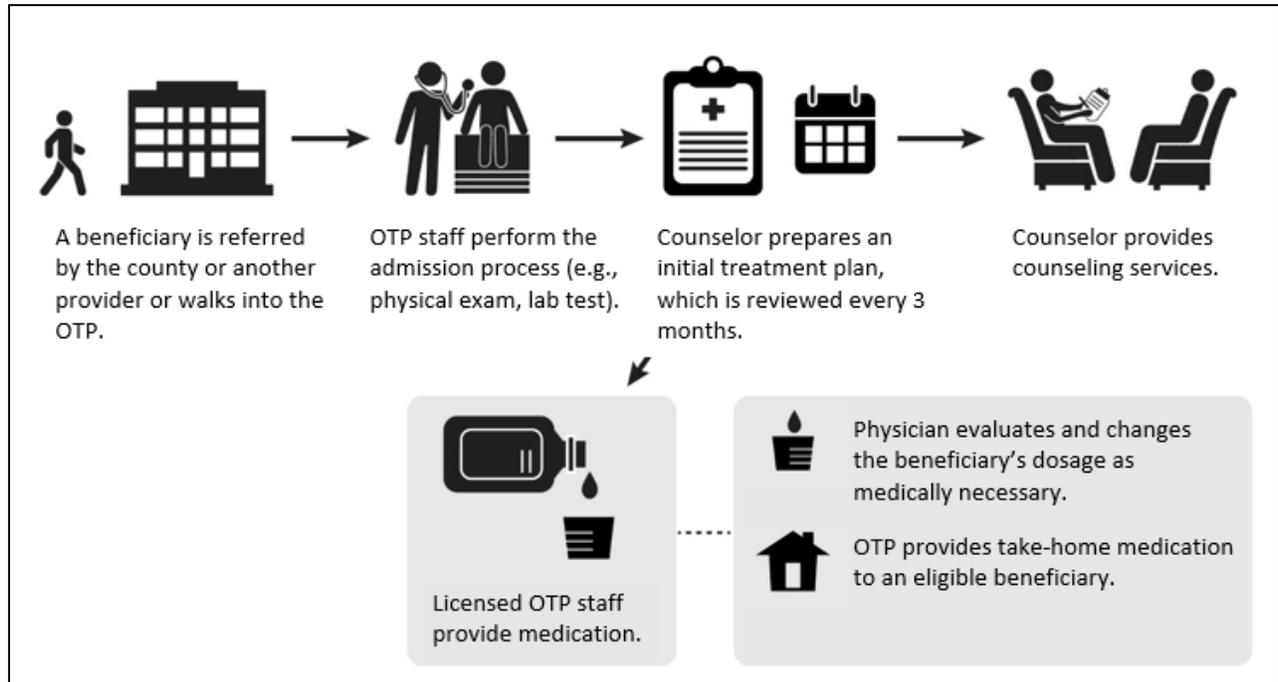
[†] Buprenorphine is used to treat opioid use disorder, disulfiram is used to treat alcohol use disorder, and naloxone is used to reverse an opioid overdose.

⁷ The submission process and format of electronic claims under the DMC and DMC-ODS programs are the same.

⁸ An edit is programming within the claims processing system that verifies and validates claim information to determine whether a claim should be paid, denied, or suspended for manual review.

The figure shows an OTP's general process for providing maintenance treatment services.

Figure: An OTP's General Process for Providing Maintenance Treatment Services



Administration of Opioid Treatment Program Services in California

The State agency administers the DMC and DMC-ODS programs. It is responsible for implementing applicable statutory and regulatory requirements for licensure and for monitoring the compliance of all public and private OTPs in California.⁹

The State agency performs annual provider-licensing inspections to determine whether OTPs under the DMC and DMC-ODS programs complied with Federal and State requirements.¹⁰ As part of these licensing inspections, the State agency selects a certain number of patient records at each OTP to review whether the OTP met these requirements. Once the inspection of an OTP is completed, the State agency issues to the OTP a report with findings, which requires the OTP to submit a corrective action plan for each deficiency identified. The OTP submits the corrective action plan to the State agency for review and followup.

Furthermore, for OTP services provided under the DMC program, the State agency performs “postservice prepayment” monitoring reviews and “postservice postpayment” utilization

⁹ The purpose of statutory and regulatory requirements is to ensure the safety and well-being of OTP beneficiaries, the community, and the public.

¹⁰ OTPs must comply with 42 CFR part 8; the California Health and Safety Code, sections 11839 through 11839.34; and the California Code of Regulations (CCR), Title 9, division 4, chapter 4, sections 10000 through 10425.

reviews of OTPs.¹¹ These reviews verify whether OTPs are in compliance with standards of care and other DMC requirements.¹² For OTPs that are audited on a prepayment basis, the State agency reviews beneficiary records (e.g., admission and treatment plan documentation) before claims are paid. For OTPs that are audited on a postpayment basis, the State agency recovers from each OTP the payments made for OTP services that were not provided in full compliance with State regulations (22 CCR § 51341.1(k)).

In addition, for counties under the DMC-ODS program, the State agency performs programmatic compliance reviews annually to determine whether the counties complied with the intergovernmental agreement. Under the agreement, counties are required to perform reviews of county-contracted OTPs annually and submit their annual monitoring reports to the State agency. The State agency verifies that the counties have monitored their contracted OTPs, submitted their annual monitoring reports, and submitted those reports in a timely manner. Once the programmatic compliance review of a county is completed, the State agency issues to the county a report with findings, which requires the county to submit a corrective action plan for each deficiency identified. The county submits the corrective action plan to the State agency for review and followup.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicaid claims for OTP services provided by 135 OTPs from January 1, 2018, through December 31, 2019 (audit period). The OTP services consisted of individual and group counseling services, methadone and other medication-assisted treatment dosing services, case management, and physician consultation.^{13, 14} We summarized the Medicaid claims into 731,472 beneficiary-months; each beneficiary-month included all claims for OTP services provided to a beneficiary in a month.¹⁵ The 135 OTPs received Medicaid reimbursement of \$371.6 million (\$259.8 million Federal share).¹⁶

¹¹ Federal regulations provide requirements for State agencies' prepayment and postpayment reviews (42 CFR § 447.45).

