

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**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**

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Office of Inspector General

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Report in Brief

Date: February 2020

Report No. A-02-17-01021

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



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-assisted treatment coupled with counseling and behavioral therapies for people diagnosed with an opioid use disorder. This audit is part of the OIG's oversight of the integrity and proper stewardship of Federal funds used to combat the opioid crisis.

Our objective was to determine whether New York claimed Medicaid reimbursement for OTP services provided in the New York City metropolitan area in accordance with Federal and State requirements.

How OIG Did This Audit

Our audit covered more than 10.7 million Medicaid claims for OTP services, totaling over \$445 million (\$272 million Federal share), provided in the New York City metropolitan area during calendar years 2014 through 2017.

We reviewed a stratified random sample of 150 claims to determine compliance with Federal and State requirements. We also identified 6,700 potentially duplicate claims totaling \$267,000 (\$160,000 Federal share) from the 10.7 million claims and selected a nonstatistical sample of 598 claims to determine compliance with Federal and State requirements.

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

What OIG Found

New York claimed Federal Medicaid reimbursement for OTP services that did not comply with Federal and State requirements. Of the 150 claims in our random sample, 115 claims complied with Medicaid requirements, but 35 claims did not. In addition, of the 598 claims in our nonstatistical sample, 299 claims totaling \$8,905 (\$5,830 Federal share) were billed in error. Specifically, 220 claims were duplicate claims, and 79 claims were for services that the providers stated were not provided. On the basis of our sample results, we estimated that New York improperly claimed at least \$39.3 million in Federal Medicaid reimbursement for OTP services during our audit period.

These improper claims occurred because providers (1) failed to maintain or provide documentation of OTP services, (2) did not ensure that OTP services were provided in accordance with beneficiaries' treatment plans, and (3) did not maintain signatures for OTP services. Further, although New York inspects providers to verify compliance with Federal and State Medicaid requirements, it did not ensure that its oversight prevented the errors identified by our audit.

What OIG Recommends and New York State's Comments

We recommended that New York (1) refund \$39.3 million to the Federal Government, (2) ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services, and (3) implement procedures to detect and prevent duplicate claims for OTP services.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions it planned to take to address them. Specifically, New York stated that its Office of the Medicaid Inspector General will review the claims identified in our draft report as not having complied with Medicaid requirements and determine an appropriate course of action. New York also stated that it would issue guidance to OTP providers reminding them of their obligations to comply with Federal and State laws for providing and claiming Medicaid reimbursement for OTP services. Finally, New York stated that it would investigate whether edits to its Medicaid claims processing system will be required to detect and prevent duplicate claims for OTP services.

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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 2017 alone, there were 47,600 opioid-related overdose deaths in the United States. Opioid treatment programs (OTPs) provide medication-assisted treatment coupled with counseling and behavioral therapies (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 audited OTPs located in the New York City metropolitan area.¹

OBJECTIVE

Our objective was to determine whether the New York State Department of Health (State agency) claimed Medicaid reimbursement for OTP services provided in the New York City metropolitan area in accordance with Federal and State requirements.

BACKGROUND

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.

New York’s Opioid Treatment Programs

In New York, the State agency administers the Medicaid program and provides Medicaid reimbursement to OTP providers (providers) certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). OASAS inspects providers at least once every 3 years to assess compliance with Federal and State requirements when OASAS re-certifies the providers.²

¹ Specifically, we audited OTP services provided in New York City (Bronx, Kings, New York, Queens, and Richmond Counties), Long Island (Nassau and Suffolk Counties), Westchester County, and Rockland County.

² Title 14 §§ 810.14(c) and 810.14(k) of the New York Compilation of Codes, Rules, and Regulations (NYCRR).

OASAS-certified providers administer OTP services for beneficiaries diagnosed with an opioid use disorder. A beneficiary may receive OTP services at either a freestanding or a hospital-based outpatient clinic. Before treating a beneficiary, providers are required to verify with OASAS's opioid treatment access and dosage registry (central registry) that the beneficiary is not enrolled in another OTP and document the verification. Federal regulations generally limit access to enrollment information contained in the central registry to providers and solely to prevent beneficiary enrollment in multiple OTPs.³ Therefore, OASAS and the State agency do not have access to the central registry.

