Department of Health and Human Services
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January 2026 | A-01-24-00006

Maine Made at Least $45.6 Million in Improper Fee-for-Service Medicaid Payments for Rehabilitative and Community Support Services Provided to Children Diagnosed With Autism

REPORT HIGHLIGHTS

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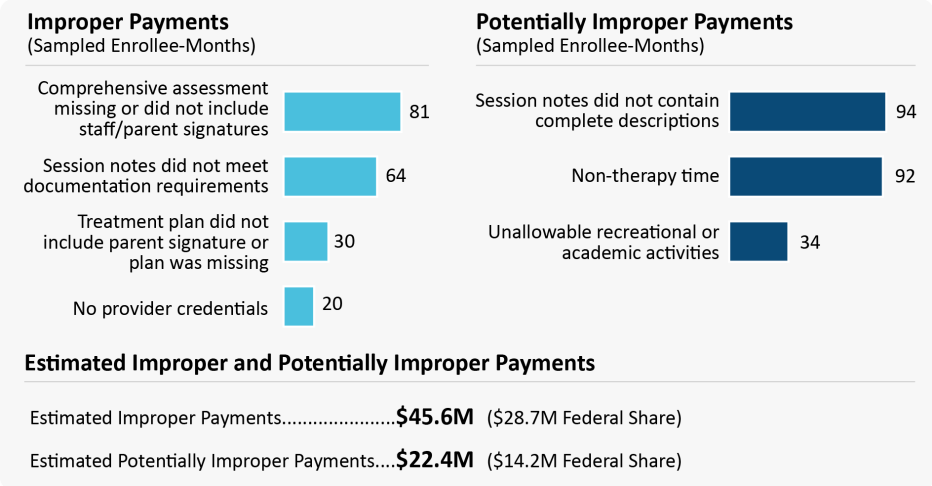
Maine Made at Least $45.6 Million in Improper Fee-for-Service Medicaid Payments for Rehabilitative and Community Support Services Provided to Children Diagnosed With Autism

Why OIG Did This Audit

- Early treatment for autism is important because proper care can reduce children's difficulties while helping them build on their strengths and learn new skills. In Maine, rehabilitative and community support (RCS) services for children diagnosed with autism include applied behavior analysis and other treatments for autism.
- Maine's fee-for-service (FFS) Medicaid payments for RCS services in 2019 were $52.2 million, and by 2023, these payments had increased to $80.6 million.
- This audit examined whether Maine's FFS Medicaid payments for RCS services for 2023 complied with Federal and State Requirements.

What OIG Found

Maine's payments for RCS services did not fully comply with Federal and State requirements. All 100 sampled enrollee-months included payments for one or more claim lines that were improper or potentially improper. On the basis of our sample results, we estimated the State agency made improper payments of at least $45.6 million ($28.7 million Federal share).



What OIG Recommends

We made four recommendations, including that Maine refund $28.7 million to the Federal Government, provide additional guidance to RCS providers for documenting RCS services, and periodically perform a statewide postpayment review of Medicaid payments for RCS services to educate providers on requirements.

Maine potentially concurred with our first recommendation and concurred with our remaining recommendations. Maine detailed steps it plans to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Autism spectrum disorder (autism) is a condition related to brain development that is characterized by some degree of difficulty with social interaction and communication, as well as by limited and repetitive patterns of behavior. The symptoms and severity of autism vary widely among those who have the condition. Early treatment for autism is important because proper care can reduce children's difficulties while helping them build on their strengths and learn new skills. Although there are other treatments for autism, applied behavior analysis (ABA) is a commonly used therapy for managing autism symptoms, usually centered on improving social and communication skills. In Maine, rehabilitative and community support (RCS) services for children diagnosed with autism include ABA and other treatments for autism.

The Centers for Medicare & Medicaid Services (CMS) issued a bulletin in July 2014 to clarify that State Medicaid programs must cover diagnosis and treatment, which may include ABA and other services, for children with autism.[1] In the past several years, Federal and State agencies have identified questionable billing patterns (e.g., billing for excessive units of service) by some ABA providers and Federal and State payments to providers for unallowable services.[2] Maine's fee-for-service (FFS) Medicaid payments for RCS services, including ABA, in calendar year (CY) 2019 were $52.2 million, and by CY 2023 these payments had increased to $80.6 million.[3] Therefore, we conducted this audit of the Maine Department of Health and Human Services' (State agency's) FFS Medicaid payments for RCS services for CY 2023 (audit period). The Office of Inspector General (OIG) performed similar audits to determine whether Indiana's and Wisconsin's FFS Medicaid payments for ABA provided to children diagnosed with autism complied with Federal and State requirements.[4]

OBJECTIVE

Our objective was to determine whether the State agency's FFS Medicaid payments for RCS services provided to children diagnosed with autism complied with Federal and State requirements.

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[1] CMS, Center for Medicaid and CHIP Services Informational Bulletin, "Clarification of Medicaid Coverage of Services to Children with Autism," July 7, 2014. Accessed on July 16, 2025.

[2] See, for example, the Department of Defense (DOD), Office of Inspector General (OIG), *The Defense Health Agency Improperly Paid for Autism-Related Services to Selected Companies in the TRICARE South Region* (DODIG-2017-064), March 10, 2017. Accessed on July 16, 2025. DOD-OIG, *TRICARE North Region Payments for Applied Behavior Analysis Services for the Treatment of Autism Spectrum Disorder* (DODIG-2018-084), March 14, 2018. Accessed on July 16, 2025. State of Nevada Performance Audit, *Delivery of Treatment Services for Children With Autism 2020* (LA22-04), January 6, 2021. Accessed on July 16, 2025.

[3] In CY 2024, FFS payments for RCS increased to $103.8 million.

[4] OIG, *Indiana Made at Least $56 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavior Analysis Provided to Children Diagnosed With Autism* (A-09-22-02002), Dec. 16, 2024, and OIG, *Wisconsin Made at Least $18.5 Million in Improper Fee-for-Service Medicaid Payments for Applied Behavioral Analysis Provided to Children Diagnosed With Autism* (A-06-23-01002), July 14, 2025.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, 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.

The Federal Government pays its share of a State's medical assistance expenditures (called Federal financial participation, or the Federal share) based on the Federal medical assistance percentage (FMAP), which varies depending on the State. (During our audit period, Maine's FMAP ranged from 62.65 to 63.29 percent.) To claim the Federal share, States report their Medicaid expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

Maine's Medicaid Program

In Maine, the State agency's Office of MaineCare Services (OMS) administers the Medicaid program, known as MaineCare. OMS contracts directly with health care providers, including behavioral health providers that provide RCS services. Within the State agency, the Maine Office of Behavioral Health provides oversight for children's behavioral health services, including RCS services. The behavioral treatment benefits, including RCS services, are administered through FFS.

Rehabilitative and Community Support Services and Applied Behavior Analysis

RCS services help children with developmental disabilities, including autism, build skills in areas of daily living and behavioral management to support the child's functioning in their home and community. There are two different levels of treatment for children diagnosed with autism under Maine's RCS services: standard RCS and specialized RCS.[5, 6] RCS services can be provided individually to one child or in a group setting. These services are provided in a child's home or school or in community settings. According to the State agency, although some components of ABA (e.g., prompting and skill modeling) can be delivered as a standard RCS service, ABA services

Examples of ABA Techniques

Mand Training
Uses prompting and reinforcement to help a child communicate

Discrete Trial Training
Breaks skills into small units to teach one by one

Natural Environment Training
Targets skill development in a less structured environment

Modeling
Presents an example of a desired behavior for the child to imitate

[5] MBM, chapter 2, §§ 28.04-1 and 28.04-2.

[6] The State refers to nonspecialized RCS services as standard RCS services.

are typically delivered as a specialized RCS service. Examples of ABA techniques (i.e., specialized RCS services) are shown in the box to the right.