¹² See footnote 10. 22 CCR §§ 51341.1, 51490.1, and 51516.1.

¹³ Individual counseling and methadone dosing services accounted for 99 percent of the services provided to beneficiaries during our audit period.

¹⁴ For individual counseling services, the DMC program reimburses providers based on units of service. A 10-minute interval of service is considered a unit. For example, for State fiscal year (SFY) 2019 (July 1, 2018, through June 30, 2019), the DMC program's reimbursement rate was \$15.88 per unit. For methadone dosing services, the DMC program reimburses providers based on a daily dosing rate. For example, for SFY 2019, the DMC program's reimbursement rate was \$13.54 per day. Dosing services include the administration of medication prescribed by health care providers to beneficiaries.

¹⁵ A beneficiary was identified using a client index number assigned by the State agency. The month in which a service was considered to have been provided was based on the ending date of service.

¹⁶ The number of OTPs was determined using the count of unique national provider identifier numbers from the claim records.

We selected a stratified random sample of 130 beneficiary-months, totaling \$71,202 (\$56,133 Federal share), to determine compliance with Federal and State requirements. (We refer to each sampled beneficiary-month as a “sample item.”) We reviewed supporting documentation (e.g., admission records, the treatment plan, counseling notes, and the dosing log) for each sample item to determine whether the OTP services were allowable.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency claimed Medicaid reimbursement for some OTP services that did not meet Federal and State requirements. Of the 130 sample items, 88 had services that were all allowable, but 42 had services that were unallowable. Table 2 summarizes the deficiencies and the number of sample items that had unallowable services for each type of deficiency.

Table 2: Summary of Deficiencies in Sample Items*

Deficiency	No. of Sample Items With Unallowable OTP Services
Individual counseling services were not supported with adequate documentation	18
Take-home medications were not provided in accordance with Federal or State regulations	12
Individual counseling and methadone dosing services were provided when a treatment plan had not been updated by a primary counselor or countersigned by a physician	6
Frequency of individual counseling services provided exceeded the frequency specified in the treatment plan	5
Beneficiaries were admitted into maintenance treatment without adequate physician documentation	3
Methadone dosing services were administered without proper authorization	3
Methadone dosing services were claimed when they were not administered	2

* The total number of sample items with unallowable services is more than 42 because 7 sample items had more than 1 deficiency. Not all claims for OTP services within a sample item (i.e., a beneficiary-month) were unallowable. We identified the unallowable OTP services in the sampled beneficiary-month.

On the basis of our sample results, we estimated that the State agency claimed at least \$23.1 million in unallowable Federal Medicaid reimbursement for OTP services during our audit period.¹⁷

At the OTP level, these deficiencies occurred because OTPs: (1) followed guidance from their respective counties that conflicted with State regulations when billing for counseling services, (2) had a practice of providing take-home medications without a rationale approved under Federal and State regulations, and (3) made human errors. In addition, OTPs did not explain why some of the deficiencies occurred (e.g., an OTP did not explain why it did not document the date when a counseling service note was completed). At the State level, the State agency's oversight activities (e.g., postservice prepayment monitoring reviews), guidance, and system edits did not ensure that all OTP services met Federal and State requirements.

We also identified deficiencies in three areas that did not result in unallowable services but could impact the quality of care provided to beneficiaries receiving OTP services. Specifically, OTPs:

- provided fewer counseling services than were identified as clinically necessary in the beneficiary's treatment plan (11 sample items),
- did not include all the required information in beneficiaries' admission documentation (5 sample items), and
- did not review treatment plans within the 14-day period as required (3 sample items).

THE STATE AGENCY CLAIMED REIMBURSEMENT FOR UNALLOWABLE OPIOID TREATMENT PROGRAM SERVICES

Individual Counseling Services Were Not Supported With Adequate Documentation

A State plan must provide for agreements with every person or institution providing services under the State plan to keep such records as necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan.¹⁸

The counselor providing a counseling service must document information, such as the date and type of the service (e.g., individual or group) and a summary of the service, in the patient's medical record within 14 calendar days of the service. Furthermore, the counselor must document the duration of the counseling service in 10-minute intervals, excluding the time

¹⁷ The total unallowable Federal Medicaid reimbursement claimed was at least \$23,139,767. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

¹⁸ Social Security Act § 1902(a)(27).

required to document the summary of the service (i.e., documentation time).¹⁹ A 10-minute interval of service is considered a unit.

The State agency must not reimburse a provider for services that were not provided to or received by a patient.²⁰

For 18 of 130 sample items, OTPs did not have adequate documentation to support individual counseling services:²¹

- For seven sample items, OTPs included documentation time as part of the duration of the counseling service. For example, for one sample item, an OTP claimed 6 units of counseling services. The counseling service note stated that the service started at 9:45 a.m. and ended at 10:35 a.m. (i.e., a 50-minute service), and there was 10 minutes of documentation time associated with the service. The OTP explained that it followed a county's manual and provided a copy of the manual.²² The manual stated: "In order to receive reimbursement for documentation time, each progress note documenting the service must include the beneficiary's name, date of service, date documentation was completed, and the start/end times of the documentation." The county's manual was not consistent with the State requirement (9 CCR § 10345(d)), which states that the duration of the counseling service excludes the time it takes to document the service.²³
- For six sample items, OTPs did not document the date when the counseling service notes were completed or did not document the service within 14 calendar days of the service as required. Specifically, for four sample items, the counseling service notes included the service date and duration of each service, and the counselors signed the counseling service notes. However, the counselors did not indicate the dates that they completed and signed those notes. For another sample item, the counseling service note did not have a counselor's signature and date. For the remaining sample item, the signature date was 20 calendar days after the service. Not all OTPs explained why these deficiencies occurred. OTPs that provided reasons for these deficiencies attributed the deficiencies to human error.

¹⁹ 22 CCR §§ 51341.1(h)(3)(C) and (m); 9 CCR § 10345(d).

²⁰ 22 CCR § 51341.1(j).

²¹ The total number of sample items with unallowable services is more than 18 because 1 sample item had more than 1 deficiency.

²² *Alameda County Behavioral Health Care Services DMC-ODS Documentation Standards Manual*, version 06/07/19.