HOW WE CONDUCTED THIS AUDIT

We limited our audit to Medicaid claims for OTP services provided in the New York City metropolitan area from January 1, 2014, through December 31, 2017 (audit period). During this period, 35 providers submitted 10,754,849 claims and received Medicaid reimbursement totaling \$445,463,540 (\$271,790,254 Federal share). We selected a stratified random sample of 150 claims to determine compliance with Federal and State requirements. We also identified 6,700 potentially duplicate claims totaling \$267,083 (\$159,827 Federal share) from the 10,754,849 claims and selected a nonstatistical sample of 598 claims to determine compliance with Federal and State requirements.

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 contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains a list of related OIG reports.

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some OTP services that did not comply with Federal and State requirements. Of the 150 claims in our sample, 115 claims complied with Medicaid requirements, but 35 claims did not. Table 1 (on the next page) summarizes the deficiencies we noted and the number of claims that contained each type of deficiency.

³ 42 CFR § 2.34(b).

Table 1: Summary of Deficiencies in Sampled Claims

Deficiency	Number of Unallowable Claims⁴
Central registry verifications not adequately documented	18
Diagnosis of opioid addiction not documented	8
Medical records not signed	5
Services not documented or supported	4
Treatment plans missing or not reviewed	4
Toxicology tests not documented	3
Services not identified in treatment plan	1

These deficiencies occurred because providers (1) failed to maintain or provide documentation of OTP services, (2) did not ensure that OTP services were provided in accordance with beneficiaries' treatment plans, and (3) did not maintain signatures for OTP services. Further, although OASAS inspects providers to verify compliance with Federal and State requirements, the State agency did not ensure that OASAS's oversight prevented the errors identified by our audit.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$39,329,059 in Federal Medicaid reimbursement for OTP services during our audit period.⁵

In addition, of the 598 claims in our nonstatistical sample, 299 claims totaling \$8,905 (\$5,830 Federal share) were billed in error.⁶ Specifically, 220 claims were duplicate claims and 79 claims were for services that the providers stated were not provided. Although OASAS inspected providers to verify compliance with Federal and State requirements, the State agency did not ensure that OASAS prevented the errors we identified. Further, OASAS had not implemented procedures to prevent duplicate claims for OTP services.

⁴ The total exceeds 35 because 8 claims contained more than 1 deficiency.

⁵ 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.

⁶ The amount billed in error is included in our estimate of unallowable claims; therefore, we are not recommending a separate recovery of these funds.

THE STATE AGENCY CLAIMED REIMBURSEMENT FOR UNALLOWABLE OPIOID TREATMENT PROGRAM SERVICES

Central Registry Verifications Not Adequately Documented

Providers are required to verify with the central registry that a beneficiary is not enrolled in another OTP and document the verification in the clinical records.⁷

For 18 of the 150 claims in our sample, the providers did not adequately document that they reviewed the central registry to verify that the associated beneficiary was not enrolled in another OTP.⁸ Specifically, for 15 claims, the providers did not document that they had verified that the beneficiary was not enrolled in another OTP. For the remaining three claims, the provider documented its verification; however, the documentation did not contain the date the verification was performed. Therefore, there was not adequate evidence that the verification was performed before the sampled service date. Verifying a beneficiary's enrollment status ensures that beneficiaries are not receiving unnecessary and potentially excessive OTP services for methadone or other maintenance medication administration.⁹

Diagnosis of Opioid Addiction Not Documented

Providers must ensure that beneficiaries are admitted for OTP services by qualified personnel who have determined that the beneficiaries are addicted to an opioid drug. Providers must document beneficiaries' opioid addiction or dependence, and beginning August 25, 2015, the diagnosis must be included in the beneficiaries' treatment plans.¹⁰

For 8 of the 150 claims in our sample, the providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug. Specifically, for two claims with treatment plans dated before August 25, 2015, the beneficiary's *clinical*

⁷ 14 NYCRR §§ 1040.5(b)(5) and 1040.17(a)(2) (effective 1992 through July 18, 2000), 14 NYCRR § 828.7(c) (effective July 19, 2000, through June 28, 2011), 14 NYCRR § 822-5.4(c) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.16(a)(3) (effective August 25, 2015). Additionally, Federal regulations state that providers must document that they made a "good faith effort" to review whether a beneficiary is enrolled in any other OTP (42 CFR § 8.12(g)(2)).