Maine's Medicaid Coverage of Rehabilitative and Community Support Services

The State agency began covering RCS services for the treatment of autism on April 1, 2010. The State agency's minimum requirements for Medicaid coverage are stated in the *MaineCare Benefits Manual* (MBM).[7] The MBM, chapter 2, section 28, contains the requirements for RCS services for children with cognitive impairments and functional limitations.[8]

The State agency has the responsibility for policy development and revision including the development and revision of MaineCare rules regarding the amount, duration, and scope of services and the management of the State plan. In addition, the State agency publishes provider help and guidance through emails and its online portal. The State agency's website also includes a Behavioral Health Professional (BHP) Training and Certification Program that includes a module on best practices for clinical documentation.[9]

MaineCare covers RCS services for children who are under 21 years of age and have a behavioral health diagnosis, including a diagnosis of autism (MBM, chapter 2, § 28.02(C)). To be eligible for RCS services for children, the State agency requires that the enrollee must have completed a mutiaxial evaluation with an Axis I or an Axis II behavioral health diagnosis.[10] Providers must make this diagnosis using the most recent version of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (for Axis I or Axis II) or the most recent *Diagnostic Classification of Mental Health or Developmental Disorders of Infancy and Early Childhood Manual* (for Axis I).[11, 12]

[7] The MBM is codified into the State's regulations at Code of Maine Rules 10-144-101.

[8] The MBM, chapter 1, § 1 (General Administrative Policies and Procedures) and chapter 2, § 28, both contain provisions describing required elements of documentation, including those that pertain to RCS services.

[9] The State agency, Office of Behavioral Health, "Development & Training." Accessed on July 7, 2025.

[10] A multiaxial evaluation is a comprehensive mental health assessment and evaluation of the patient's presenting symptoms, general medical condition, psychosocial and environmental problems, and level of function. Axis I focuses on mental disorders. Axis II focuses on personality disorders and intellectual disabilities.

[11] MBM, chapter 2, § 28.02(C)(1).

[12] For enrollees under the age of 6, the enrollee must have a diagnosis from a physician of a specific congenital or acquired condition and a written assessment from a physician that there is a significant probability that because of that condition (e.g., autism), the enrollee will meet the functional impairment requirement later in life if medically necessary services and supports are not provided (MBM, chapter 2, § 28.02(C)(2)).

To provide specialized RCS services, BHPs must be under the supervision of a licensed psychologist or a BCBA or equivalent.[13] BCBAs must be certified by the Behavior Analyst Certification Board (the Board).[14] Requirements for RCS provider types in Maine are shown in the box to the right.[15]

Requirements for RCS Provider Types in Maine

1 Behavioral Health Professional (BHP)

- 18 years of age or older
- High school diploma or equivalent
- Complete BHP certification within 1 year of hire
- For Home and Community Based Treatment, complete 1 of the following:
  - 60 higher education credit hours in an ABA related field,
  - 90 higher education credits in an unrelated field, or
  - 3 years of direct experience working with children in a behavioral health program

2 Board Certified Behavior Analyst (BCBA)

- Graduate-level degree in an ABA-related field
- Pass BCBA exam
- Certification by the Behavior Analyst Certification Board

To receive Medicaid payments for RCS services, a provider must obtain prior authorization from the State agency prior to the start of all services (MBM, chapter 2, § 28.08-1(B)).[16] Providers must submit to the State agency a prior authorization request, including the diagnosis for which the request is being made, along with supporting documentation (i.e., diagnostic studies and treatment completed to date along with results, and clinical records upon which the request has been made) (MBM, chapter 1, § 1.14-1). After submitting a prior authorization request, the provider will receive prior authorization with a description of the type, duration, and cost of the services authorized. The State agency contracts with an outside administrative services organization to review and process requests for prior authorizations for behavioral health services, including RCS services.

The provider must keep a written record for each enrollee that must include a comprehensive assessment, an individual treatment plan (ITP), and dated progress notes (MBM, chapter 2, § 28.05-1).

Levels of Rehabilitative and Community Support for Children With Autism

Standard RCS treatment covers in-home and community services that help youth with autism and their families develop prosocial, safe behaviors and activities of daily living. A BHP works in the home to support the family in skill development. RCS focuses on skill building and does not have a therapy

[13] MBM, chapter 2, § 28.08-2(C)(2)(a). State agency officials stated that the State is permitted to approve a supervisor who can demonstrate to the State that they possess comparable knowledge, skills, or training equivalent to a licensed psychologist or BCBA. State agency officials stated that although BHPs deliver most standard and specialized RCS services, qualified supervisors are responsible for some components of service delivery. Supervisors of direct care staff must meet certain professional qualifications (e.g., licensed professional counselor, psychologist, or physician).

[14] The Board certifies two levels of BCBAs: a master's degree level and a doctorate degree level. The doctorate degree level is differentiated by a "D" (i.e., BCBA-D). In this report, we refer to both levels as "BCBAs."

[15] Maine State plan (TN No. 20-0010), attachment 3.1-A, page 5(a)(xxiv).

[16] The State agency received a waiver under section 1135 of the Act to suspend Medicaid FFS prior authorization requirements during the COVID-19 public health emergency (PHE). Medicaid.gov, *Section 1135 Waiver Flexibilities–Maine Coronavirus Disease 2019*, April 7, 2020. Accessed on July 16, 2025. The PHE ended on May 11, 2023.

component.[17] The MBM refers to these services as treatment services for children with cognitive impairments and functional limitations. These services are designed to retain or improve functional abilities.

Specialized RCS is an in-home community support service that uses evidence-based interventions through ABA to help families of youth with autism address significant impairments in communication, life skills, and self-regulation skills to improve social functioning and increase developmentally appropriate skills. A clinical specialist (e.g., BCBA) and a BHP work in the home to support this work.[18] The MBM refers to these services as specialized services for children with cognitive impairments and functional limitations. These services use behavioral interventions designed to improve socially significant behaviors and developmentally appropriate skills to a measurable degree.

Providers' Use of Healthcare Common Procedure Codes for Billing Rehabilitative and Community Support Services

During our audit period, providers in Maine used Healthcare Common Procedure Coding System (HCPCS) codes to bill for RCS services.[19] Specifically, Maine used procedure code H2021 for children's standard RCS services and specialized RCS services. Each of these HCPCS codes is billed in 15-minute increments (i.e., 1 unit) of service provided to a person enrolled in Medicaid (enrollee). Providers typically attach modifiers to this HCPCS code to indicate whether the BHP provided one-to-one or group treatment, standard or specialized treatment, and to distinguish school-based treatment from home and community-based services.

HOW WE CONDUCTED THIS AUDIT

Our audit covered the State agency's FFS Medicaid payments of $76,715,537 ($48,391,817 Federal share) for 165,309 claim lines for RCS services, which we grouped into 11,777 enrollee-months with dates of service from January 1, 2023, through December 31, 2023.[20] Our audit included only enrollee-months with payments totaling more than $1,000.[21] We selected a stratified random sample of 100 enrollee-months, with payments totaling $779,742 ($491,941 Federal share).[22]

The 100 enrollee-months in our sample consisted of 31 unique providers and 96 unique enrollees. Total payments for each sampled enrollee-month ranged from $1,024 to $22,099. We requested the

[17] The State agency, *Rehabilitative & Community Support (RCS)*. Accessed July 16, 2025.

[18] The State agency, *Specialized Rehabilitative & Community Support (Specialized RCS)*. Accessed on July 16, 2025.

[19] HCPCS codes are a collection of standardized codes that represent medical procedures, supplies, products, and services. The codes are used to facilitate the processing of health insurance claims by Medicare and other insurers.

[20] An enrollee-month consisted of all FFS Medicaid claim lines for RCS services for an individual enrollee for which the service date of each claim line fell within the month. A claim line consisted of a specific RCS service, generally for a specific date of service. Each claim line was paid individually.

[21] Enrollee-months with payments totaling less than $1,000 accounted for approximately 1 percent of total ABA payments.

[22] There were 731 claims, and 1,491 lines associated with the 100 sampled enrollee-months.

following supporting medical record documentation from providers for each sampled enrollee-month: (1) the approved prior authorization, (2) completed evaluations and diagnostic conclusions (e.g., comprehensive assessments or diagnostic evaluation), (3) the ITP, (4) provider licensure and credentials, and (5) the session notes supporting the units of RCS paid.