²³ We considered 1 unit (i.e., 10 minutes) of each counseling service as documentation time and disallowed 1 unit for each applicable counseling service for the seven sample items.

- For three sample items, OTPs had counseling service notes with start and end times that conflicted with the times shown in the counselors' timesheets. For example, for one sample item, an OTP claimed 5 units of counseling services based on a note indicating that the service on August 8, 2018, started at 11:05 a.m. and ended at 11:42 a.m. (i.e., a 37-minute service). However, the counselor's timesheet showed that the counselor was on break from 10:41 a.m. to 11:41 a.m. The OTP did not explain why the notes showed that the counseling service was provided when the counselor's timesheet showed that the counselor was on break and stated that the counselor was no longer employed at the OTP.
- For two sample items, OTPs had counseling service notes that did not support the number of units claimed. For example, for one sample item, a counseling service note had a start time of 11:00 a.m. and an end time of 12:00 p.m. (i.e., a 60-minute service). The provider should have billed 6 units. However, the provider claimed and was reimbursed for 60 units (600 minutes). According to the OTP, ". . . the error was likely made in keying the information into the billing portal and was not caught in our reconciliation process."
- For one sample item, an OTP claimed and was reimbursed for 5 units of counseling services without supporting documentation. According to the OTP, the counseling service note was written for the wrong beneficiary.²⁴

Take-Home Medications Were Not Provided in Accordance With Federal or State Regulations

Self-administered take-home medication may be provided to a patient only if the medical director or program physician has determined, in his or her clinical judgment, that the patient is responsible in handling narcotic medications and has documented in the patient's medical record his or her rationale (e.g., the patient is participating in gainful educational activity, and the patient's daily attendance at the program would be incompatible with such an activity).²⁵ The physician's rationale should be based on consideration of eight criteria, such as the absence of recent drug abuse, including alcohol, and the length of time in maintenance treatment. If the medical director or program physician determines that the patient is responsible in handling narcotic medication, the patient may be placed on one of six step levels on the take-home medication schedule based on the length of time in treatment.²⁶ For example, if the patient's length of time in treatment is less than or equal to 90 days, the patient is considered to be at step level 1, which allows one take-home medication per week.

²⁴ The OTP stated that, as of August 2021, it was in the process of returning this overpayment to the State agency.

²⁵ 42 CFR § 8.12(i); 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10370. State regulations (9 CCR § 10385) provided exceptions to section 10370(b); however, these exceptions were later rescinded by California's Department of Alcohol and Drug Programs Bulletin 12-10 because they were less stringent than the Federal regulations.

²⁶ 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10375.

The medical director or program physician must restrict a patient's take-home privileges by moving back the patient at least one step level on the take-home medication schedule (e.g., from step level 2 to step level 1) if the patient, after receiving a supply of take-home medication, is inexcusably absent from or misses a scheduled appointment with the program without authorization from the program staff. The medical director or program physician must order the restriction or revocation of take-home privileges within 15 days from the date the program has obtained evidence that a restriction or revocation is necessary.²⁷

For 12 of 130 sample items, OTPs did not provide take-home medications in accordance with Federal or State regulations:

- For 10 sample items, OTPs provided take-home medications without an adequate rationale for take-home privileges. For example, for one sample item, the OTP did not have any supporting documentation of the physician's approval of and justification for the patient's take-home doses on December 25, December 29, and December 30, 2018. The OTP stated that it was unable to locate the documentation.
- For two sample items, OTPs did not properly restrict take-home medications. For example, for one sample item, the beneficiary was at step level 6 and received 27 days of take-home medication. From April 4 through April 8, 2018, the beneficiary was inexcusably absent from the program. When the physician reinstated the beneficiary in the program on April 9, 2018, the physician did not order the beneficiary's take-home medication to be restricted by moving back the beneficiary to step level 5, which allowed 14 days of take-home medication. Instead, the physician ordered the beneficiary to receive 22 days of take-home medication (5 days less than what the patient had previously received), covering until May 1, 2018, which was the sampled beneficiary-month. According to the OTP, the beneficiary received the 22 days of take-home medication because the "patient was compliant with counselling and testing, however had transportation hardship including [medical issues]."²⁸

Individual Counseling and Methadone Dosing Services Were Provided When a Treatment Plan Had Not Been Updated by a Primary Counselor or Countersigned by a Physician

A treatment plan must be reviewed and updated to reflect a patient's: (1) personal history; (2) current needs for medical, social, and psychological services; and (3) current needs for education, vocational rehabilitation, and employment services.²⁹ The primary counselor is required to evaluate and update the patient's maintenance treatment plan whenever necessary or at least once during each 3-month period from the date of admission into maintenance

²⁷ 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10390.

²⁸ The beneficiary did not return to the OTP in May 2018 and was discharged on May 31, 2018.

²⁹ 42 CFR § 8.12(f)(4); 22 CCR § 51341.1(h)(2)(B); 9 CCR § 10305.

treatment. The treatment plan must be signed by the primary counselor.³⁰ The medical director or program physician must review all updated treatment plans within 14 calendar days from the effective dates and must countersign these documents to signify concurrence with their content (e.g., treatment goals and frequency of services).³¹

For 6 of 130 sample items, OTPs provided individual counseling services and methadone dosing services when a treatment plan had not been updated for the service dates by a primary counselor or countersigned by a physician. Specifically, for four sample items, treatment plans were not updated during the 3-month period as required. For the two remaining sample items, treatment plans were not countersigned by a physician. Only one OTP provided a reason why this deficiency occurred and stated that it missed the treatment plan update and “developed a more comprehensive process of staying up to date with updating treatment plans.”

Frequency of Individual Counseling Services Provided Exceeded the Frequency Specified in the Treatment Plan

The frequency of counseling services should not exceed the frequency specified in the treatment plan.³²

For 5 of 130 sample items, OTPs provided individual counseling services at a frequency that exceeded the frequency specified in the beneficiary’s treatment plan. For example, for one sample item, an OTP furnished and was reimbursed for five counseling services in a month. However, the physician ordered four counseling services per month in the beneficiary’s treatment plan. According to the OTP, a crisis had not occurred that justified exceeding the frequency of counseling services ordered in the beneficiary’s treatment plan.