⁸ Because Federal regulations generally limit access to enrollment information contained in the central registry to providers and solely to prevent beneficiary enrollment in multiple OTPs, we were unable to verify whether the beneficiaries were enrolled in other OTPs.

⁹ Methadone is an opioid that, when taken under medical supervision, is used to treat opioid use disorder. Methadone curbs cravings and minimizes withdrawal symptoms. Addiction to methadone can develop if the drug is overprescribed, used without a prescription, or combined with other substances of abuse. Long-term use of methadone can cause nerve, liver, and brain damage.

¹⁰ 42 CFR § 8.12(e)(1), 14 NYCRR § 822-5.4(a) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR §§ 822.8(d)(2) and 822.9(b)(1) (effective August 25, 2015).

record did not contain a diagnosis of an opioid addiction or dependence. For the remaining six claims with treatment plans dated on or after August 25, 2015, the *treatment plans* did not contain a diagnosis of an opioid addiction or dependence. Without documenting a diagnosis of an opioid addiction or dependence, providers cannot ensure that they are providing necessary OTP services to beneficiaries.

Medical Records Not Signed

Medical records of OTP services delivered to beneficiaries must be written and signed (physical or electronic signature) by the staff member that provided the service.¹¹ These records must be maintained in beneficiary case records for 6 years from the date the services were furnished.¹²

For 5 of the 150 claims in our sample, the providers did not maintain signed documentation for OTP services. The providers stated that they had updated or converted their software systems after the sampled service dates, and as a result, the signatures of staff members that provided the services were not retained. Without these signatures, providers cannot demonstrate that services were actually provided by qualified provider staff members.¹³

Services Not Documented or Supported

Providers must maintain medical records of OTP services in beneficiary case records for a period of 6 years from the date the services were furnished.¹⁴

For 4 of the 150 claims in our sample, the providers did not maintain documentation to support the OTP services. The providers stated that two claims were billed in error and that the providers were unable to locate the documentation to support the services for the remaining two claims. Without this documentation, providers cannot demonstrate that services were actually provided in accordance with beneficiaries' treatment plans by qualified provider staff members.

¹¹ 14 NYCRR § 822-2.5(a)(1) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.11(a)(1) (effective August 25, 2015).

¹² 18 NYCRR § 504.3(a), 14 NYCRR § 822-3.1(f)(2) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.6(c) (effective August 25, 2015).

¹³ 42 CFR § 8.12(h), 14 NYCRR § 822-5.9(g)(3) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.7(k)(3)(iv) (effective August 25, 2015).

¹⁴ 18 NYCRR § 504.3(a), 14 NYCRR § 822-3.1(f)(2) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.6(c) (effective August 25, 2015).

Treatment Plans Missing or Not Reviewed

Providers must prepare a treatment plan for each beneficiary, and the plan must be reviewed and updated. The treatment plan must be reviewed, and revised if necessary, at least every 180 calendar days after the beneficiary's first year of treatment.¹⁵ The treatment plan and all reviews and updates must be maintained in the beneficiary's case records.¹⁶

For 4 of the 150 claims in our sample, the providers did not maintain treatment plans covering the sampled service date. Specifically, for one claim, the provider stated that it was unable to locate a treatment plan covering the sampled service date. For the remaining three claims for OTP services provided after the beneficiaries' first year of treatment, the most recent treatment plans were dated more than 180 days before the sampled service dates.¹⁷ The continued review of patient-centered treatment plans is essential to ensuring that beneficiaries receive appropriate and necessary OTP services.

Toxicology Tests Not Documented

Providers must conduct at least eight random drug abuse tests per year, per beneficiary in maintenance treatment (i.e., receiving maintenance medications).¹⁸ Specifically, providers must conduct toxicology tests for the presence of benzodiazepines, cocaine, and opioids¹⁹ and include all laboratory test results in beneficiaries' records.²⁰

For 3 of the 150 claims in our sample, the providers did not document that they conducted at least 8 random toxicology tests per year on the associated beneficiaries. Specifically, for a beneficiary associated with one claim, the provider did not provide *any* toxicology test results for the 1-year period before the sampled service date. For beneficiaries associated with two other claims, the provider documented only six toxicology tests within the 1-year period before

¹⁵ 42 CFR § 8.12(f)(4), 14 NYCRR § 822-5.5(f) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.9(c) (effective August 25, 2015).