We reviewed the documentation to determine whether: (1) the prior authorization was approved and covered the sampled enrollee-month, (2) the documentation confirmed a diagnosis of autism, (3) the comprehensive assessment was developed, (4) the ITP included the required elements (i.e., services to be provided with methods, frequency, and duration of services), (5) session notes included required elements (such as the name of the child and the duration of RCS services) and supported the units of RCS services paid, and (6) services were provided by qualified providers.

We did not use a medical reviewer to determine whether the services were medically necessary. We shared documentation for some of the sampled enrollee-months that contained claim lines that were improper or potentially improper payments with the State agency and asked the State agency to provide input on whether the documentation supported the paid services. We also held meetings with the State agency to discuss what type of support it would expect to see in the providers' session notes and other documentation.

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 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 B describes our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D shows our audit results by sampled enrollee-month.

FINDINGS

The State agency's FFS Medicaid payments for RCS services provided to children diagnosed with autism did not fully comply with Federal and State requirements. Specifically, all 100 sampled enrollee-months included payments for 1 or more claim lines that were improper or potentially improper.[23] For 92 of the 100 sampled enrollee-months, the State agency made payments of $576,421 ($363,717 Federal share) for at least 1 claim line that did not comply with the requirements. Specifically, we found the following deficiencies:[24]

- RCS services were provided to children who either did not receive the required comprehensive assessments or the assessments did not include signatures of the staff who conducted the

[23] Each sampled enrollee-month had claim lines that we determined to be improper or potentially improper. When a claim line could be considered improper for one reason and potentially improper for a different reason, we considered the claim improper to avoid double counting.

[24] The number of deficiencies is greater than 92 because 63 sampled enrollee-months had more than 1 deficiency.

assessments or the parents or guardians (81 sampled enrollee-months).

- Session notes describing the RCS services provided did not meet documentation requirements (e.g., session notes did not support the number of units billed) (64 sampled enrollee-months).

- The ITPs did not include parent signatures, or the ITP was missing (30 sampled enrollee-months).

- Documentation did not include provider credentials (20 sampled enrollee-months).

On the basis of our sample results, we estimated that the State agency made improper payments of at least $45.6 million ($28.7 million Federal share).[25, 26] In addition, for 95 of 100 sampled enrollee-months, the State agency made potentially improper payments for RCS services. We identified the following issues with the supporting documentation for these sampled enrollee months:[27]

- Session notes did not contain a full description of the services provided or did not include the goals addressed or data collected (94 sampled enrollee-months).

- Session notes included nontherapy time (e.g., lunch, naps, and breaks) (92 sampled enrollee-months).

- Session notes referred to recreational or academic activities that may not have been allowable RCS activities (34 sampled enrollee-months).

We set aside for State agency resolution $128,224 (Federal share) for 46 sampled enrollee-months because documentation was not complete enough to support that payments complied with Federal and State requirements, or documentation was unreliable.[28] Based on our sample results, we estimated that the State agency made approximately $22.4 million ($14.2 million Federal share) of potentially improper payments for RCS services.[29] Figure 1 on the next page shows a summary of our findings.

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[25] The actual estimated amount was $45,638,476 ($28,796,366 Federal share).

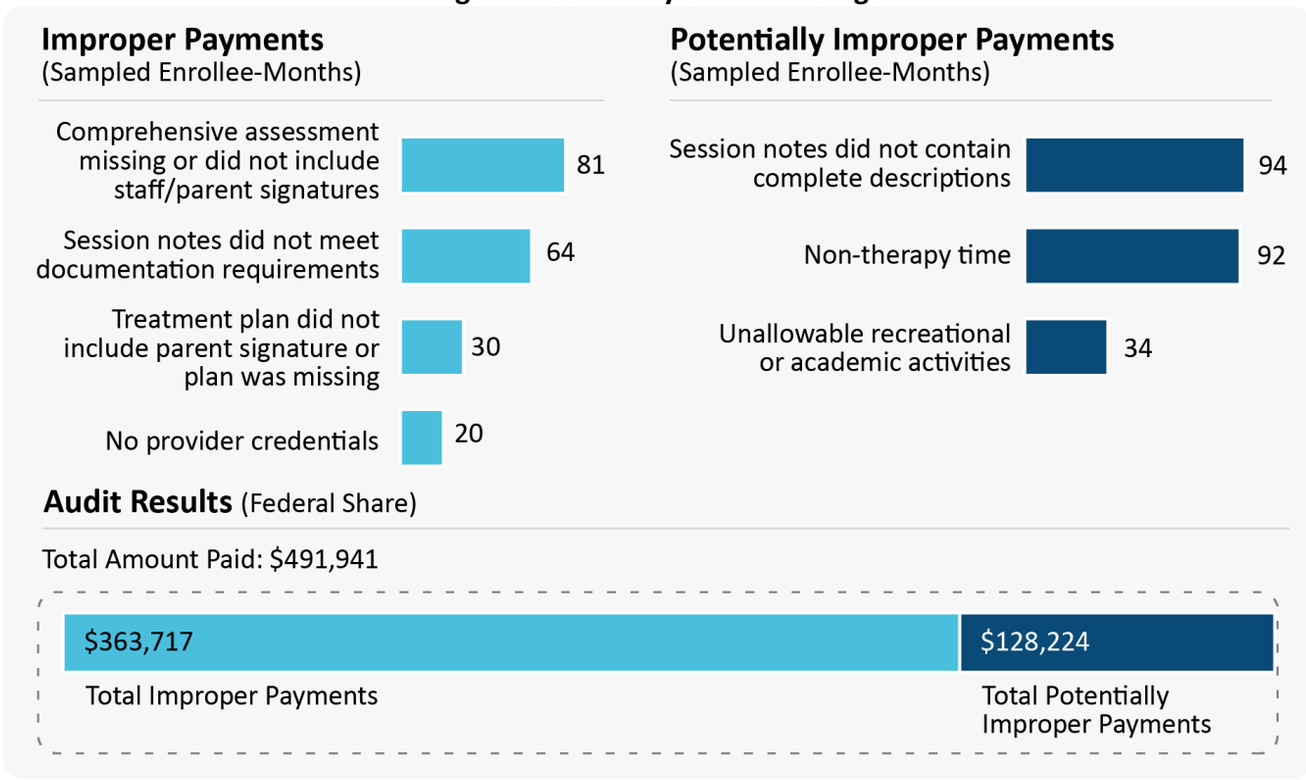
[26] To be conservative, we recommend recovery of improper payments at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual improper payment total 95 percent of the time.

[27] The number of deficiencies is greater than 95 because 92 sampled enrollee-months had more than 1 deficiency.

[28] Of the 100 sampled enrollee-months, 95 had payments that were potentially improper. For 49 of the 95 enrollee-months, we determined all of the payments were improper. For estimation purposes, we only included the payment error amounts in the improper category to avoid double counting for claim lines that were both improper and potentially improper.

[29] The actual estimated amount was $22,440,690 ($14,163,521 Federal share).

Figure 1: Summary of Our Findings



The State agency made improper and potentially improper payments because it did not provide effective oversight of FFS Medicaid payments for RCS services. Specifically, since the program began in 2010, the State agency had not performed a statewide postpayment review of payments to RCS providers to verify that providers complied with Federal and State requirements related to documentation. Performing periodic postpayment reviews and sharing the results with providers as part of ongoing education may have prevented the State agency from making improper or potentially improper payments. In addition, the State agency did not provide sufficient guidance to providers for documenting RCS services.

THE STATE AGENCY MADE IMPROPER PAYMENTS FOR REHABILITATIVE AND COMMUNITY SUPPORT SERVICES

For 92 of the 100 sampled enrollee-months, the State agency made FFS Medicaid payments for RCS Services that: (1) were provided to children who either did not receive the required comprehensive assessments or the assessments did not include signatures of the staff who conducted the assessments or the parents or guardians, (2) had session notes describing the RCS services provided that did not meet documentation requirements, (3) had ITPs that did not include parent signatures or in one instance did not have an ITP, and (4) had documentation that did not include provider credentials. In total, the State agency improperly paid $576,421 for the sampled enrollee-months (Appendix D). These improper payments occurred because the State agency did not perform a statewide postpayment review of payments to RCS providers to verify that providers complied with Federal and State documentation requirements. Additionally, the State agency did not provide sufficient guidance to providers for documenting RCS services.