Beneficiaries Were Admitted Into Maintenance Treatment Without Adequate Physician Documentation

OTPs must ensure that patients are admitted into maintenance treatment by qualified personnel who have determined, using accepted medical criteria such as those listed in the *Diagnostic and Statistical Manual of Mental Disorders*, that the person is currently addicted to an opioid drug and became addicted at least 1 year before admission for treatment.^{33, 34} For maintenance treatment, the OTP physician must document a physician’s certification of the

³⁰ 22 CCR §§ 51341.1(h)(2)(B) and (m)(3)(B); 9 CCR § 10305(f).

³¹ 22 CCR §§ 51341.1(h)(2)(B) and (m)(3)(B); 9 CCR § 10305(h); 9 CCR § 10110.

³² 22 CCR § 51341.1(m)(4)(C).

³³ 42 CFR § 8.12(e).

³⁴ The *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* is published by the American Psychiatric Association. It includes the classification of mental disorders using a common language and standard criteria. Available online at <https://www.psychiatry.org/psychiatrists/practice/dsm>. Accessed on Nov. 10, 2021.

patient's fitness for replacement narcotic therapy (e.g., methadone maintenance) based on a physical examination, medical history, and indicated laboratory findings.³⁵

For 3 of 130 sample items, OTPs did not have adequate documentation to support the admission of beneficiaries into maintenance treatment. Specifically, the OTPs did not document that a physician certified the beneficiaries' fitness for methadone maintenance based on a physical examination, medical history, and laboratory findings. For example, for one sample item, the patient's admission documentation did not indicate whether the patient was admitted into maintenance or detoxification treatment. When we asked the OTP why the patient's admission documentation did not indicate the type of treatment, the OTP did not provide a reason.

Methadone Dosing Services Were Administered Without Proper Authorization

Dosing and administration decisions must be made by a program physician.³⁶ Only the medical director or program physician is authorized to change a patient's medication dosage schedule.³⁷

For 3 of 130 sample items, OTPs administered methadone dosing services to beneficiaries without an authorization by the medical director or program physician. For example, for one sample item, an OTP administered to a beneficiary a dosage of 155 milligrams of methadone in April 2018. Treatment plans prepared in January and April 2018 (covering the sampled beneficiary-month of April 2018) stated that the beneficiary should receive a daily dose, but the plans did not include a prescribed dosage. When we asked the OTP to provide a physician's order for the 155-milligram dose, the OTP stated that it was unable to locate the signed doctor's order for April 2018.

Methadone Dosing Services Were Claimed When They Were Not Administered

The State agency must not reimburse a provider for services that were not provided to or received by a patient.³⁸

For 2 of 130 sample items, OTPs claimed and were reimbursed for methadone dosing services when they were not administered. For example, for one sample item, an OTP claimed and was reimbursed for one dose of methadone when the documentation did not indicate that the doses were dispensed. The dosing log did not show that a medication dose was dispensed on that day. The OTP stated that it was a billing error.

³⁵ 22 CCR §§ 51341.1(h)(1)(C) and (m); 9 CCR § 10270(d)(4).

³⁶ 42 CFR § 8.12(h); 22 CCR §§ 51341.1(b)(28)(B) and (m); 9 CCR § 10110.

³⁷ 22 CCR §§ 51341.1(d)(1) and (m); 9 CCR § 10355(g).

³⁸ 22 CCR § 51341.1(j).

THE STATE AGENCY’S OVERSIGHT ACTIVITIES, GUIDANCE, AND SYSTEM EDITS DID NOT ENSURE THAT ALL OPIOID TREATMENT PROGRAM SERVICES MET FEDERAL AND STATE REQUIREMENTS

The State agency’s oversight activities (e.g., postservice prepayment monitoring reviews), guidance, and system edits did not ensure that all OTP services met Federal and State requirements.

The State Agency’s Oversight Activities Were Not Adequate To Ensure That Only Allowable Opioid Treatment Program Services Were Paid

Although the State agency performed oversight activities, such as postservice prepayment monitoring reviews, those oversight activities were not adequate to ensure that all OTP services that were paid met Federal and State requirements. Specifically, during CYs 2018 and 2019, the State agency did not verify that deficiencies identified during the annual provider-licensing inspections were corrected. During these years, the State agency performed 292 annual provider-licensing inspections to determine whether OTPs complied with State licensing requirements. As part of these reviews, it required OTPs to submit corrective action plans for each deficiency identified but did not always verify that OTPs implemented corrective action plans before approving them. According to the State agency, an OTP would submit to the State agency evidence that it had implemented corrective actions to resolve identified deficiencies if it implemented those actions before it submitted its corrective action plan. However, if an OTP did not implement corrective actions before submitting a corrective action plan, the State agency would review implementation during the next fiscal year’s inspection.^{39, 40}

In addition, during CY 2019, the State agency performed postservice prepayment monitoring reviews at only 2 of the 135 OTPs.⁴¹ Furthermore, during CYs 2018 and 2019, the State agency did not perform postservice postpayment utilization reviews.⁴²

³⁹ The State agency did not provide documentation to support that it verified implementation of the corrective action plans submitted by five OTPs for which we requested documentation.

⁴⁰ According to the State agency, it revised and implemented new procedures for obtaining evidence of corrective actions as a result of our report *California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider’s Opioid Treatment Program Services* ([A-09-20-02001](#)), issued Jan. 25, 2021. To improve its oversight, the State agency required that OTPs submit evidence of implementing corrective action plans within 30 days of plan approval if the implementation did not occur before submission of the corrective action plans.

⁴¹ During CY 2018, the State agency did not perform postservice prepayment monitoring reviews.

⁴² From CYs 2013 through 2020, the State agency did not perform postservice postpayment utilization reviews. During CY 2021, it performed the review at only one OTP. According to the State agency, it had performed a risk analysis of OTP services in the past and determined that these services were low-risk. However, based on the results of our statewide audit, the State agency said it would consider performing additional postservice postpayment utilization reviews.