¹⁶ 14 NYCRR § 822-2.2(b)(4) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.10(b)(4) (effective August 25, 2015).

¹⁷ For two claims, the treatment plans did not specify the period covered by the plans. Rather, they contained the date the plans were revised, which were between 213 and 317 days before the sampled service dates. For the remaining claim, the period covered by the plan ended 94 days before the sampled service date.

¹⁸ 42 CFR § 8.12(f)(6), 14 NYCRR § 822-5.8(d) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.7(g)(5)(i) (effective August 25, 2015).

¹⁹ 14 NYCRR § 822-5.8(a) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.7(g)(5)(i) (effective August 25, 2015).

²⁰ 14 NYCRR § 822-2.4(a)(2) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.10(c)(2) (August 25, 2015).

the sampled service date. Without conducting required toxicology tests, providers cannot verify that beneficiaries are not using illicit drugs and that their treatment plans are assessed to ensure that caution is used when providing OTP services for methadone or other maintenance medication administration.

Services Not Identified in Treatment Plan

Providers must perform an initial assessment of beneficiaries to determine the most appropriate combination of services and treatment. The assessment must include preparation of a treatment plan that identifies the medical services needed, as well as the frequency these services are to be provided.²¹

For 1 of the 150 claims in our sample, the beneficiary was administered methadone even though the treatment plan did not authorize the use of this medication. Dispensing methadone without proper medical authorization could cause serious harm to beneficiaries, as methadone doses are specifically tailored for individual beneficiaries and methadone may interact with other medications.

THE STATE AGENCY CLAIMED REIMBURSEMENT FOR DUPLICATE MEDICATION ADMINISTRATION SERVICES

New York allows more than one provider to bill for OTP services provided to a beneficiary on the same date of service. This ensures that beneficiaries seeking treatment for opioid use disorders are not denied needed services while transferring from one OTP to another. However, beneficiaries may not be *enrolled* in more than one OTP.²² In addition, providers may bill for methadone or other maintenance medication administration no more than once per day for any beneficiary.²³ Providers must also prepare and maintain service documentation for 6 years from the date the services were furnished²⁴ and document the services in the beneficiaries' case record.²⁵

²¹ 42 CFR § 8.12(f)(4), 14 NYCRR § 822-5.5(d) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.9 (effective August 25, 2015).

²² 42 CFR § 8.12(g)(2), 14 NYCRR § 822-5.3(b) (effective July 1, 2011, through August 24, 2015), and 14 NYCRR § 822.16(a)(3) (effective August 25, 2015).

²³ 14 NYCRR § 822-3.1(h)(9) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 841.14(i)(9) (effective August 25, 2015).

²⁴ 18 NYCRR § 504.3(a).

²⁵ 14 NYCRR § 822-3.1(f)(2) (effective July 1, 2011, through August 24, 2015) and 14 NYCRR § 822.6(c) (effective August 25, 2015).

For 299 of the 598 claims in our nonstatistical sample, we determined that 220 claims totaling \$6,689 (\$4,461 Federal share) were duplicate claims and 79 claims totaling \$2,216 (\$1,369 Federal share) were for services that providers stated were not provided.^{26, 27}

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund \$39,329,059 to the Federal Government,
- ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services, and
- implement procedures to detect and prevent duplicate claims for OTP services.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations; however, it described actions it planned to take to address them. Specifically, the State agency stated that its Office of the Medicaid Inspector General will review the claims identified in our draft report as not having complied with Medicaid requirements and determine an appropriate course of action. The State agency noted that for all 8 of the 150 claims in our sample for which providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug, the providers documented an opioid dependence on claims submitted to the State agency. The State agency also indicated that OASAS planned to issue guidance to providers reminding them of their obligations to comply with Federal and State laws for providing and claiming Medicaid reimbursement for OTP services. Finally, the State agency stated that it planned to investigate whether edits to its Medicaid claims processing system will be required to detect and prevent duplicate claims for OTP services.