Federal and State Requirements

States are required to have agreements with providers to keep such records as are necessary to fully disclose the extent of the services provided (the Act § 1902(a)(27)). Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (*State Medicaid Manual* § 2497.1). Federal financial participation is available for covered services furnished only by certified providers (*State Medicaid Manual* § 2497.1).

Providers must maintain and retain contemporaneous financial, provider, and professional records sufficient to fully and accurately document the nature, scope, and details of the health care or related services or products provided. Records must include, but are not limited to, all required signatures, treatment plans, progress notes, date and nature of services, duration of services, and titles of persons providing the services (MBM, chapter 1, § 1.03-8(M)).

In the absence of proper and comprehensive records, no payment will be made or payments previously made may be recouped (MBM, chapter 1, § 1.18). The State agency may recoup identified overpayments for breaching the requirements of section 1.03-8 for provider participation (MBM, chapter 1, § 1.20-1(G)). The State agency may also impose a penalty equal to 25 percent when the provider's records lack a required signature from a member or the member's guardian (MBM, chapter 1, § 1.20-2(H.2))

Records must also include a comprehensive assessment, ITP, and dated progress notes (MBM, chapter 2, § 28.05-1).

A supervisor must complete a comprehensive assessment within 30 days of initiation of services, and it must be included in the member's record. The comprehensive assessment must include a direct encounter with the enrollee, if appropriate, and parents or guardians (MBM, chapter 2, § 28.05-2(A)). The comprehensive assessment must contain the reason for the referral, family history relevant to family functioning, the enrollee's developmental history, if known, and the enrollee's strengths and needs regarding functioning (MBM, chapter 2, § 28.05-2(B)). The comprehensive assessment must be summarized, signed, and credentialed with licensure or certification, if applicable, and dated by the staff conducting the assessment. In addition, the parent or guardian and the member, if appropriate, must sign the assessment, and it must include the source and date of the diagnosis (MBM, chapter 2, § 28.05-2(C)).

The ITP must be developed within 30 days of initiation of services and must contain the following: (1) diagnosis and reason for receiving the service; (2) services to be provided with methods, frequency, and duration of services, and designation of who will provide the service; and (3) objectives with target dates that allow for measurement of progress toward meeting goals. The ITP must also include special accommodations needed to address barriers to provide the service. The parent or guardian and the member, if applicable, must sign and date the ITP (MBM, chapter 2, § 28.05-3(A) and (B)).

Providers must maintain written progress notes for all treatment services in chronological order. The progress notes must include the treatment services provided, the provider's signature, the date of

service, the duration of service, and the enrollee's progress toward attaining the goals or outcomes identified in the ITP (MBM, chapter, 2 § 28.05-4).

The State agency will limit reimbursement for RCS services to those that are documented and approved in the treatment plan. The State agency will not reimburse for services provided during the child's regular sleeping hours (MBM, chapter 2, § 28.06-1). Services that are primarily academic, vocational, social, recreational, or custodial in nature are not covered and are not reimbursable (MBM, chapter 2, § 28.07, and chapter 1, § 1.06-4(B)(3)).

The documentation must demonstrate only one staff person's time is billed for any specific activity provided to the member (MBM, chapter 2, § 28.09).

RCS services provided by a BHP must be supervised by a qualified professional supervisor (MBM, chapter 2, § 28.08-2(B)). Specialized RCS services must be provided under the supervision of a licensed psychologist or a BCBA or equivalent (MBM, chapter 2, § 28.08-2(C)).

Comprehensive Assessment Was Missing or Did Not Include Signatures of Staff or Parents or Guardians

For 81 sampled enrollee-months from 21 providers, the State agency paid the providers for RCS services provided to children who either did not receive required comprehensive assessments, the assessments did not include signatures of the staff who conducted the assessments or signatures of the parents or guardians, or the assessments did not include the source and date of the diagnosis. Specifically, for 47 sampled enrollee-months, there was no documentation of comprehensive assessments. For 33 sampled enrollee-months, the comprehensive assessments did not include signatures of the staff who conducted the assessments or the signatures of the parents or guardians. For 1 sampled enrollee-month, the comprehensive assessment did not include the source and date of the diagnosis. Specifically, for this sample, the assessment included only a diagnosis code and a description of the diagnosis (i.e., autism spectrum disorder).

Session Notes Did Not Meet Documentation Requirements

Session Notes Did Not Support the Number of Units of Rehabilitative and Community Support Services Paid

For 53 sampled enrollee-months from 16 providers, the State agency paid the providers for more units of RCS services than the number of units supported by the session notes. Specifically, one or more of the following deficiencies occurred at each provider: (1) units of RCS services were paid that exceeded the overall time shown in the session notes, (2) session notes did not support that RCS services were provided during the time that providers documented other services for a child (e.g., speech therapy, occupational therapy, or physical therapy), or (3) RCS services were paid for services that two BHPs provided the same enrollee during the same timeframe.

For 30 sampled enrollee-months from 12 providers, units of RCS services were billed and paid in excess of the time the session notes supported. For example, one session note showed that on 1 day the child received RCS services from 8:30 to 11:00 (10 units); however, the provider billed and was paid for

12 units. During the same enrollee-month, the session notes showed that on 2 additional days the child received RCS services from 8:30 to 11:30 (12 units each day); however, the provider billed and was paid for 14 units each day.

For 24 sampled enrollee-months from seven providers, the State agency paid for RCS services for which the session notes did not support that RCS services were provided during the time that providers documented other therapy services for a child (i.e., speech therapy occupational therapy, or physical therapy). For example, for 1 sampled enrollee-month, the session notes for six dates of service did not support that RCS services were provided while the child received speech or occupational therapy. Specifically, the provider documented that the child received 30 minutes of speech therapy each day (e.g., 11:00 to 11:30) during the same timeframe that the provider billed for RCS services (12 units total). The provider also documented that on 1 of these days, a child received occupational therapy from 3:00 to 4:00 (4 units). However, the session notes did not include documentation of any RCS services provided. Therefore, for this sampled enrollee month, the State agency paid for 16 units of RCS services that were not supported by the session notes.

For 7 sampled enrollee-months from one provider, the State agency paid for services that two BHPs provided to the same enrollee during the same timeframe. For example, one session note showed that a BHP provided RCS services to a child from 7:30 to 2:00 (26 units). However, on the same day another session note showed that a different BHP provided RCS services to the same enrollee from 11:00 to 2:00 (12 units). Thus, the provider billed and was paid for 38 units but should have been paid for only 26 units.

Session Notes Did Not Include Signatures of Providers Who Rendered Rehabilitative and Community Support Services

For 17 sampled enrollee-months from eight providers, the State agency paid for RCS services for which the session notes did not include signatures of the providers who rendered the services. If there was not a provider signature at the time the services were rendered, it is not possible to confirm the author of the session notes or that the service was provided as documented.

Session Notes Were Missing

For 12 sampled enrollee-months from six providers, the State agency paid for RCS services provided on one or more dates of service for which the providers were unable to provide session notes.

Treatment Plan Did Not Include a Parent or Guardian Signature or the Treatment Plan Was Missing

For 30 sampled enrollee-months from 10 providers, the treatment plan did not include a parent or guardian signature (29 sampled enrollee months) or there was no documentation of a treatment plan (1 sampled enrollee month).

Documentation Did Not Include Provider Credentials

For 20 sampled enrollee-months from seven providers, the State agency paid for RCS Services for which the documentation did not include provider credentials (i.e., BHP and or BCBA certificates). For

these samples, we could not confirm that RCS services were provided by staff who had the appropriate credentials and that the quality of care that children received was appropriate.

The State Agency Did Not Perform a Statewide Postpayment Review of Payments for Rehabilitative and Community Support Services and Did Not Provide Sufficient Guidance to Providers

The State agency made improper payments for the 92 sampled enrollee-months because it had not performed a statewide postpayment review of RCS services and shared the results with providers as part of ongoing education since the program began in 2010. Performing periodic postpayment reviews and sharing the results with providers as part of ongoing education may have prevented the State agency from making improper payments. In addition, the State agency did not provide sufficient guidance to providers for documenting RCS services.