The State Agency's Billing Manual Did Not Specify Certain Documentation Requirements for Counseling Services

The State agency's *Drug Medi-Cal Billing Manual* issued in April 2019 stated that documentation time is billable for DMC-ODS outpatient services.^{43, 44} The manual did not specify that OTPs cannot bill documentation time for counseling services.⁴⁵ (The State regulation (9 CCR § 10345(d)) requires the duration of counseling services to be documented in 10-minute intervals, excluding the time required to document the service.) The manual also did not specify that counseling service notes should be documented within 14 days from a service (as stated in 9 CCR § 10345(d)).

The State Agency Did Not Have a System Edit for Identifying Claims With an Unreasonable Number of Counseling Service Units

The State agency's claims adjudication system did not have a system edit to identify claims with an unreasonable number of counseling service units billed on a single day.⁴⁶ According to the State agency, before State Plan Amendment (SPA) 15-012 (effective January 1, 2015), the claims adjudication system included an edit to deny a service line if it exceeded 20 units (200 minutes) per month. However, because SPA 15-012 allowed minutes beyond the 200-minute limit based on medical necessity, the State agency removed the edit.

THE STATE AGENCY COULD IMPROVE THE QUALITY OF CARE PROVIDED TO BENEFICIARIES RECEIVING OPIOID TREATMENT PROGRAM SERVICES

We identified deficiencies in three areas that did not result in unallowable services but could impact the quality of care provided to beneficiaries receiving OTP services.

⁴³ The DMC-ODS services include a continuum of care based on the American Society of Addiction Medicine Criteria, such as OTP services, outpatient services, intensive outpatient services, and residential treatment services.

⁴⁴ The *Drug Medi-Cal Billing Manual* issued in June 2017, which was also applicable to our audit period, did not include a statement regarding billable documentation time for counseling services.

⁴⁵ As noted on page 8 of our report, an OTP participating in a county under the DMC-ODS program stated that it was following the county manual. The county's manual was not consistent with the State requirement (9 CCR § 10345(d)), which states that the duration of the counseling service excludes the time it takes to document the service.

⁴⁶ We identified 568 claims for individual counseling services, totaling \$490,310 (\$346,413 Federal share), that were paid for more than 200 minutes (20 units) in a single day. These claims were included in our sampling frame, so we did not audit the claims separately. We considered 200 minutes of counseling services in a single day as high risk because SPA 15-012 permitted up to 200 minutes per calendar month, although additional services may be provided if medically necessary. In addition, the State agency said that its claims processing system had an edit limiting counseling services to 200 minutes per month before SPA 15-012 was effective.

Specifically, OTPs:

- provided fewer counseling services than were identified as clinically necessary in the beneficiary's treatment plan (11 sample items),
- did not include all of the required information in beneficiaries' admission documentation or document that the physical evaluation was performed under the supervision of a program physician (5 sample items), and
- did not review treatment plans within the 14-day period as required (3 sample items).

Fewer Counseling Services Were Provided Than Were Identified as Clinically Necessary in the Treatment Plan

OTPs must provide adequate substance abuse counseling services to each patient as clinically necessary.⁴⁷ The treatment plan must identify the frequency with which services, such as counseling, are to be provided.

For 11 of 130 sample items, OTPs provided fewer counseling services than were identified as clinically necessary in the beneficiary's treatment plan. For example, for one sample item, the treatment plan stated that the beneficiary would receive one counseling service a month, but no services were provided in June 2019, which was the sampled beneficiary-month. The OTP did not explain why a counseling service was not provided during the month.

Providing fewer counseling services than are clinically necessary may negatively affect the outcome of a beneficiary's treatment.

Admission Documentation Did Not Include All Required Information or Document That the Physical Evaluation Was Performed Under the Supervision of a Program Physician

OTPs should require each patient to undergo a complete, fully documented physical evaluation by a program physician or a primary care physician, or an authorized health care professional under the supervision of a program physician, before admission to the OTP. The full medical examination, including the results of serology and other tests (e.g., tests for drug use, tuberculosis, and syphilis), must be completed within 14 days following admission.⁴⁸ The purpose of the initial medical evaluation is to confirm the diagnosis of opioid use disorder and identify co-occurring medical and psychiatric conditions that may make medication-assisted

⁴⁷ 42 CFR § 8.12 (f)(5); 22 CCR § 51341.1(h)(2)(B); 9 CCR § 10305.

⁴⁸ 42 CFR § 8.12(f)(2); 22 CCR § 51341.1(h)(1)(C); 9 CCR § 10270.

treatment unsafe, limit its effectiveness, influence the selection of pharmacotherapy, or require prompt medical attention.⁴⁹

For 5 of 130 sample items, OTPs did not include all required information in beneficiaries' admission documentation or document that the physical evaluation was performed under the supervision of a program physician before a beneficiary's admission:

- For four sample items, OTPs did not maintain documentation to demonstrate that a drug use, tuberculosis, or syphilis test was performed. Only one OTP provided a reason why this deficiency occurred and stated that it did not perform the drug test upon admission.
- For one sample item, a physician signed the admission documentation 49 days after the date of admission. The documentation was unclear as to whether the physical evaluation was performed under the supervision of a program physician. When we asked the OTP why the physician signed the document 49 days after admission, the OTP was not sure why there was a delay in signing the admission documentation.

If admission documentation is not maintained to show that laboratory tests were performed and that the physical evaluation was performed under the supervision of a program physician, OTPs may not identify issues that require prompt medical attention (e.g., co-occurring medical and psychiatric conditions).

Treatment Plans Were Not Reviewed Within the 14-Day Period as Required

A treatment plan must be reviewed and updated to reflect a patient's: (1) personal history; (2) current needs for medical, social, and psychological services; and (3) current needs for education, vocational rehabilitation, and employment services.⁵⁰ The medical director or program physician must review all updated treatment plans within 14 calendar days from the effective dates and must countersign these documents to signify concurrence with their content (e.g., treatment goals and frequency of services).⁵¹

For 3 of 130 sample items, OTPs did not have treatment plans that were countersigned within the 14-day period as required to signify that the physician reviewed the treatment plan and concurred with the content. For example, for one sample item, the counselor signed the treatment plan on December 13, 2018. The physician signed the treatment plan on January 9, 2019 (27 days after the counselor).