We commend the State agency for taking appropriate corrective actions in response to our recommendations. We note, however, that we did not review the effectiveness of these proposed corrective actions. Regarding the eight sample claims for which providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug, we maintain that our findings are valid. Specifically, documenting a diagnosis on a claim submitted to the State agency does not satisfy the Medicaid requirement that

²⁶ We did not identify any instances in which a beneficiary was administered opioid treatment medication more than one time in a day.

²⁷ The amount billed in error is included in our estimate of unallowable claims; therefore, we are not recommending a separate recovery of these funds.

providers must document beneficiaries' opioid addiction or dependence because information contained on Medicaid claims must be supported by providers' records.²⁸ Further, beginning August 25, 2015, the diagnosis must be included in the beneficiaries' treatment plans.^{29, 30}

The State agency's comments are included in their entirety as Appendix E.

²⁸ 14 NYCRR § 822-5.4(a) (effective July 1, 2011, through August 24, 2015) and 18 NYCRR § 504.3(a).

²⁹ 14 NYCRR §§ 822.8(d)(2) and 822.9(b)(1) (effective August 25, 2015).

³⁰ As indicated in the report, for two sample claims with treatment plans dated before August 25, 2015, the beneficiary's clinical record did not contain a diagnosis of an opioid addiction or dependence. For six other sample claims for which providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug, the associated treatment plans were dated on or after August 25, 2015. (See pages 4 and 5.)

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our audit to Medicaid claims for OTP services provided in the New York City metropolitan area. During our audit period, 35 providers submitted 10,754,849 claims and received Medicaid reimbursement totaling \$445,463,540 (\$271,790,254 Federal share). We selected a stratified random sample of 150 claims to determine compliance with Federal and State requirements. We also identified 6,700 potentially duplicate claims totaling \$267,083 (\$159,827 Federal share) from the 10,754,849 claims and selected a nonstatistical sample of 598 claims to determine compliance with Federal and State requirements.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS)³¹ for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims' data in the MMIS with the State agency's claims for reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures (CMS-64).

During our audit, we did not assess the overall internal control structure of the State agency, OASAS, or Medicaid. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's and OASAS's offices in Albany, New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency and OASAS officials to gain an understanding of the OTP program;
- obtained from New York's MMIS a sampling frame of 10,754,849 claims for OTP services provided during our audit period by New York City metropolitan area providers, totaling \$445,463,540 (\$271,790,254 Federal share);
- reconciled the claims for OTP services that the State agency claimed for Federal Medicaid reimbursement on the CMS-64 to the sampling frame of paid claims for OTP services obtained from New York's MMIS file for specific quarters within our audit period;

³¹ The MMIS is a computerized payment and information reporting system used to process and pay Medicaid claims.

- selected a stratified random sample of 150 claims from our sampling frame and, for each claim, reviewed provider and beneficiary records to determine whether the providers documented in the beneficiaries' records the following:
 - verification with the central registry that the beneficiary was not enrolled in another OTP,
 - diagnoses that the beneficiaries were addicted to or dependent on an opioid drug,
 - signed documentation supporting the services provided on the sampled service dates,
 - beneficiary treatment plans that authorized the services provided on the sampled services dates, and
 - at least eight random toxicology tests within the 1-year period before the sampled service dates;
- used computer programming to identify 6,700 potentially duplicate claims³² in our sampling frame totaling \$267,083 (\$159,827 Federal share);
- selected a nonstatistical sample of 598 claims from the potentially duplicate claims in our sampling frame, and for each claim, reviewed beneficiary records supporting the claim to determine whether the claims complied with Federal and State requirements;
- estimated the total amount of Federal Medicaid reimbursement for unallowable OTP services made to the State agency during the audit period; and
- discussed our results with State agency and OASAS officials.

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.

³² We defined a potentially duplicate claim as an instance in which more than one Medicaid claim for medication administration services was billed on a single day by one or more providers for the same beneficiary.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of six Access files containing 10,754,849 claims for OTP services provided during our audit period by New York City metropolitan area providers, totaling \$445,463,540 (\$271,790,254 Federal share).³³ The Medicaid claims were extracted from the MMIS.

SAMPLE UNIT

The sample unit was an OTP claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. To accomplish this, we separated the sampling frame into three strata as shown in Table 2.