THE STATE AGENCY MADE POTENTIALLY IMPROPER PAYMENTS FOR REHABILITATIVE AND COMMUNITY SUPPORT SERVICES

For 95 of 100 sampled enrollee-months, the State agency made potentially improper payments for RCS services for which documentation was not complete or was unreliable. Specifically, session notes: (1) did not include a complete description of each service provided, (2) included nontherapy time, or (3) referred to unallowable recreational or academic activities. In total, the State agency made potentially improper payments of $128,224 for 46 sampled enrollee-months (Appendix D). These potentially improper payments occurred because the State agency did not perform a statewide postpayment review of payments for RCS services to verify that providers complied with Federal and State documentation requirements. Additionally, the State agency did not provide sufficient guidance to providers for documenting RCS services and did not issue guidance to providers on what it considers billable RCS service time.

Federal and State Requirements and Guidance

States are required to have agreements with providers to keep such records as are necessary to fully disclose the extent of the services provided (the Act § 1902(a)(27)). Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (*State Medicaid Manual* § 2497.1).

Providers must maintain written progress notes for all treatment services in chronological order. The progress notes must include the treatment services provided, the provider's signature, the date of service, the duration of service, and the enrollee's progress toward attaining the goals or outcomes identified in the ITP (MBM, chapter 2, § 28.05-4).

The State agency will limit reimbursement for RCS services to those that are documented and approved in the treatment plan. The State agency will not reimburse for services provided during the child's regular sleeping hours (MBM, chapter 2, § 28.06-1). Services that are primarily academic, vocational, social, recreational, or custodial in nature are not covered and are not reimbursable (MBM, chapter 2, § 28.07, and chapter 1, § 1.06-4(B)).

The documentation must demonstrate only one staff person's time is billed for any specific activity provided to the member (MBM, chapter 2, § 28.09).

CMS issued guidance related to the cloning of session notes (i.e., notes that appear to be identical for different visits).[30] The guidance advised providers to watch for cloned notes because the notes may not reflect the uniqueness of an encounter.

Session Notes Did Not Contain a Complete Description of Services Provided, the Goals Addressed, or Data Collected

For 94 sampled enrollee-months from 28 providers, session notes did not have a complete description of the services rendered. Specifically, session notes did not contain a complete description of the specific RCS service techniques used or provide a clear picture of how those techniques were used. Because the State agency's requirements do not specify how detailed session notes should be, we could not conclude whether the notes satisfied State agency requirements that providers document the enrollee's progress toward attaining the goals or outcomes identified in the ITP. We found that most session notes had only a brief summary of the session. For example, 24 sampled enrollee-months for one provider did not include data collected and included only a schedule of the child's activities. For example, one session note did not contain any data collected and stated only that the child "had a pretty good day" and "first time to learn was rough but after that he was productive. When the behavior occurred, I used strategies in the plan to get it under control and it worked. When the behaviors were not occurring, goals were worked on in his plan."

For another example, the session notes indicated the "BHP observed and supported" the child "during his lunch routine" and "helped" the child "cut his pizza" and "use his utensils." The notes further stated that the BHP would use interventions "in the future" (i.e., "will gesture and verbally praise . . . to help him with his goal.") The notes also did not specify which goals or outcomes in the ITP were addressed.

In addition, 5 sampled enrollee-months included notes that appeared to be cloned (i.e., copied from other ABA sessions). The session notes were not reliable to support which services the children received or the quality of care that they received. For 5 sampled enrollee-months from two providers, session notes for multiple days were identical. For example, for 1 of the sampled enrollee-months, the session notes were copied from previous session notes and pasted electronically. These notes did not contain a description of the specific RCS service techniques used or the enrollee's progress toward attaining goals or outcomes.

Some notes did not include any description of the services rendered or the RCS service techniques used.

Session Notes Included Potential Nontherapy Time

For 92 sampled enrollee-months from 29 providers, session notes may not have supported the time billed because they included potential nontherapy time. Specifically, RCS services were billed

[30] CMS, *Matters Fact Sheet, Medicaid Documentation for Behavioral Health Practitioners*, December 1, 2015. Accessed on June 13, 2025.

continuously for several hours or the session notes referred to potential nontherapy time (e.g., naps or lunch) that was included in the time billed. The session notes did not include details about the RCS service techniques used during these times. Most session notes or data collected included either the start and end times of the child's day (e.g., 8:30 to 3:00), the start and end times of the child's morning and afternoon sessions (e.g., 8:30 to 12:00 and 12:00 to 3:00), or the start and end times for each BHP who rendered services (e.g., 8:30 to 11:45 and 12:00 to 3:00). Even when multiple BHPs rendered services consecutively, the majority of session notes for the sampled enrollee-months documented that RCS service time was billed continuously without any adjustment to the units of service for potential nontherapy times, such as meals, breaks, or naps.

Specifically, 24 sampled enrollee-months from one provider contained session notes on the associated child taking multiple breaks or time eating. For example, for 1 of the 24 sampled enrollee-months, the session notes for 1 day showed the child's day started at 9:00 and ended at 3:15. During this timeframe, the session notes showed the child engaged in 15 breaks, 2 lunches, and 3 snack times. The session notes did not include details about the RCS service techniques used during the potential nontherapy times. However, the provider billed and was paid continuously for RCS services from 9:00 to 3:15 without any adjustment to the units of service for breaks, meals, and snack times.

Session Notes Referred to Unallowable Recreational or Academic Activities

For 34 sampled enrollee-months from seven providers, session notes referred to recreational or academic activities but did not include details about the RCS service techniques used during the activities. Without those details, the session notes did not support that the activities were therapeutic and not primarily recreation or academic oriented. For example, for multiple sampled enrollee-months, the session notes referred to "free-play" or "playground" without including the RCS service techniques used. For 11 sampled enrollee-months from two providers, the session notes contained information related to academic activities. For example, for 1 of the 11 sampled enrollee-months, the session notes included a classroom activity log that indicated the child primarily spent time engaged in academic activities such as math.

The State Agency Did Not Perform a Statewide Postpayment Review of Payments for Rehabilitative and Community Support Services and Did Not Provide Clear Guidance to Providers

The State agency made potentially improper payments for 95 sampled enrollee-months because it had not performed a statewide postpayment review of RCS services and shared the results with providers as part of ongoing education since the program began in 2010. Performing periodic postpayment reviews and sharing the results with providers as part of ongoing education may have prevented the State agency from making improper or potentially improper payments. In addition, the State agency did not provide guidance to RCS service providers clarifying State requirements that progress notes must include the enrollee's progress toward attaining the goals or outcomes identified in the ITP. The State agency also did not provide sufficient guidance to RCS service providers including how detailed session notes should be and what it considers billable RCS service time (e.g., whether time billed should include recreational activities, meals, and breaks).

CONCLUSION

For our audit period, 92 of the 100 sampled enrollee-months included payments for RCS services that did not comply with Federal and State requirements. In addition, 95 of the sampled enrollee-months included potentially improper payments for RCS services. The issues that led to improper and potentially improper payments could have had a significant effect on the quality of care provided to children with autism.

For 92 of the sampled enrollee-months, the State agency made the following types of improper payments for RCS services: (1) comprehensive assessments were missing or did not include signatures of staff or parents or guardians; (2) session notes did not meet documentation requirements; (3) ITPs did not include parent or guardian signatures, or the plan was missing; and (4) documentation did not include provider credentials. In addition, for 95 sampled enrollee-months, the State agency made potentially improper payments for RCS services for which documentation supporting the services provided was not detailed or documentation was unreliable. For example, session notes were not complete in describing the services rendered, referred to recreational or academic activities that may not have been allowable RCS services, and included nontherapy time.

On the basis of our sample results, we estimated that the State agency paid at least $45.6 million ($28.7 million Federal share) for RCS services that did not meet Federal and State requirements. Additionally, we estimated that the State agency made approximately $22.4 million ($14.2 million Federal share) of potentially improper payments for RCS services. In addition, cloned or otherwise unreliable session notes are an indication that children with autism may not have received the type of RCS services needed.