⁴⁹ Substance Abuse and Mental Health Services Administration's *Federal Guidelines for Opioid Treatment Programs*, January 2015.

⁵⁰ 42 CFR § 8.12(f)(4); 22 CCR § 51341.1(h)(2)(B); 9 CCR § 10305.

⁵¹ 22 CCR §§ 51341.1(h)(2)(B) and (m)(3)(B); 9 CCR § 10305(h); 9 CCR § 10110.

If treatment plans are not reviewed and countersigned by physicians within the required timeframe, OTPs may not address treatment issues that require prompt attention.

RECOMMENDATIONS

We recommend that the California Department of Health Care Services:

- refund \$23,139,767 to the Federal Government,
- verify that deficiencies identified during annual provider-licensing inspections were corrected and that OTPs implemented their corrective action plans,
- consider performing additional postservice prepayment monitoring and postservice postpayment utilization reviews,
- implement a system edit for identifying claims with an unreasonable number of counseling service units in 1 day and take appropriate action for the claims identified, and
- revise the *Drug Medi-Cal Billing Manual* or provide additional guidance to OTPs regarding the allowable number of counseling service units and work with counties to ensure that their OTP billing manuals do not conflict with State regulations.

We also recommend that the California Department of Health Care Services take actions to ensure that OTPs:

- comply with Federal and State requirements for providing and claiming reimbursement for OTP services;
- provide the number of counseling services specified in a beneficiary's treatment plan or document the reasons that counseling services were not provided as specified in the treatment plan;
- maintain documentation supporting that a complete physical evaluation of a patient was performed, including the results of drug use, tuberculosis, and syphilis tests and the identity of the person who performed the physical evaluation; and
- have their physicians review and countersign beneficiaries' treatment plans within the 14-day period as required.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with all of our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. The State agency's comments are included in their entirety as Appendix E.

The State agency had the following comments on our first five recommendations:

- Regarding our first recommendation, the State agency commented that it will repay the Federal Government \$23,139,767 by June 30, 2022.
- Regarding our second recommendation, the State agency commented that it will conduct inspections of the OTPs included in our audit. The State agency also commented that, after the inspections are completed, the State agency will review, accept, and monitor for resolution the corrective action plans.
- Regarding our third recommendation, the State agency commented that it conducts a risk assessment of providers on an annual basis. The State agency also commented that effective with the State fiscal year 2021–2022 review cycle, the State agency assigned specific staff to conduct additional postservice postpayment reviews of OTPs.
- Regarding our fourth recommendation, the State agency commented that it will determine a guideline for the maximum units per day for counseling services and initiate a system change to enforce the guideline.
- Regarding our fifth recommendation, the State agency commented that it will update the *Drug Medi-Cal Billing Manual* to clarify guidance regarding the allowable number of counseling service units and notify counties of the update.

Regarding our four recommendations related to actions that the State agency should take to ensure that OTPs comply with Federal and State requirements, the State agency commented that it will continue to conduct annual licensing inspections and once those inspections are completed, corrective action plans will be reviewed, accepted, and monitored for resolution to ensure ongoing monitoring of quality of care.⁵² The State agency also commented that it will provide technical assistance to ensure that OTPs are providing counseling services as outlined in signed treatment plans and will review treatment plans for documentation justifying any reductions in counseling services. Finally, the State agency commented that it will ensure that OTPs maintain supporting documentation for admission requirements, test results, and physical evaluations.

⁵² In its written comments, the State agency referred to these four recommendations as "Recommendation 6."

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicaid claims for OTP services provided from January 1, 2018, through December 31, 2019. The OTP services consisted of individual and group counseling services, methadone and other medication-assisted treatment dosing services, case management, and physician consultation.⁵³ We summarized the Medicaid claims into 731,472 beneficiary-months; each beneficiary-month included all claims for OTP services provided to a beneficiary in a month.⁵⁴ The 135 OTPs received Medicaid reimbursement of \$371,620,959 (\$259,792,712 Federal share).

We selected a stratified random sample of 130 beneficiary-months, totaling \$71,202 (\$56,133 Federal share), to determine compliance with Federal and State requirements. (We refer to each sampled beneficiary-month as a “sample item.”)

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data provided by the State agency for our audit period.⁵⁵ We also established reasonable assurance of the completeness of the data by tracing a judgmental sample of aggregate claim record amounts to supporting claim schedules and State controller warrant documentation. Furthermore, we matched these totals to supporting documentation used to report amounts on the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

During our audit, we did not assess the overall internal control structure of the State agency. Rather, we limited our review to the State agency’s internal controls for reporting expenditures on the Form CMS-64, reviewing claims submitted by OTPs, and monitoring OTPs’ compliance with Federal and State requirements and claiming reimbursement for OTP services.

We conducted our audit from September 2020 to March 2022.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with officials at the State agency to gain an understanding of OTPs;

⁵³ See footnote 13.

⁵⁴ See footnote 15.

⁵⁵ The State agency extracted the data from its Short-Doyle Medi-Cal Application Remediation Technology (SMART) system and Short-Doyle Medi-Cal adjudication system.

- obtained data from the State agency that contained records of Medicaid claims for OTP services (the State agency extracted data fields for the OTP claims from its SMART system and Short-Doyle Medi-Cal adjudication system);
- created a sampling frame of 731,472 beneficiary-months, which included all claims for OTP services provided to a beneficiary in a month furnished by 135 OTPs to 54,553 Medicaid beneficiaries during our audit period, totaling \$371,620,959 (\$259,792,712 Federal share);⁵⁶
- reconciled the claims data for OTP services to the totals on claim schedule and warrant payment documentation to determine whether the State agency claimed reimbursement on the Form CMS-64 for those services;⁵⁷
- selected a stratified random sample of 130 items from our sampling frame and, for each sample item, reviewed supporting documentation (e.g., admission records, the treatment plan, counseling notes, and the dosing log) to determine whether OTP services provided to a beneficiary during a selected month (i.e., for the sample item) were allowable in accordance with Federal and State requirements;
- verified dosing nurse qualifications for 10 judgmentally selected sample items (of the 130 total sample items) and counselor qualifications for all 130 sample items using publicly available State licensing and certification databases and contacted certifying organizations as appropriate;
- estimated the total amount of Federal Medicaid reimbursement that the State agency claimed for unallowable OTP services during our audit period; and
- discussed the results of our audit with State agency officials.