Table 2: Frame Description and Sample Size

Stratum Number	Dollar Range of OTP Claims	Total Claims	Total Reimbursement	Total Federal Share	Claims Sampled
1	≤\$12.25	4,219,308	\$96,707,630	\$48,355,143	59
2	>\$12.25 and ≤\$21.255	3,569,568	94,851,291	66,028,938	50
3	>\$21.255	2,965,973	253,904,619	157,406,173	41
	Total	10,754,849	\$445,463,540	\$271,790,254	150

Note: The strata bounds were based on Federal share amounts.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services, statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 150 random numbers following our stratified design, we selected the corresponding claims in the sampling frame for our sample.

³³ We excluded claim lines associated with a provider that was under indictment for Medicaid fraud.

ESTIMATION METHODOLOGY

We estimated the total amount of the unallowable OTP claims for which the State agency claimed reimbursement at the lower limit of the two-sided 90-percent confidence interval. We also used the statistical software to calculate the corresponding point estimate and upper limit of the two-sided 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results

Stratum Number	Total Claims	Total Federal Share	Claims Sampled	Value of Sample (Federal share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal share)
1	4,219,308	\$48,355,143	59	\$677	13	\$146
2	3,569,568	66,028,938	50	929	11	215
3	2,965,973	157,406,173	41	2,613	11	413
Total	10,754,849	\$271,790,254	150	\$4,220³⁴	35	\$774

Table 4: Estimated Value of Unallowable Claims (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$55,647,993
Lower limit	39,329,059
Upper limit	71,966,927

³⁴ Differences in total calculations are due to rounding.

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<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
<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>	<u>A-03-17-03302</u>	3/28/2019
<i>New York Did Not Provide Adequate Stewardship of Substance Abuse Prevention and Treatment Block Grant Funds</i>	<u>A-02-17-02009</u>	3/20/2019

APPENDIX E: STATE AGENCY COMMENTS



Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 27, 2019

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javits Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: **02-17-01021**

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report **A-02-17-02021** entitled, "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."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Diane Christensen
Elizabeth Misa
Geza Hrazdina
Dan Duffy
Jeffrey Hammond
Jill Montag
Michael Spitz
James DeMatteo
James Cataldo
OHIP Audit SM

**New York State Department of Health
Comments on the Department of Health and Human Services
Office of Inspector General Draft Audit Report A-02-17-01021 entitled,
“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”**

The following are the New York State Department of Health’s (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-17-01021 entitled, “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”.

Recommendation #1:

Refund \$39,329,059 to the Federal Government.

Response #1:

As part of the Office of the Medicaid Inspector General’s (OMIG) ongoing efforts in auditing Opioid Treatment Program (OTP) providers, the State has identified and refunded \$4 million to date to the Federal Government. Additional OMIG audits of 10 OTP providers are underway. OMIG has requested records and supporting documentation from the OIG to analyze the findings of this audit and, in conjunction with the Department and the Office of Addiction Services and Supports (OASAS), will determine an appropriate course of action.

Recommendation #2:

Ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services.

Response #2:

OASAS will issue guidance to OTP providers reminding them of their obligations to comply with state and federal laws and rules for providing and claiming Medicaid reimbursement for OTP services including Utilization Review requirements (14 NYCRR 822.7) and Medicaid Compliance Program obligations (18 NYCRR Part 521). To the extent OTPs discover billing anomalies, they will be reminded to comply with the requirements of self-disclosure of overpayments to the OMIG.

Of note, for all of the 8 of 150 claims in the sample that the providers did not document that the associated beneficiary was diagnosed as being addicted to or dependent on an opioid drug in the clinical record or treatment plans, the 8 claims submitted by the providers documented the following diagnoses: F1120- Opioid Dependence, Uncomplicated or 30400- Opioid Type Dependence, Unspecified.

Recommendation #3:

Implement procedures to detect and prevent duplicate claims for OTP services.

Response #3:

OASAS will issue guidance in January 2020 to OTP providers reminding them of their obligations to comply with Utilization Review requirements (14 NYCRR 822.7) and Medicaid Compliance Program obligations (18 NYCRR Part 521). To the extent such reviews reveal duplicate claims, they will be reminded to comply with the requirements of self-disclosure of overpayments to the OMIG.

Additionally, the Department is investigating if system edits will be required to detect and prevent duplicate claims for OTP services.