The State agency made improper and potentially improper payments because it did not provide effective oversight of FFS Medicaid payments for RCS services. Specifically, the State agency did not provide sufficient guidance to providers for documenting RCS services, including guidance on: (1) completeness of session notes needed to support RCS services provided, (2) what the State agency considers billable RCS service time, (3) State signature requirements, and (4) State requirements that progress notes must include the enrollee's progress toward attaining the goals or outcomes identified in the ITP.

Furthermore, since the program began in 2010, the State agency had not performed a statewide postpayment review of payments to providers of RCS services to verify that providers complied with Federal and State requirements related to documentation and claim requirements.

RECOMMENDATIONS

We recommend that the Maine Department of Health and Human Services:

- refund $28,796,366 (Federal share) to the Federal Government for FFS Medicaid payments for RCS services that did not comply with Federal and State requirements;

- exercise reasonable diligence to review and determine whether any of the estimated ($14,163,521 Federal share) in potentially improper payments for RCS services did not comply

with Federal and State requirements and refund the Federal share of any improper payment amount to the Federal Government;

- provide additional guidance to providers about how to document RCS services, including the information needed in session notes to support RCS services provided, billable RCS service time, and signature requirements; and

- periodically conduct a statewide postpayment review of Medicaid payments for RCS services, including reviewing medical records, and provide additional training in the areas in which errors were identified by postpayment reviews.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency stated that it potentially concurred with our first recommendation and concurred with our other three recommendations. The State agency detailed steps it has taken and plans to take in response to our recommendations. The State agency further stated that, at the end of our audit, we shifted our focus from ABA services to all RCS services. However, our audit focused on RCS services, including ABA services, provided to children diagnosed with autism. We maintain that our sampling frame, stratified random sample, audit criteria, and methodology remained consistent throughout the audit.

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

Regarding our first recommendation, the State agency stated it will conduct reviews of the providers and claims that we identified (i.e., with improper payments for RCS services). The State agency further stated that, to the extent those reviews identify overpayments, it will recover overpayments from providers and refund the Federal share.

Regarding our second recommendation, the State agency stated that it agrees that our finding of potentially improper payments warrants review and that it will conduct reviews of the providers and claims that we identified. The State agency further stated that, to the extent those reviews identify overpayments, it will recover overpayments from providers and refund the Federal share.

Regarding our third recommendation, the State agency stated that it is in the process of updating State rules governing RCS services and will issue guidance to providers with respect to documentation requirements. The State agency also stated that it will continue to conduct training and provide technical assistance to providers. The State agency further stated that it will continue to offer initial training to new providers, including guidance on documentation requirements.

Regarding our fourth recommendation, the State agency stated that it will plan annual reviews of a sample of providers delivering RCS services as part of its yearly strategic review plan for the next few years and will identify recurring issues to inform provider training and guidance.

We maintain that our first recommendation is valid. We continue to recommend that the State agency refund the estimated amount of $28,796,366 (Federal share) for FFS Medicaid payments for RCS

services that did not meet Federal and State requirements. We appreciate the actions that the State agency plans to take to address each of our recommendations.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the State agency's FFS Medicaid payments of $76,715,537 ($48,391,817 Federal share) for 165,309 claim lines for RCS services, which we grouped into 11,777 enrollee-months with dates of service from January 1, 2023, through December 31, 2023 (audit period).[31] Our audit included only enrollee-months with payments totaling more than $1,000.[32] We selected a stratified random sample of 100 enrollee-months, with payments totaling $779,742 ($491,941 Federal share).[33]

The enrollee-months in our sample consisted of 31 unique providers with 96 unique enrollees. Total payments for each sampled enrollee-month ranged from $1,024 to $22,099. We requested the following supporting medical record documentation from providers for each sampled enrollee-month: (1) the approved prior authorization, (2) completed evaluations and diagnostic conclusions (e.g., comprehensive assessments, diagnostic evaluation), (3) the ITP, (4) provider licensure and credentials, and (5) the session notes supporting the units of paid RCS services.

We did not use a medical reviewer to determine whether the services were medically necessary. We shared documentation for some of the sampled enrollee-months that contained claim lines that were improper or potentially improper payments with the State agency and asked the State agency to provide input on whether the documentation supported the paid services. We also held meetings with the State agency to discuss what type of support it would expect to see in the providers' session notes and other documentation.

We did not assess the State agency's overall internal control structure. Rather, we limited our audit of internal controls to those applicable to our audit objective. Specifically, we reviewed the State agency's policies, procedures, and system edits related to payments for RCS services and the State agency's oversight of its prior authorization and the RCS service providers.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the Medicaid Management Information System (MMIS) FFS claims data that the State agency provided for our audit period. We also established reasonable assurance of the completeness of the claim data by verifying with the State agency that the aggregate claim data amounts matched the amounts that the State agency claimed on Form CMS-64.

We conducted our audit from August 2024 to October 2025.

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[31] An enrollee-month consisted of all FFS Medicaid claim lines for RCS services for an individual enrollee for which the end date of each claim line fell within the month.

[32] Enrollee-months with payments totaling less than $1,000 accounted for approximately 1 percent of total payments for RCS services.

[33] There were 731 claims, and 1,491 lines in the 100 sampled enrollee-months.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;

- interviewed State agency staff to gain an understanding of: (1) Medicaid billing requirements for RCS services, (2) the prior authorization review process, (3) the types of guidance that the State agency posted on its official State Medicaid website related to billing for RCS services, and (4) the State agency's oversight activities related to RCS service providers and payments;

- obtained from the State agency the MMIS's Medicaid FFS data for RCS services provided to enrollees 21 years of age and younger with dates of service during our audit period;

- reconciled the MMIS's RCS service data with the State agency's Form CMS-64;

- created a sampling frame that contained 11,777 enrollee-months, consisting of 165,309 claim lines for Medicaid RCS services provided during our audit period, and selected a stratified random sample of 100 enrollee-months for review (Appendix B);

- requested supporting documentation from providers for each sampled enrollee-month and reviewed the documentation to determine whether: (1) the prior authorization was approved and covered the sampled enrollee-month, (2) the documentation confirmed a diagnosis of autism, (3) the comprehensive assessment was developed, (4) the ITP included the required elements (i.e., services to be provided with methods, frequency, and duration of services), and (5) session notes included required elements (such as the name of the child and the duration of RCS services) and supported the units of paid RCS services, and (6) services were provided by qualified providers;

- shared documentation for some of the sampled enrollee-months that contained claim lines that were improper or potentially improper payments with the State agency and asked the State agency to provide input on whether the documentation supported the paid services, and also held meetings with the State agency to discuss what type of support it would expect to see in the session notes and other documentation;

- summarized our audit results for payments for each sampled enrollee-month into 2 categories: improper payments and potentially improper payments (Appendix D);

- estimated the amounts of the improper and potentially improper payments in the sampling frame (Appendix C);

- estimated the Federal shares of the improper and potentially improper payment amounts in the sampling frame (Appendix C); and

- discussed the results of our audit with State agency 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame comprised 11,777 enrollee-months, consisting of 165,309 claim lines for RCS services provided during our audit period, with total Medicaid payments of $76,715,537 ($48,391,817 Federal share).[34] The sampling frame consisted of enrollee-months in which the total paid amount for each enrollee-month was greater than $1,000 for services rendered by providers that were not under investigation by the Office of Inspector General (OIG).[35]

SAMPLE UNIT

The sample unit was an enrollee-month.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample, consisting of two strata (Table 1).

Table 1: Strata for Our Sample

Stratum	Description	Frame Size	Value of Frame	Sample Size
1	Enrollee-months with payment amounts from $1,003.84 to $8,416.76	8,333	$34,879,880	50
2	Enrollee-months with payment amounts from $8,416.90 to $36,750.36	3,444	41,835,657	50
Total		**11,777**	**$76,715,537**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We sorted in ascending order the items in each stratum by enrollee (the field "Person ID Unencrypted") and month, and then consecutively numbered the items in each stratum in the

[34] An enrollee-month consisted of all FFS Medicaid claim lines for RCS services for an individual enrollee for which the service date of each claim line fell within the month. The date range of the claim (from "Date Professional Detail Service" to "Professional Detail Last Service Date") may have been longer than 1 day.