See Appendix C for our statistical sampling methodology and Appendix D for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁵⁶ We did not review claims for the selected provider from our prior audit *California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider's Opioid Treatment Program Services (A-09-20-02001)*.

⁵⁷ A claims schedule is a payment request document that is submitted by the State agency to the California State Controller's Office for invoiced claims. A warrant is a payment (e.g., a check) issued by the State Controller's Office to pay the claim schedule.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>SAMHSA’s Oversight Generally Ensured That the Commission on Accreditation of Rehabilitation Facilities Verified That Opioid Treatment Programs Met Federal Opioid Treatment Standards</i>	<u>A-09-20-01002</u>	10/1/2021
<i>About Seventy-Nine Percent of Opioid Treatment Program Services Provided to Medicaid Beneficiaries in Colorado Did Not Meet Federal and State Requirements</i>	<u>A-07-20-04118</u>	9/21/2021
<i>Oklahoma’s Oversight of Medicaid Outpatient Services for Opioid Use Disorder Was Generally Effective</i>	<u>A-06-20-08000</u>	8/12/2021
<i>California Claimed at Least \$2 Million in Unallowable Medicaid Reimbursement for a Selected Provider’s Opioid Treatment Program Services</i>	<u>A-09-20-02001</u>	1/25/2021
<i>Opioid Treatment Programs Reported Challenges Encountered During the COVID-19 Pandemic and Actions Taken To Address Them</i>	<u>A-09-20-01001</u>	11/18/2020
<i>Update on Oversight of Opioid Prescribing and Monitoring of Opioid Use: States Have Taken Action To Address the Opioid Epidemic</i>	<u>A-09-20-01000</u>	10/7/2020
<i>SAMHSA’s Oversight of Accreditation Bodies for Opioid Treatment Programs Did Not Comply With Some Federal Requirements</i>	<u>A-09-18-01007</u>	3/6/2020
<i>New York Claimed Tens of Millions of Dollars for Opioid Treatment Program Services That Did Not Comply With Medicaid Requirements Intended To Ensure the Quality of Care Provided to Beneficiaries</i>	<u>A-02-17-01021</u>	2/4/2020
<i>California Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-09-18-01006</u>	12/10/2019
<i>New York Achieved Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-02-18-02001</u>	8/8/2019
<i>Oversight of Opioid Prescribing and Monitoring of Opioid Use: States Have Taken Action To Address the Opioid Epidemic</i>	<u>A-09-18-01005</u>	7/24/2019
<i>The University of Kentucky Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-04-18-02012</u>	5/30/2019
<i>Washington State Made Progress Toward Achieving Program Goals for Enhancing Its Prescription Drug Monitoring Program</i>	<u>A-09-18-01001</u>	4/15/2019

Report Title	Report Number	Date Issued
<i>The Substance Abuse and Mental Health Services Administration Followed Grant Regulations and Program-Specific Requirements When Awarding State Targeted Response to the Opioid Crisis Grants</i>	A-03-17-03302	3/28/2019
<i>New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds</i>	A-02-17-02009	3/20/2019

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of a Microsoft Excel file containing 731,472 beneficiary-months totaling \$371,620,959 (\$259,792,712 Federal share) for OTP services provided from January 1, 2018, through December 31, 2019.

SAMPLE UNIT

The sample unit was a beneficiary-month.⁵⁸

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample (Table 3). The four strata were based on Federal share amounts for the beneficiary-months and Medi-Cal OTP program type.

Table 3: Strata

Stratum	Dollar Range of Beneficiary-Months and OTP Program Type	Frame Paid Amount	Frame Federal Share	No. of Items in Sampling Frame	Sample Size
1	Less than \$400 under DMC	\$78,273,569	\$41,240,564	151,463	20
2	Greater than or equal to \$400 under DMC	54,481,826	50,797,047	91,493	30
3	Less than \$350 under DMC-ODS	118,177,539	63,904,660	281,139	30
4	Greater than or equal to \$350 under DMC-ODS	120,688,025	103,850,441	207,377	50
	Total	\$371,620,959	\$259,792,712	731,472	130

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the OIG, Office of Audit Services (OAS), statistical software.

⁵⁸ A beneficiary-month consisted of all Medicaid OTP claims for services provided to a beneficiary in a month. A beneficiary was identified using a client index number assigned by the State agency. The month in which a service was considered to have been provided was based on the ending date of service.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sampling frame in three steps. First, we sorted the sample units using a field that identified whether the sample unit was in the DMC or DMC-ODS program. Second, we sorted the sample units by Federal share amount in ascending order. Third, because some sample units had the same Federal share amount, we sorted them in ascending order by using beneficiaries' client index numbers assigned by the State agency. After generating the random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total dollar amount of Federal Medicaid reimbursement that the State agency claimed for unallowable OTP services (Appendix D). To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 4: Sample Details and Results

Stratum	No. of Items in Sampling Frame	Value of Items in Sampling Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Sample Items With Unallowable Services*	Value of Unallowable Services (Federal Share)
1	151,463	\$41,240,564	20	\$5,621	5	\$636
2	91,493	50,797,047	30	17,040	7	2,412
3	281,139	63,904,660	30	6,936	12	1,189
4	207,377	103,850,441	50	26,536	18	3,367
Total	731,472	\$259,792,712	130	\$56,133	42	\$7,604

* Not all claims within a sample item (i.e., a beneficiary-month) were unallowable. We identified the unallowable OTP services in the sampled beneficiary-month.

Table 5: Estimated Value of Unallowable Services in the Sampling Frame (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$37,279,387
Lower limit	23,139,767
Upper limit	51,419,007

APPENDIX E: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

March 30, 2022

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

DRAFT AUDIT REPORT RESPONSE

Dear Ms. Ahlstrand:

The Department of Health Care Services (DHCS) is submitting the enclosed response to the Office of Inspector General (OIG) draft audit report number A-09-19-02009 titled, "California Improperly Claimed at Least \$23 Million of \$260 Million in Total Medicaid Reimbursement for Opioid Treatment Program Services."

In the above audit report, OIG issued six recommendations for DHCS. DHCS agrees with all of OIG's recommendations and has prepared corrective action plans for implementation.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any other questions, please contact Internal Audits at (916) 445-0759.

Sincerely,

Michelle Baass
Director

Enclosure

cc: See Next Page

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Ms. Lori Ahlstrand
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March 30, 2022

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Department of Health Care Services

Audit: California Improperly Claimed at Least \$23 Million of \$260 Million in Total Medicaid Reimbursement for Opioid Treatment Program Services

Audit Entity: Office of Inspector General

Report Number: A-09-20-02009 (21-03)

Response Type: Draft Audit Report Response

Finding 1 The State Agency claimed reimbursement for unallowable Opioid Treatment Program (OTP) services.

Recommendation 1

We recommend that the Department of Health Care Services (DHCS) refund \$23,139,767 to the Federal Government.

DHCS Agreement: Agrees with Recommendation

DHCS Implementation: Will Implement

Estimated Implementation Date: 6/30/2022

Implementation Plan:

To allow for budget processing, DHCS will send a memo to repay the federal government \$23,139,767 by June 30, 2022.

Finding 2 The State Agency's oversight activities, guidance, and system edits did not ensure that all OTP services met Federal and State requirements.

Recommendation 2

We recommend that DHCS verify that deficiencies identified during annual provider-licensing inspections were corrected and that OTPs implemented their corrective action plans.

DHCS Agreement: Agrees with Recommendation

DHCS Implementation: Will Implement

Estimated Implementation Date: 12/31/2023

Implementation Plan:

DHCS will request the list of sampled providers from the Office of Inspector General. Upon receipt of the list, DHCS will conduct inspections on the list of providers. Once the provider-licensing inspection is completed, the corrective action plan (CAP) will be

reviewed, accepted, and monitored for resolution. DHCS will ensure ongoing monitoring of OTPs during annual compliance inspections to ensure the OTP implemented and maintained the CAP previously approved by DHCS.

Recommendation 3

We recommend that DHCS consider performing additional postservice prepayment monitoring and postservice postpayment utilization reviews.

DHCS Agreement: Agrees with Recommendation

DHCS Implementation: Implemented

Implementation Date: 9/20/2021

Implementation Plan:

DHCS conducts a risk assessment of Drug Medi-Cal (DMC) providers on an annual basis. Beginning with Fiscal Year (FY) 2021/2022, the annual list includes 18 Narcotic Treatment Programs (NTPs), 24 providers identified for Post Service Post Payment (PSPP) reviews, and eight providers identified for Post Service Pre Payment reviews for a total of 50 identified providers. Effective with the FY 2021/2022 review cycle, DHCS has assigned specific staff (see Attachment 6) to conduct additional PSPP reviews of NTP providers, while the remaining staff conducts PSPP reviews of DMC provider types. DHCS expects to conduct between 15-18 NTP PSPP reviews (see Attachment 5 and 7), 21-24 PSPP reviews, and 7-8 Postservice Prepayment Reviews of other DMC provider types on an annual basis.

Recommendation 4

We recommend that DHCS implement a system edit for identifying claims with an unreasonable number of counseling service units in 1 day and take appropriate action for the claims identified.

DHCS Agreement: Agrees with Recommendation

DHCS Implementation: Will Implement

Estimated Implementation Date: 7/1/2023

Implementation Plan:

DHCS will determine counseling maximum units per day guidelines and initiate a system change to Short Doyle Medi-Cal adjudication system to enforce the guideline. A Behavioral Health Informing Notice (BHIN) will be developed and published on July 1, 2023, informing counties of the new adjudication rules.

Recommendation 5

We recommend that DHCS revise the Drug Medi-Cal Billing Manual or provide additional guidance to OTPs regarding the allowable number of counseling service units and work with counties to ensure that their OTP billing manuals do not conflict with State regulations.

DHCS Agreement: Agrees with Recommendation

DHCS Implementation: Will Implement

Estimated Implementation Date: 5/31/2022

Implementation Plan:

DHCS will update the Drug Medi-Cal Billing Manual to clarify guidance per the applicable State Plan sections, regulations, and Intergovernmental Agreement regarding the allowable number of counseling service units. DHCS will notify counties of this update and advise counties to update their internal billing guidance.

Finding 3 The State Agency could improve the quality of care provided to beneficiaries receiving OTP services.

Recommendation 6

We also recommend that DHCS take actions to ensure that OTPs:

- comply with Federal and State requirements for providing and claiming reimbursement for OTP services;
- provide the number of counseling services specified in a beneficiary's treatment plan or document the reasons that counseling services were not provided as specified in the treatment plan;
- maintain documentation supporting that a complete physical evaluation of a patient was performed, including the results of drug use, tuberculosis, and syphilis tests and the identity of the person who performed the physical evaluation; and
- have their physicians review and countersign beneficiaries' treatment plans within the 14-day period as required.

DHCS Agreement: Agrees with Recommendation

DHCS Implementation: Will Implement

Estimated Implementation Date: 12/21/2023

Implementation Plan:

DHCS will continue to conduct annual licensing inspections to ensure compliance with Federal and State requirements. Once the annual licensing inspection is completed, the CAP will be reviewed, accepted, and monitored for resolution to ensure ongoing

monitoring of the quality of care provided to the beneficiaries receiving OTP services. DHCS will also provide technical assistance to ensure OTPs are providing counseling services as outlined in signed treatment plans. Additionally, DHCS will review treatment plans for documentation justifying any reductions in the amount of counseling services provided. DHCS will ensure OTPs are maintaining supporting documentation in the patient files for admission requirements, test results and physical evaluations.

In addition, effective FY 2021/2022, DHCS has increased the number of NTP PSPP reviews being conducted to 15-18 reviews per year which will occur on an annual basis. For items found to be out of compliance a CAP is required. DHCS follows up with counties/providers utilizing an established CAP acceptance and resolution process geared to ensure all findings/deficiencies are accurately and effectively resolved. The process includes reviewing CAP responses for specific details and thoroughness prior to acceptance, offering technical assistance and feedback to counties during the corrective phase, and requiring either evidence from the provider or an attestation from the county of which the deficiencies have been fully corrected before resolving the CAP.