[35] Enrollee-months in which the total paid amount was less than $1,000 accounted for 1 percent of the value of the sampling frame.

sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total dollar amount and the Federal share of FFS Medicaid payments in the sampling frame, for RCS services provided to children diagnosed with autism, that did not comply with Federal and State requirements.[36] To be conservative, we recommend recovery of improper payments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculate in this manner are designed to be less than the actual overpayment total 95 percent of the time.

We also used the OIG-OAS statistical software to calculate the point estimate for the total dollar amount and the Federal share of FFS Medicaid payments in our sampling frame, for RCS services provided to children diagnosed with autism, that were potentially improper. We also calculated two-sided 90-percent confidence intervals for these estimates.

[36] Month was associated with the end service date (the field ""Professional Detail Last Service Date") on the claim lines in the sample unit.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results for Enrollee-Months With Improper Payments for Rehabilitative and Community Support Services (Total Payments)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Improper Payments for RCS Services	Value of Enrollee-Months With Improper Payments for RCS Services
1	8,333	$34,879,880	50	$205,072	46	$118,797
2	3,444	41,835,657	50	574,670	46	457,624
Total	**11,777**	**$76,715,537**	**100**	**$779,742**	**92**	**$576,421**

Table 3: Sample Results for Enrollee-Months With Improper Payments for Rehabilitative and Community Support Services (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Improper Payments for RCS Services	Value of Enrollee-Months With Improper Payments for RCS Services
1	8,333	$21,998,634	50	$129,485	46	$74,960
2	3,444	26,393,183	50	362,456	46	288,756
Total	**11,777**	**$48,391,817**	**100**	**$491,941**	**92**	**$363,717**

Table 4: Estimated Values of Improper Payments in the Sampling Frame *(Limits Calculated at the 90-Percent Confidence Level)*

	Total	Federal Share
Point estimate	$51,319,810	$32,382,403
Lower limit	45,638,476	28,796,366
Upper limit	57,001,143	35,968,440

Table 5: Sample Results for Enrollee-Months With Potentially Improper Payments for Rehabilitative and Community Support Services (Total Payments)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Potentially Improper Payments for RCS Services	Value of Enrollee-Months With Potentially Improper Payments for RCS Services
1	8,333	$34,879,880	50	$205,072	32	$86,275
2	3,444	41,835,657	50	574,670	14	117,045
Total	**11,777**	**$76,715,537**	**100**	**$779,742**	**46**	**$203,320**

Table 6: Sample Results for Enrollee-Months With Potentially Improper Payments for Rehabilitative and Community Support Services (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Enrollee-Months With Potentially Improper Payments for RCS Services	Value of Enrollee-Months With Potentially Improper Payments for RCS Services
1	8,333	$21,998,634	50	$129,485	32	$54,525
2	3,444	26,393,183	50	362,456	14	73,700
Total	**11,777**	**$48,391,817**	**100**	**$491,941**	**46**	**$128,224**

Table 7: Estimated Values of Potentially Improper Payments in the Sampling Frame *(Limits Calculated at the 90-Percent Confidence Level)*

	Total	Federal Share
Point estimate	$22,440,690	$14,163,521
Lower limit	17,725,406	11,187,219
Upper limit	27,155,974	17,139,823

APPENDIX D: AUDIT RESULTS BY SAMPLED ENROLLEE-MONTH

		Improper Payments				Potentially Improper Payments			Audit Results	
Sample Item Number	Amount Paid (Federal Share)	Comprehensive Assessments Missing or Did Not Include Signatures	Session Notes Did Not Meet Documentation Requirements	Treatment Plans Did Not Include Signatures or the Plan Was Missing	No Provider Credentials	Session Notes Did Not Contain Complete Descriptions	Potential Nontherapy Time	Unallowable Recreational or Academic Activities	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
1-1	2,779	x	x			x	x		2,779	
1-2	5,302		x			x	x	x	4,066	1,236
1-3	4,914		x			x	x	x	4,259	655
1-4	1,012	x			x	x	x		1,012	
1-5	1,454	x	x					x	363	1,090
1-6	2,271	x	x	x		x	x		568	1,704
1-7	3,114	x	x			x	x		818	2,297
1-8	3,027	x	x	x	x	x	x		3,027	
1-9	4,352	x				x	x		1,088	3,264
1-10	3,517	x	x	x	x				3,517	
1-11	3,443	x				x	x		861	2,582
1-12	896		x			x	x		896	
1-13	1,800			x		x	x		450	1,350
1-14	648					x	x	x		648
1-15	749	x				x	x		187	561
1-16	1,735	x	x	x	x	x	x		1,735	
1-17	1,561					x	x			1,561
1-18	1,213	x				x	x		303	910
1-19	1,001	x				x	x		1,001	
1-20	1,951	x				x	x		488	1,464
1-21	2,747	x	x		x	x	x		2,747	
1-22	1,265	x	x			x	x		404	860
1-23	3,385	x				x	x	x	846	2,539
1-24	4,008	x				x	x		1,002	3,006
1-25	3,948	x				x	x		987	2,961

		Improper Payments				Potentially Improper Payments			Audit Results	
Sample Item Number	Amount Paid (Federal Share)	Comprehensive Assessments Missing or Did Not Include Signatures	Session Notes Did Not Meet Documentation Requirements	Treatment Plans Did Not Include Signatures or the Plan Was Missing	No Provider Credentials	Session Notes Did Not Contain Complete Descriptions	Potential Nontherapy Time	Unallowable Recreational or Academic Activities	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
1-26	1,885	x	x	x		x	x		1,885	
1-27	736	x				x	x		184	552
1-28	4,578	x	x	x	x	x	x		4,578	
1-29	3,810	x	x			x	x		953	2,858
1-30	1,643				x	x	x		1,643	
1-31	1,756	x	x			x	x		1,756	
1-32	5,168		x			x	x	x	3,559	1,608
1-33	3,007	x				x	x		752	2,255
1-34	5,007	x				x	x		5,007	
1-35	2,268	x	x	x		x	x	x	867	1,401
1-36	1,781	x				x	x		445	1,336
1-37	3,017	x	x	x		x	x		3,017	
1-38	3,749	x	x	x		x	x		3,749	
1-39	1,553	x				x	x		388	1,165
1-40	2,766	x		x		x	x		692	2,075
1-41	2,930	x	x	x		x	x		2,930	
1-42	5,238	x	x	x		x	x		1,339	3,899
1-43	1,841					x	x			1,841
1-44	1,484	x				x	x		371	1,113
1-45	756					x	x			756
1-46	3,574		x			x	x	x	2,740	834
1-47	923	x	x	x		x	x		923	
1-48	2,308	x	x		x	x	x		2,308	
1-49	1,906	x	x			x	x		544	1,363
1-50	3,709	x				x	x		927	2,782
2-1	13,383	x	x			x	x		13,383	
2-2	5,960	x			x	x	x	x	5,960	

		Improper Payments				Potentially Improper Payments			Audit Results	
Sample Item Number	Amount Paid (Federal Share)	Comprehensive Assessments Missing or Did Not Include Signatures	Session Notes Did Not Meet Documentation Requirements	Treatment Plans Did Not Include Signatures or the Plan Was Missing	No Provider Credentials	Session Notes Did Not Contain Complete Descriptions	Potential Nontherapy Time	Unallowable Recreational or Academic Activities	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
2-3	13,917	x	x			x	x	x	13,917	
2-4	6,354		x			x	x	x	4,378	1,975
2-5	6,993	x	x	x	x	x	x		6,993	
2-6	9,695	x	x			x	x	x	9,695	
2-7	6,452	x	x			x	x		2,771	3,681
2-8	7,208	x	x	x	x				7,208	
2-9	7,327	x	x	x	x				7,327	
2-10	5,890	x				x	x		1,472	4,417
2-11	10,865	x	x	x		x	x		3,303	7,562
2-12	8,503					x				8,503
2-13	6,125					x	x			6,125
2-14	7,236	x	x			x	x	x	7,236	
2-15	6,467	x	x			x	x	x	6,467	
2-16	6,704	x	x			x	x	x	6,704	
2-17	5,395	x	x			x	x	x	5,395	
2-18	6,509	x	x		x	x	x	x	6,509	
2-19	7,288	x	x			x	x	x	7,288	
2-20	7,896	x	x		x	x	x	x	7,896	
2-21	5,664	x	x			x	x	x	5,664	
2-22	8,739	x	x			x	x	x	8,739	
2-23	5,503	x	x	x		x	x		1,873	3,630
2-24	11,767	x	x	x		x			3,217	8,549
2-25	7,552	x	x			x	x	x	7,552	
2-26	5,941	x		x	x	x	x		5,941	
2-27	8,265	x	x	x		x	x		8,265	
2-28	5,584	x	x	x		x	x		5,584	
2-29	5,469	x		x	x	x	x		5,469	

		Improper Payments				Potentially Improper Payments			Audit Results	
Sample Item Number	Amount Paid (Federal Share)	Comprehensive Assessments Missing or Did Not Include Signatures	Session Notes Did Not Meet Documentation Requirements	Treatment Plans Did Not Include Signatures or the Plan Was Missing	No Provider Credentials	Session Notes Did Not Contain Complete Descriptions	Potential Nontherapy Time	Unallowable Recreational or Academic Activities	Improper Payments (Federal Share)	Potentially Improper Payments (Federal Share)
2-30	6,310	x	x			x	x		6,310	
2-31	9,498	X	x			x	x	x	9,498	
2-32	5,339	x				x	x		1,335	4,004
2-33	6,407	x				x	x	x	6,407	
2-34	7,700	x	x			x	x	x	7,700	
2-35	7,031	x	x			x	x	x	7,031	
2-36	8,234	x	x	x		x	x		2,282	5,952
2-37	6,806	x	x	x	x				6,806	
2-38	5,852					x	x			5,852
2-39	5,953	x	x			x	x	x	5,953	
2-40	5,629		x			x	x	x	3,902	1,727
2-41	6,450	x	x			x	x	x	6,450	
2-42	6,891		x	x	x	x	x	x	6,891	
2-43	8,568	x		x		x	x		8,568	
2-44	6,427	x	x	x		x	x		6,427	
2-45	6,989					x	x	x		6,989
2-46	6,426	x	x			x	x	x	6,426	
2-47	6,393	x	x			x	x	x	6,393	
2-48	6,927	x			x	x	x	x	6,927	
2-49	6,404	x	x	x	x				6,404	
2-50	5,572		x			x	x		840	4,732
*	**$491,941**	**81**	**64**	**30**	**20**	**94**	**92**	**34**	**$363,717**	**$128,224**

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner

Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

November 24, 2025

Curtis M. Roy
Regional Inspector General
U.S. Department of Health and Human Services
Office of the Inspector General
Office of Audit Services, Region I
15 Sudbury Street
Boston, ME 02203

Re: Report Number: A-01-24-00006

Dear Mr. Roy:

The Maine Department of Health and Human Services, Office of MaineCare Services (OMS) is providing the following written response to the Department of Health and Human Services Office of Inspector General (OIG) draft report titled *Maine Made at Least $45.6 Million in Improper Fee-for-Service Medicaid Payments for Rehabilitative and Community Support Services Provided to Children Diagnosed With Autism.* The following represents both our response and corrective action plan.

The claims sampled and reviewed in the OIG audit represent dates of service in calendar year 2023. As the draft report notes, MaineCare fee-for-service payments for Rehabilitative and Community Support (RCS) Services increased significantly from 2019 to 2023. This expenditure growth could be the result of various factors, including: increases in member population, state efforts to increase the availability of behavioral health services, reimbursement rate increases, and increased utilization of services.

Maine's Medicaid program, MaineCare, covers Rehabilitative and Community Support (RCS) Services to children with autism diagnoses under Section 28 of its MaineCare Benefits Manual. RCS services are not limited to children with autism. RCS services include a suite of treatment modalities, including, but not limited to, Applied Behavioral Analysis. Prior to notification of this audit, OMS Program Integrity (OMS PI) has previously identified the need to review RCS services. OMS PI has conducted reviews of various providers delivering those services over the years and continues to review providers delivering RCS services. During the audit, OIG reviewers requested information about OMS PI's prior reviews involving ABA services. At the end of the audit, the OIG shifted its focus from ABA services to all RCS services but did not expand its earlier ask which sought only OMS PI reviews of all RCS services. Had OIG made that request, OMS PI would have supplied information about the number of additional reviews it had conducted of RCS services as a whole above and beyond those limited to ABA services.

Many of the issues identified in the OIG audit are specific to deficiencies in provider documentation of services. OMS PI's current provider review activities will help address the specific recommendation in the OIG report and the corrective steps outlined below.

RECOMMENDATIONS

- **Refund $28,796,366 (Federal share) to the Federal Government for FFS Medicaid payments for RCS services that did not comply with Federal and State requirements**

Response: Potential Concurrence

OMS agrees that OIG's improper payment findings warrant OMS review of RCS providers' claims and associated documentation. At this time, OMS has not had sufficient time to: assess the degree of OMS concurrence with the overpayments identified by the OIG, determine that the OIG-identified overpayments represent the correct sanction to be applied under state rules, or verify the statistical validity of the OIG's extrapolation methodology. OMS Program Integrity will conduct reviews of the identified providers and claims to determine whether violations occurred and, if so, the appropriate sanction(s) to impose against the providers as authorized by and in accordance with state rule. To the extent those reviews identify overpayments, OMS will recover overpayments from providers and refund the Federal share of any such overpayments under its standard Program Integrity review and repayment processes.

Corrective Action Plan: OMS will conduct post-payment provider reviews of the providers and claims identified by the OIG to determine: (1) where violations of the applicable federal or state regulations exist, and (2) the appropriate sanction(s) to apply under state rules for any identified violations. OMS will recover any identified overpayments from those providers and refund the federal share of those overpayments to the Federal Government.

- **Exercise reasonable diligence to review and determine whether any of the estimated $14,163,521 (Federal share) in potentially improper payments for RCS services did not comply with Federal and State requirements and refund the Federal share of any improper payment amount to the Federal Government**

Response: Concurrence.

OMS agrees that OIG's potentially improper payment findings warrant OMS review of RCS providers' claims and associated documentation. OMS PI will conduct reviews of the identified providers and claims to determine whether violations occurred and, if so, the appropriate sanction(s) to impose against the providers as authorized by and in accordance with state rule. To the extent those reviews identify overpayments, OMS will recover overpayments from providers and refund the Federal share of any such overpayments under standard Program Integrity review and repayment processes.

Corrective Action Plan: OMS will conduct post-payment provider reviews of the providers and claims identified by the OIG to determine: (1) where violations of the applicable federal or state regulations exist, and (2) the appropriate sanction(s) to apply under state rules for any identified violations. OMS will recover any identified overpayments from those providers and refund the federal share of those overpayments to Federal Government.

- **Provide additional guidance to providers about how to document RCS services, including the information needed in session notes to support RCS services provided, billable RCS service time, and signature requirements**

Response: Concurrence

Corrective Action Plan: OMS is in the process of updating the state rules governing RCS services. OMS will issue guidance to providers with respect to documentation requirements through periodic provider e-messages. OMS will conduct training and provide technical assistance to providers on any policy changes. OMS will continue to offer initial training through its provider relations team to all new providers, and that training includes guidance on documentation requirements. OMS will also continue to have a dedicated provider relations unit available to respond to provider inquiries and a school-based services liaison who hosts in-person and virtual events in collaboration with the Maine Department of Education and develops training materials to educate MaineCare-enrolled schools and other providers of school-based services on MaineCare service and provider requirements.

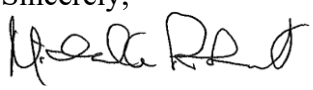
- **Periodically conduct a statewide postpayment review of Medicaid payments for RCS services, including reviewing medical records, and provide additional training in the areas in which errors were identified by postpayment reviews.**

Response: Concurrence

Corrective Action Plan: OMS PI will plan annual reviews of a sample of providers delivering RCS services as a part of its yearly strategic review plan for the next few years. OMS Program Integrity will identify recurring issues in reviews to inform provider training and guidance.

We thank you for the opportunity to respond to the draft report. If you have questions or require additional information, do not hesitate to contact us.

Sincerely,



Michelle Probert, Director
Office of MaineCare Services

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U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov