
Drug Medi-Cal Program Limited Scope Review



Prepared by the
California Department of Health Care Services
Audits & Investigations Division

November 2013



Department of Health Care Services
MEMORANDUM

DATE: November 30, 2013

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SUBJECT: DMC Limited Scope Review

The Audits and Investigations Division (A&I) is pleased to present the results of its limited scope review of the Department of Health Care Services (DHCS) Drug Medi-Cal (DMC) Program.

As a continuation of the internal Business Process Reengineering efforts that began in early 2012 to ensure a smooth transition of the Substance Use Disorder Services (SUD) programs of the former Department of Alcohol and Drug Programs to DHCS, we worked collaboratively with management and staff from the two SUD divisions to perform a limited scope review and gap analysis of the DMC program.

For purposes of this project, gaps were defined as internal control weaknesses, inefficient or ineffective business practices and lack of sufficient statutory or regulatory authority to meet performance expectations, ensure program integrity and effectively mitigate financial or legal risks to the department.

We were not engaged to express an opinion on the effectiveness of the SUD divisions as a whole. Accordingly, we did not conduct a full examination, nor do we express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

If you have any questions or comments about this report, please do not hesitate to contact me at the number above, or via email at bruce.lim@dhcs.ca.gov.

cc: Karen Johnson, CPA, Chief Deputy Director, DHCS
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Executive Summary

Assembly Bill 106 (Chapter 32, Statutes of 2011) approved the transfer of California's Drug Medi-Cal (DMC) program from the Department of Alcohol and Drug Programs (ADP) to the Department of Health Care Services (DHCS), effective July 1, 2012.

The 2012-13 enacted State budget approved eliminating ADP altogether and transferring ADP's remaining functions and programs to other departments within the California Health and Human Services Agency (CHHS). Assembly Bill 75 (Committee on Budget, Chapter 22, Statutes of 2013) approved the transfer of the remaining substance use disorder ADP programs and staff to DHCS and the Department of Public Health effective July 1, 2013.

These former ADP services, now within DHCS' Mental Health and Substance Use Disorder Services (MHSUD), are administered by two divisions. The Substance Use Disorder (SUD) Prevention, Treatment and Recovery Services (PTRS) Division is responsible for offering statewide SUD prevention and treatment programs. Its core functions include developing and implementing AOD prevention strategies; reviewing and approving county SUD treatment program contracts; and granting applications submitted for State and federal funds for SUD services.

The SUD Compliance Division focuses on county and program compliance with State and federal statutes, regulations, and other governing requirements. The Division oversees the licensing and certification functions, monitoring, and complaints for Driving Under the Influence (DUI) Programs, DMC, Narcotic Treatment Programs, and outpatient and residential providers. The Division also ensures compliance with the statewide criminal justice treatment programs and counselor certification.

California's statewide treatment, recovery and prevention network consists of public and private community-based service providers that serve approximately 230,000 unique treatment clients. In addition, approximately four million people receive primary prevention services and 150,000 people receive DUI services on an annual basis.

Prior to the transition of the DMC program to DHCS on July 1, 2012, DHCS completed a Business Process Reengineering (BPR) Project that fully assessed all transferring functions from ADP to DHCS. The as is environments for all transferring functions were fully flow-charted and evaluated. Process improvement opportunities as well as areas of potential risks were then identified and documented. The deliverables from the project have since been used as a roadmap for implementation and integration of the former ADP functions into the DHCS environment.

As a continuation of the process improvement efforts and to ensure that all transferred DMC and remaining ADP functions to DHCS are operating effectively and efficiently within their new environment, DHCS A&I Division (A&I) worked collaboratively with management and staff from the two SUD divisions to perform a gap analysis in the following areas:

- Licensing and Certification
- Monitoring and Compliance
- Post-Service Post-Payment (PSPP) Utilization Reviews

- Financial Audits
- Complaint and Fraud Referral Process
- Statutes and Regulations

For purposes of this project, gaps were defined as internal control weaknesses, inefficient or ineffective business practices and lack of sufficient statutory or regulatory authority to meet performance expectations, ensure program integrity and effectively mitigate financial or legal risks to the Department.

Once the gaps were identified, we provided recommendations for use by DHCS Director's Office and SUD management sorted by immediate remedies followed by short-term and long-term fixes. Special attention was placed on areas of greatest risk in order to address the areas as quickly as possible.

It is important to note that the process improvement efforts will need to be ongoing. The outcome of this project will not resolve all deficiencies immediately, but presents a roadmap for positive change and remedies in the SUD program on a go-forward basis.

Summary of Results

Our review concludes that the DMC program's weak internal control structure has exposed the Department to financial and legal risks as well as increased risks to fraud, waste and abuse within DMC program.

Processes that are intended to serve as vital checks and balances within the program have not been effective. We also observed an organization that has historically focused more heavily on programmatic deliverables and services for DMC beneficiaries than measures associated with program integrity.

Under the former ADP, management's attitude towards program integrity could have been strengthened, as evidenced by the following broad observations made during our limited scope review:

- Weak performance / certification standards for participating providers.
- No re-certification of DMC providers.
- Inconsistent monitoring of both DMC providers and counties for compliance with certification standards and State/county contract requirements, respectively.
- Lack of adequate financial oversight of Narcotic Treatment Programs.
- Minimal sanctions or penalties imposed on DMC providers in the past.
- Staff integrity issues.

The current DHCS SUD management team continues to make significant strides towards closing the gaps identified. The SUD management staff members interviewed during this engagement appeared to be both knowledgeable about the program and committed to improving the integrity, effectiveness and efficiency of their respective SUD divisions. An abundance of suggestions for

improvement were provided to us during the engagement, many of which have been included in this report.

With new SUD leadership in place and the positive steps that have been taken by current SUD management staff to address issues within both SUD divisions since transitioning to DHCS, we are encouraged that the SUD divisions are taking the steps necessary to move their program forward in a positive direction.

The former ADP's transition to DHCS offers the newly reorganized SUD Divisions a tremendous opportunity to strengthen the programs by leveraging DHCS' vast resources and expertise. DHCS not only offers SUD management staff an environment that will support and embrace their desire for program improvement, but a strong commitment to program integrity.

This report provides a number of recommendations starting on page 10 that will help SUD management address identified gaps and control weaknesses in its current program. A complete summary of all recommendations sorted by immediate, short-term and long-term categories is also provided on pages 64 through 68.

Background

The California Department of Alcohol and Drug Programs (ADP) was established in 1978 upon enactment of California Health and Safety Code (HSC), Division 10.5, Sections 11750, et seq., (Stats. 1977, Ch. 1252). It was designated as the Single State Agency (SSA) responsible for administering and coordinating the State's efforts in prevention, treatment, and recovery services for alcohol and other drug (AOD) abuse and problem gambling. ADP was also the primary State agency responsible for inter-agency coordination of these services. The Governor's Prevention Advisory Council (GPAC) was established within ADP to coordinate the State's strategic efforts to achieve measurable reductions in the incidence and prevalence of inappropriate use of AODs by youth and adults.

HSC Sections 11811.6 and 11963(j) required ADP to meet and confer with county alcohol and drug program administrators on issues of statewide significance. The substance use disorder services programs of the former ADP are now located in DHCS as two SUD divisions and known as the SUD area. SUD staff meet or confer weekly with members of the county Alcohol and Drug Program Administrators Association of California (CADPAAC), a statewide organization whose members represent California's 58 counties. In partnership with CADPAAC and in cooperation with numerous private and public agencies, organizations and individuals, SUD provides leadership and coordination in the planning, development, implementation and evaluation of a comprehensive statewide AOD prevention, treatment and recovery system. SUD uses each of the 58 county alcohol and drug programs as brokers of service, and the counties in turn provide services to clients directly or by contracting with local service providers.

The DMC program, which offers AOD services to Medi-Cal eligible beneficiaries, began in 1980 when the first interagency agreement was negotiated between the former ADP and what was then the California Department of Health Services, now known as the Department of Health Care Services (DHCS). Upon negotiation of the first interagency agreement, 22 counties contracted with the former ADP to participate in the DMC program and subcontracted with 40 service providers to treat DMC-eligible clients. In 1980, the two initial services offered were: outpatient drug free (ODF) counseling services and outpatient methadone maintenance services for those addicted to opiates.

As of the date of this report, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (i.e., Imperial, Orange, San Diego, Solano, Yuba-Sutter). Below is a summary of current DMC program services:

- Day Care Rehabilitative - Limited to pregnant and postpartum women (up to 60 days post-delivery) and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) clients under 21 who are Medi-Cal eligible.
- Outpatient Drug-Free - All Medi-Cal eligible clients.
- Narcotic Treatment Program - All Medi-Cal eligible adults or emancipated minors.

- Naltrexone - All Medi-Cal eligible adults or emancipated minors, with the exception of perinatal clients.
- Perinatal Residential - Limited to pregnant and post-partum women (up to 60 days post-delivery).

As the single State agency for Medicaid services in California, DHCS is responsible for Medi-Cal, California's Medicaid program. The Welfare and Institutions Code (Section 14113) authorizes DHCS to enter into contracts with other State departments (e.g., the Department of Social Services, Department of Aging, former Department of Mental Health and ADP). These other departments are responsible for Medicaid services in their respective fields of expertise. DHCS retains overall responsibility for decision-making on Medi-Cal issues such as: fair hearing practices, regulations pertaining to provision of services to beneficiaries, and provision of federal matching funds for the cost of services.

2011 Realignment

Enactment of the 2011 Public Safety Realignment marked a significant shift in the State's role in administering programs and functions related to SUD. Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. The enactment of 2012-13 and 2013-14 State budgets transferred the SUD programs from the former ADP, including DMC, to DHCS.

It must be noted that the full impact of the 2011 Realignment of funding and county responsibilities for the program has not yet been fully reviewed. Therefore, distinguishing the modified roles between the State (DHCS) and the counties is yet to be fully determined. Furthermore, statutory changes that occurred in 2012-13, which combined DMC funding with other AOD funding and MH funding, are not yet reflected in the State-county contract. The current State-county contract was extended for an additional fiscal year to avoid payment disruption during the transfer of ADP functions to DHCS. The State-county contract will be thoroughly revised and updated to reflect DHCS' new role and the changing SUD program responsibilities between the State and counties.

Expected Benefits From the Transition of ADP to DHCS

Both the SUD Prevention, Treatment and Recovery Services (PTRS) Division and SUD Compliance Division will continue to perform the aforementioned former ADP activities now within DHCS. The integration of SUD services with mental health and primary care services within DHCS is expected to result in better coordinated care.

The transition to DHCS is expected to enhance oversight of SUD programs by housing the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant and the DMC program in the same department. As a result of this decision, DHCS has oversight and responsibility at the State level for the two key

funding streams of the substance use disorder system. The 2011 Realignment created new complexities, including the need for the counties and the State to partner in tracking county expenditures to ensure California receives its full share of the SAPT Block Grant. Having one State department was intended to support this and other critical county-State partnerships.

Finally, DHCS now house the data systems associated with both programs. Instead of having to disentangle or institute data sharing agreements for these overlapping data systems, DHCS will house all of the State data systems for substance use disorders. This maintained the ability for the State, working with counties, to monitor program performance and client outcomes of these publicly-funded programs.

Drug Medi-Cal Expansion

Beginning January 1, 2014, California will provide Medi-Cal beneficiaries more extensive SUD services. Beginning January 1, 2014, California will provide Medi-Cal beneficiaries more extensive SUD services. SUD services that were previously restricted to those under 21 years of age and those who were pregnant or in the postpartum period will now be available to all Medi-Cal beneficiaries beginning next year. There also will be new benefits available through Medi-Cal Fee-for-Service and by Managed Care Plans.

As previously noted, the current DMC benefits for all Medi-Cal beneficiaries are outpatient drug free counseling, narcotic treatment, and naltrexone. Outpatient drug free counseling consists of at least two face-to-face counseling sessions every 30 days. The group size ranges from four to ten beneficiaries. Sessions can last up to 90 minutes each. Narcotic treatment therapy provides methadone to beneficiaries under a physician's supervision. Narcotic treatment therapy also includes counseling for the patient of no less than 50 minutes a month.

The expanded benefits that will be available to all beneficiaries as of January 1, 2014, are residentially based treatment services and intensive outpatient treatment. Residentially based treatment services include around-the-clock monitoring of beneficiaries in a controlled environment. The beneficiary receives SUD counseling, and depending on need, other services. Intensive outpatient treatment is face-to-face counseling for addiction that happens no fewer than three hours a day, and no fewer than three days a week.

The new Fee-for-Service or Managed Care Plan benefits available to all beneficiaries are voluntary inpatient detoxification and screening with a brief intervention for alcohol misuse. Voluntary inpatient detoxification is the immediate removal of addictive substances from the patient in a medical setting, followed by a referral to continuing treatment. Screening will include annual testing of all adult Medi-Cal beneficiaries for alcohol misuse. The physician can then make three separate referrals for treatment if he or she deems it medically necessary.

Scope & Methodology

Scope

As a continuation of the internal Business Process Reengineering efforts that began in early 2012 to ensure a smooth transition of the former ADP to DHCS, A&I worked collaboratively with management and staff from the two SUD divisions to perform a gap analysis in the following areas:

- Licensing and Certification
- Monitoring and Compliance
- Financial Audits
- Post-Service Post-Payment (PSPP) Utilization Reviews
- Complaint and Fraud Referral
- Statutes and Regulations

For purposes of this project, gaps were defined as internal control weaknesses, inefficient or ineffective business practices and lack of sufficient statutory or regulatory authority to meet performance expectations, ensure program integrity and effectively mitigate financial or legal risks to the department.

The scope of this review was limited to functions that serve as checks and balances and vital control points within the program that are critical to ensure strong program performance and program integrity. This review did not address policy areas and other general programmatic functions. Also, due to the time constraints of the engagement, this review focused strictly on high-level gaps that could be identified promptly for immediate action.

While the DMC program was the primary focus of our limited review, it was necessary to review some non-DMC processes because of overlapping functions that affect both DMC and non-DMC program areas. A number of SUD personnel also perform like functions for both DMC and non-DMC program areas.

The purpose and benefit of each area reviewed from a control standpoint are summarized below.

Area	Purpose	Benefit of Control if Executed Effectively
Licensing and Certification	<ul style="list-style-type: none"> • Authorization to participate in program. • Certifies that provider meets or exceeds specified performance standards. 	<ul style="list-style-type: none"> • Only allows qualified and legitimate providers into the program. • Assurance that providers meet and/or exceed performance standards.

Area	Purpose	Benefit of Control if Executed Effectively
Monitoring and Compliance	<ul style="list-style-type: none"> • Ensure ongoing compliance with federal laws, State statute and regulatory requirements. • Ensure the provision of effective and quality SUD and DMC services. 	<ul style="list-style-type: none"> • Minimizes financial and/or legal risks associated with provider non-compliance.
Financial Audits	<ul style="list-style-type: none"> • Audits of SUD programs with emphasis on DMC to ensure county and provider compliance with applicable federal and State laws, regulations, and guidelines associated with State General Fund (GF) and SAPT Block Grant funds. 	<ul style="list-style-type: none"> • Identifies non-compliance, improprieties and improper payments for purposes of recovery, sanctions and penalties, where warranted.
Post-Service Post-Payment Utilization Reviews	<ul style="list-style-type: none"> • Perform utilization reviews, including a focus on billing activities for propriety and identification of aberrant trends and red flags. 	<ul style="list-style-type: none"> • Identifies potential fraud, waste and abuse for referral to appropriate entities for investigation and prosecution, where warranted. • Identifies improper payments. • Can lead to overpayment recovery and placement of sanction and utilization controls, when warranted.
Complaint and Fraud Referral Process	<ul style="list-style-type: none"> • Represents first point of contact for all complaints within the program. • Determines which complaints warrant investigation and action. • Refers substantiated complaints to appropriate program/department for further investigation. 	<ul style="list-style-type: none"> • Leads to investigation or referral of legitimate complaints. • Results in corrective action, sanctions, penalties and prosecution when warranted.
Statutes and Regulations	<ul style="list-style-type: none"> • A statute is the rules of law that provides the authority and limits of an entity's actions. 	<ul style="list-style-type: none"> • Provides clarity and authorization for the proper execution of the program.

Area	Purpose	Benefit of Control if Executed Effectively
Statutes and Regulations (Continued)	<ul style="list-style-type: none"> Regulations guide the activity of those regulated by the government agencies and also the activity of the agency's employees. Regulations also function to ensure uniform application of the law. 	<ul style="list-style-type: none"> Provides proper authorization to enforce program requirements and issue fines and penalties where warranted.

Once the gaps were identified, we provided recommendations for use by the DHCS Director's Office and SUD management sorted by immediate remedies followed by short-term and long-term fixes. Special attention was placed on areas of greatest exposure in order to address those areas as quickly as possible.

It is important to note that the process improvement efforts will have to be ongoing. The outcome of this project will not resolve all deficiencies immediately, but presents a roadmap for positive change and remedies in the SUD program on a go-forward basis.

Methodology

To address the project objectives, we performed the following procedures.

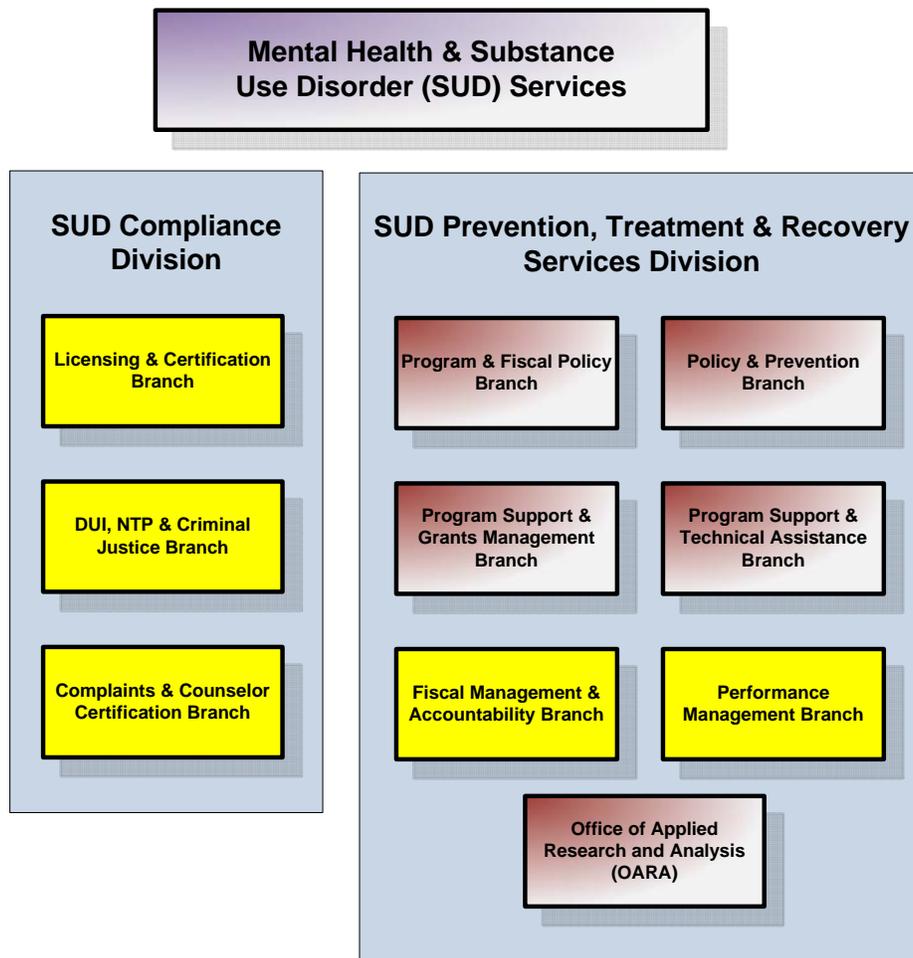
- Reviewed completed Business Process Reengineering documentation that was prepared in early 2012 as part of the DMC Program transition to DHCS effective July 1, 2012 to enhance our understanding of DMC business work flows.
- Conducted brainstorming sessions with SUD management and staff to discuss the scope and objectives of the engagement.
- Interviewed key SUD personnel to gain an understanding of past and current business practices, processes and procedures associated with the aforementioned areas of interest within Alcohol and Other Drug (AOD), Narcotic Treatment Program (NTP) and DMC program areas. Areas of exposure to financial or legal risks were a key focus of our discussion.
- Identified internal control weaknesses and areas of risks. Obtained and assessed recommendations from SUD personnel and other DHCS programs for improved processes and procedures that could improve Division performance and mitigate the identified risks to the program and Department.
- Reviewed supporting documentation (e.g., policies, procedures, review checklists, flowcharts, etc.) to corroborate representation received and to independently identify additional areas of risks and opportunities for process improvement.
- Provide recommendations based upon the work performed.

Assessment & Recommendations

Organization

The Deputy Director over DHCS' Mental Health and Substance Use Disorder Services (MHSUD) is responsible for two divisions dedicated to the SUD programs, including DMC. The SUD Prevention, Treatment and Recovery Services Division is primarily responsible for program policy and monitoring while the SUD Compliance Division is responsible for provider certification, complaint intake and ensuring county and program compliance with State and federal statute, regulations, and other governing requirements. Note, however, that there is cross-over of similar functions and objectives between the two divisions, which will be discussed in this report.

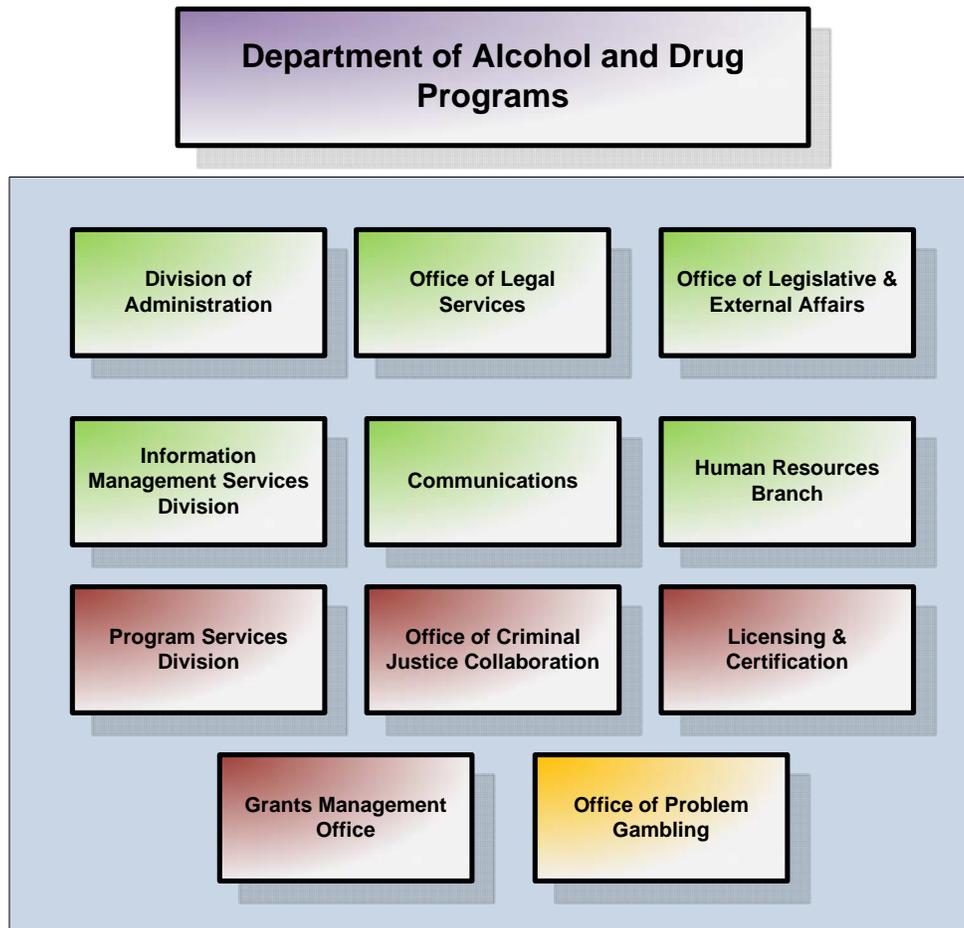
FIGURE 1 - Current Organization Chart



Note: Branches highlighted in yellow contain functions that serve as checks and balances and vital control points within the program. As such, these branches were the focus of this limited scope review.

Figure 2 depicts the organizational structure under the former ADP prior to its elimination and transition of its SUD programs to DHCS.

FIGURE 2 - Former Organization Chart



The units colored in green were merged into their equivalent functions within DHCS while the Office of Problem Gambling was transferred to the Department of Public Health. The remaining units colored in maroon were transitioned to DHCS to form the SUD Prevention, Treatment and Recovery Services Division (PTRSD) and SUD Compliance Division (SCD) within DHCS' MHSUD.

The former Program Services Division and Grants Management Office now reside with the PTRSD while the former Licensing and Certification Division (L&C) and Office of Criminal Justice Collaboration now reside within the SCD.

State-Level Administration

Background

As previously mentioned, DHCS completed a Business Process Reengineering (BPR) Project that fully assessed all transferring functions from ADP to DHCS prior to the transition of the DMC program to DHCS on July 1, 2012. The as is environments for all transferring DMC functions were fully flow-charted and evaluated. Process improvement opportunities as well as areas of potential risks were then identified and documented. The deliverables from the project have since been used as a roadmap for implementation and integration of the former ADP functions into the DHCS environment. The BPR process focused on the following DMC functions:

- Provider Certification
- Financial Audits and Appeals
- Maintenance of Provider Master File
- Claims Processing Payments
- Cost Report Settlement

The remainder of non-DMC functions that transferred from ADP to DHCS on July 1, 2013, will continue to be assessed by management to identify opportunities to streamline processes and take advantage of the economies of scale under DHCS. It is the intent of this limited scope review to expand upon the BPR work performed to further assess the SUD divisions from a program integrity standpoint.

The SUD programs of the former ADP have been fully reorganized within DHCS' Mental Health and Substance Use Disorder Services area. While both the SUD Prevention, Treatment and Recovery Services (PTRS) Division and SUD Compliance Division now co-exist with a number of other divisions within DHCS, the fact that ADP was formerly a fully functioning and independent State department makes the transition to DHCS more complex than one might think. As such, it is understood that it will take some time for the former ADP staff and operational units to get fully acclimated to their new environment within DHCS.

Observations

At the onset of this review, it was apparent that differences existed between SUD and DHCS personnel in terms of operating style. SUD staff came from a stand-alone department with 302 total authorized positions in 2011/2012 and transferred to DHCS with 3,250 total authorized positions for the same fiscal year. Because the former ADP was much smaller in size, it had been challenged with its limited resources, whereas, DHCS offers a greater pool of resources that often complement one another to achieve results. The SUD divisions will certainly benefit from leveraging DHCS' assets and resources in the future to assist them with their programmatic objectives.

During our initial discussions, SUD management staff also acknowledged an environment within the former ADP that focused heavily on program deliverables, but was less focused on program

integrity measures. This latter fact, however, has not stopped many of the SUD management staff from identifying what they consider to be gaps and deficiencies within their organization, the majority of which have been addressed in this review.

Recommendation #1 – To ensure the successful implement of remedies for identified gaps and program deficiencies, Substance Use Disorder Services management should take advantage of the recent transition to DHCS and fully leverage the Department's support and resources.

A general observation made during our review was the past gaps in communication, lack of coordination and lack of data sharing among the two SUD divisions and various branches that fall under each division. Because both divisions and various branches are responsible for DMC-related functions, it is critical that all units are working collectively as a team and effectively communicate with one another. SUD management staff fully acknowledged their past practices of operating within silos, which has negatively impacted program performance.

In light of the high visibility of the DMC program over the past several months, the SUD divisions have made significant progress in this area. Currently, communication and collaboration between SUD division staff appear to be progressively improving. It is also important to note that there have been many shifts in staff responsibilities since the transition of the DMC program and other ADP functions to DHCS.

To increase the effectiveness between all units that are responsible for DMC-related activities, the former ADP initiated the Provider Registry Information Management enterprise (PRIME) Project in June 2008 in an effort to address the need for consistent, accurate, accessible, and reliable enterprise-wide provider information. At the time, there was near universal agreement that the provider information management processes, tools and systems were in need of improvement. The PRIME project focus was to provide a central repository of ADP provider information linkages, transparent to the client using the system, to other ADP databases to fulfill the business operation needs of the ADP workforce. PRIME assigns and tracks the status of provider numbers for county and direct contract alcohol and drug treatment providers.

Recommendation #2 – To improve the effectiveness of its Provider Registry Information Management enterprise (PRIME) system, SUD management should enhance the PRIME system to accept all application, compliance, and program information (deficiencies, corrective action plans, etc) across all programs to ensure the entire universe of data is being tracked and analyzed. Data such as the non-eligible provider list(s) from the Provider Enrollment Division should also be incorporated in this effort to the extent feasible.

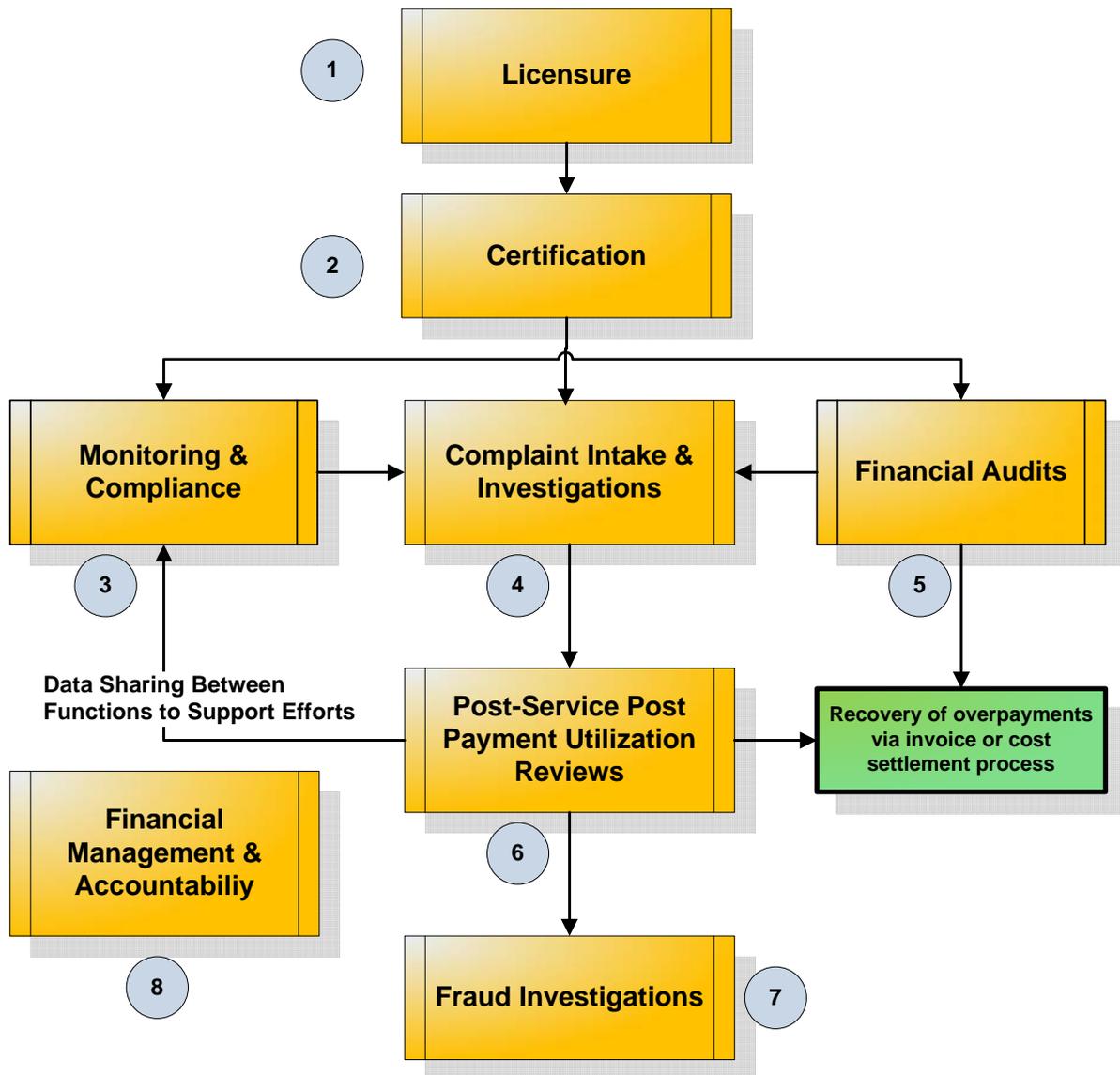
While the PRIME project is substantially in place and operational at this time for DMC, we were informed that the system still does not address the following challenges:

- Inability to determine trend analysis and track specific information, such as the name of the medical director, essential staff, compliance issues, etc.
- Cannot cross-reference non-eligible providers based on prior denials, revocations, etc.

- Alcohol and Other Drug Licensed and Certified Programs, NTPs, DUI and Complaints are not in the PRIME system. Work is being done to input these providers into the system; however, until all providers are in PRIME, the system is not complete.

The following figure visually depicts the primary control points within the SUD program followed by brief descriptions of each. Note that the descriptions include the controls' intended purpose and examples of common procedures within the respective control area. A more in-depth analysis of each control point is provided in subsequent sections of this report to assess whether the expected elements of each control are in place and working effectively.

FIGURE 3 - Substance Use Disorder Services Primary Control Points



Control Point Descriptions

1. Licensure

- Purpose of Control: Authority to Participate in Program.
- Required for 24-Hr Residential Non-Medical AOD Recovery & Treatment Facilities and NTPs.
- Not applicable to the DMC program at this time. Outpatient SUDS programs are not required to be licensed.

2. Certification

- Purpose of Control: Certifies that provider meets or exceeds specified service quality levels and are substantially in compliance with SUDS standards.
- Includes voluntary AOD and DMC certification options.

3. Monitoring & Compliance

- Purpose of Control:
 - ✓ Program monitoring ensures provider compliance with DMC standards. Function is performed by both State and county staff.
 - ✓ County monitoring ensures county compliance with State-county contract provisions. Function is the responsibility of State staff.
- Issuance of a Corrective Action Plan (CAP) when warranted.
- Non-fraud concerns identified during monitoring should be referred to SUD Complaints Unit.
- Fraud and/or billing concerns identified during monitoring should be referred to the PSPP Unit for initial review from a programmatic standpoint.

4. Complaint Intake & Investigations

- Purpose of Control: Centralized intake process for facility and counselor complaints from internal and external sources.
- Toll-Free Hotline & Email.
- Investigate complaints and deaths.
- Monitor counselor certifying organizations.
- Issue temporary suspensions and revocations to facilities.
- Fraud and billing complaints received should be referred to the PSPP Unit for initial review from a programmatic standpoint.

5. Financial Audits

- Purpose of Control: Audits of SUD providers to ensure compliance with federal and State laws and regulations.
- Financial and performance audits of SUD funds administered by counties and their sub-contractors.
- Facility or counselor concerns identified during audits should be referred to the SUD Complaints Unit.

- Fraud and/or billing concerns identified during audits should be referred to the PSPP Unit for initial review from a programmatic standpoint.

6. Post-Service Post-Payment Utilization Reviews

- Purpose of Control: Ensure provider compliance with Title 22 requirements.
- Perform risk assessments to help prioritize utilization reviews.
- Perform utilization reviews to ensure billings accurately depict services rendered to beneficiaries and treatment program compliance.
- Conduct provider education and training.
- Fraud and/or billing concerns received from the all sources are reviewed from a programmatic standpoint.
- If fraud indicators are identified or confirmed, the case should be referred to the A&I, Investigations Branch (IB).

7. Fraud Investigations

- Responsible Party: A&I (Designated Program Integrity Unit for the Medi-Cal Program)
- Purpose of Control: Preliminary investigation to determine if a credible allegation of fraud (CAF) exist.
- All Medi-Cal fraud complaints are processed via the A&I IB intake unit.
- Toll-Free Hotline and Email.
- IB conducts preliminary fraud investigations.
- IB refers the case to the Department of Justice (DOJ) if a CAF is confirmed for criminal investigation and prosecution when warranted.

8. Financial Management & Accountability

- Purpose of Controls:
 - ✓ Settle year-end cost reports for counties & providers
 - ✓ Process and reconcile DMC claims.
 - ✓ Process contracts for counties and direct providers.
 - ✓ Maintain Provider Master File.
- Provide billing data to A&I and/or DOJ to assist with fraud investigations.

Licensing and Certification

Background

Licensing and certification are important control functions that ensure only qualified and legitimate providers are allowed to provide SUD treatment services in California. These functions assure that the provider meets or exceeds specified performance standards. Both licensing and certification functions associated with DMC reside within two branches of the SUD Compliance Division --- The Licensing and Certification Branch (LCB)¹ and the Narcotic Treatment Programs (NTP)² Unit.

California law requires facilities that provide 24-hour residential nonmedical services to eligible adults who are recovering from problems related to alcohol or other drug (AOD) misuse or abuse to be licensed. Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, educational sessions, or AOD recovery or treatment planning. NTPs, which provide narcotic replacement treatment on an outpatient basis, also require a license. Additionally, facilities may be subject to other types of permits, clearances, business taxes or local fees that may be required by the cities or counties in which the facilities are located.

Many licensed facilities also obtain a voluntary certification from the State. Certification identifies those facilities which exceed minimum levels of service quality and are in substantial compliance with State program standards, specifically the AOD Certification Standards.

AOD Licensed and Certified Facilities

The LCB is responsible for conducting site inspections of all licensed and certified programs to ensure that the programs are in compliance with applicable laws. The LCB is comprised of four units: Field Units 1 and 2, which are responsible for the licensing, certification, and monitoring of AOD residential, detoxification, and outpatient programs; an administrative unit that is responsible for budgets, procurement, bill analysis, record retention, contracts, and general office functions for the branch, including mailings and processing of applications, checks, and file room maintenance; and the DMC applications unit reviews all initial DMC certification applications. LCB provides technical assistance, performs all field work necessary for the licensure and certification (and all related renewal activities and site visits) for residential, detoxification and outpatient AOD services. LCB also certifies AOD treatment services in group homes for adolescents licensed by the Department of Social Services and hospitals licensed by the Department of Public Health.

¹ Statutory/Regulatory Authority for L&C functions: State Law – Health & Safety Code (HSC) Section 11834.01 and 11830.1; Title 9, California Code of Regulations (CCR) Section 10505[a]; Alcohol and/or Other Drug Program Certification Standards.

² Statutory/Regulatory Authority for NTP functions: State Law – HSC Sections 11839-11839.34; Title 9, Division 4, Chapter 4, CCR. Federal Law - 42 CFR Part 8.

An AOD license is required for any provider of 24-hour non-medical residential services and is issued for a two year period. Staff conducts biennial site visits to determine the facility's compliance with all applicable regulatory requirements prior to license renewal. A license may be terminated, suspended, or revoked if a determination is made that the facility is not in compliance with the provisions established in the CCR. There are currently five to six facilities out of 819 licensed residential facilities receiving DMC funding since perinatal services are the only current reimbursable residential service for DMC. The number of DMC certified residential facilities is expected to greatly increase beginning January 1, 2014, due to the expanded benefit of funding all residential services.

Obtaining AOD certification is considered advantageous in gaining the confidence of both potential residents and third party payers; however, it is voluntary. Participating programs also benefit through the associated technical assistance, training and recommendations for program improvements which are available within the State's AOD network.

LCB also certifies residential facilities that are licensed by the Department of Social Services, Community Care Licensing Division, the Department of Public Health, and facilities operated by the Department of Corrections and Rehabilitation. In order to obtain residential certification, a facility must first obtain a license from the appropriate State licensing authority.

Programs are monitored and must be in compliance with the AOD program certification standards. The certification standards accommodate divergent philosophies within a consistent system of accountability and have three distinct purposes:

- To ensure an acceptable level of service quality is being provided to program participants;
- To provide the basis for certification of AOD programs; and
- To contribute to the development of quality AOD programs.

Narcotic Treatment Programs

The NTP Unit within Driving Under the Influence (DUI), NTP and Criminal Justice Branch is responsible for the review and approval of applications for NTP-DMC certification, NTP licensure, renewal, slot increases/ decreases, relocation applications, and Alcohol and Other Drug certification within NTPs. The NTP Unit, consisting of seven staff, performs initial and annual site inspections to ensure compliance with federal and State laws and regulations. The NTP Unit also works closely with the federal Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as the federal Drug Enforcement Administration (DEA). There are approximately 150 NTPs in 29 counties providing treatment to 33,956 maintenance patients and 4,586 detoxification patients, annually.

In California, persons addicted to opiates may be admitted to an NTP licensed by the State for narcotic replacement therapy with medications approved by the United States Food and Drug Administration (FDA). DHCS currently licenses NTPs in accordance with the California Code of Regulations (CCR), Title 9, Division 4, Chapter 4, by authority of Health and Safety Code (HSC), sections 11839 -11839.34. NTPs are medical in nature and clients are under the care of a physician at each licensed facility.

NTPs are licensed for no more than one year at a time, and the State will renew the license if the State determines that the program is in satisfactory compliance with the requirement of article 1, chapter 10, part 2, division 10.5, of the Health and Safety Code; and the county Alcohol and Drug Program Administrator submits to the State a certification of need for continued services of the NTP and a recommendation for renewal of the license.

Site visits are conducted prior to initial licensure of a new program, prior to the approval of a program relocation, at least once annually, and in such other cases as the State deems necessary or desirable. The State may revoke the license of any NTP which fails to comply with any statutory requirement or regulation.

DMC Certification

The Department offers DMC Certification to those clinics wishing to provide services to Medi-Cal beneficiaries with the DMC program providing reimbursement to the clinics. A clinic may provide SUD treatment services in a residential or outpatient setting. Clinics desiring to provide services in a residential setting must obtain a residential license prior to being granted approval to be reimbursed/provide DMC services; outpatient programs do not need any additional approval to provide DMC services, unless those services are being provided in a NTP setting, as noted below. Currently, clinics that are DMC certified may be reimbursed for the following services:

- Narcotic Treatment Program (the facility must first obtain a license as an NTP program prior to gaining approval to be reimbursed for this service).
- Outpatient Drug Free Treatment
- Day Care Habilitative Treatment
- Naltrexone Treatment
- Residential-Perinatal Treatment (the facility must first obtain a license as a Substance Use Disorder Treatment facility prior to gaining approval to be reimbursed for this service).

As part of the enacted 2013-14 State budget, the State expanded SUD benefits for Medi-Cal beneficiaries. The above DMC services will continue to be provided, and the following additional services may be offered with the completion of the application process, as noted below:

- Residential Treatment Services (non-perinatal)
- Intensive Outpatient Treatment (renamed from Day Care Habilitative Treatment)
- Medically Necessary Inpatient Detoxification Services (facility must be licensed by the California Department of Public Health prior to gaining the approval to be reimbursed for this service).

A clinic that is DMC certified and has a contract with either the county or the State is authorized to provide and be reimbursed for services that have been approved by a physician as medically necessary to an individual who is otherwise Medi-Cal eligible. DMC certification is site specific. DMC certification standards address fire safety, use permits, accessibility, physical plant, utilization review (UR), patient health records, administrative policies, health records, pharmaceutical service requirements, basic services, and staffing requirements (includes medical director, clinic director, substance abuse professional). Once DHCS determines that the provider's application is complete

and acceptable, an on-site review is scheduled to ensure that the clinic is in full compliance with federal and State Medicaid requirements. Once the requirements are met, certification is granted.

Providers cannot bill for DMC reimbursement without a contract with the county where the facility is located, or directly with DHCS. Participation in the DMC program requires both DMC certification and a contract.

Observations

The first observation we made when reviewing the licensing and certification function was the fact that standards and processes differ for AOD, DMC and NTP program areas. Furthermore, licensing and certification duties are not consolidated within a single unit but are handled by both the LCB and NTP Units, as mentioned above. While separation of like functions is not in itself a control weakness, the need for communication between both units are important to ensure processes such as DMC certification are executed in a consistent manner. The LCB administers DMC certification for AOD service providers, while the NTP Unit administers DMC certification for NTPs. See Table 1 for a comparison of licensing and certification requirements and options.

Table 1 - AOD Versus NTP Licensing & Certification

	AOD Treatment and Program Facilities	Narcotic Treatment Programs (NTP)
<p>Licensing</p>	<ul style="list-style-type: none"> • DHCS has sole authority to license facilities located in California which provide 24-hour residential non-medical services to adults with problems related to AOD abuse which require AOD treatment services. • License is <u>required</u> for any residential facility providing one or more of the following services to adults: alcohol or drug detoxification; group, individual or educational sessions, and/or recovery or treatment planning. • Initial onsite reviews are conducted prior to licensure of AOD facilities to ensure compliance with applicable laws and regulations and that the provider meets appropriate safety requirements for the persons 	<ul style="list-style-type: none"> • DHCS has sole authority to license NTPs. • License is required to operate a NTP. • NTPs provide replacement narcotic therapy in outpatient, medically supervised settings to people addicted to opioids. • Services include, but are not limited to, replacement narcotic medication and counseling. • There are approximately 150 NTPs in 29 counties providing treatment to about 34,000 maintenance patients and 4,600 detoxification patients, annually. • NTPs are medical in nature and clients are under the care of a physician at each licensed facility.

	<p>served.</p> <ul style="list-style-type: none"> • Non-medical outpatient AOD programs and cooperative living arrangements (e.g., sober living environment, transitional housing, or alcohol and drug-free housing) are not required to be licensed. 	<ul style="list-style-type: none"> • Initial onsite reviews are conducted prior to licensure of NTPs. An onsite inspection is also conducted prior to the approval of program relocations.
AOD Certification	<ul style="list-style-type: none"> • The SUD Licensing and Certification Branch (LCB) offers <u>voluntary</u> AOD certification to residential (must be licensed) and non-residential programs which exceed minimum levels of quality and are in compliance with State Certification standards. • Many counties and health insurance plans require that a program obtain this voluntary AOD certification from the State prior to contracting for the payment of services with a program. • LCB also certifies AOD treatment services in group homes for adolescents licensed by the Department of Social Services and hospitals licensed by the Department of Public Health. 	<ul style="list-style-type: none"> • The NTP Unit offers <u>voluntary</u> AOD certification to NTPs.
DMC Certification	<ul style="list-style-type: none"> • LCB also certifies programs for the DMC program, a program that offers AOD services (e.g., outpatient drug-free clinics) to Medi-Cal eligible beneficiaries. A clinic that is DMC certified and has a contract with either the county or the State is authorized to provide and be reimbursed for services that have been approved by a physician as medically necessary to an individual who is otherwise Medi-Cal eligible. 	<ul style="list-style-type: none"> • The NTP Unit certifies NTPs for the DMC program

Lifetime Certification

The two primary gaps identified in the licensing and certification program area are the lack of any re-certification process for DMC providers and weak certification standards. Once a provider is DMC certified, the certification is valid for life. There is no expiration date. This lifetime certification poses the risk that providers that no longer meet certification standards continue to provide services. Should a sub-standard provider remain in the program, the risk of fraud, waste and abuse increases as well as increased risk of patient harm.

Key Observation #1

DMC certifications do not expire. The lack of a re-certification process increases the risk that sub-standard providers remain in the DMC program.

Per our review of the *Drug Medi-Cal Certification Standards For Substance Abuse Clinics* procedures, effective July 1, 2004, a section describing re-certification procedures does exist. Below is an excerpt from the procedures describing the re-certification process:

"Recertification" means the process by which a new certificate is issued to a clinic or satellite site that has been previously certified. Recertification may occur with or without an on-site visit. On-site visits shall be conducted at clinics when any of the following circumstances occur:

- 1. The clinic changes ownership.*
- 2. The provider changes the scope of services such that the new services result in more restrictive or higher standards of program services and/or increase treatment hours of clients.*
- 3. The provider has significant changes in physical plant, i.e., substantial remodeling.*
- 4. The provider changes address and/or location.*

The provider shall notify ADP at least 60 days prior to any occurrence of the items listed in 1 through 4 above. Failure to provide ADP with 60 days advance notification or complete documentation may result in suspension from participation in the Medi-Cal program.

On-site inspections are not limited to purposes of recertification, but may be conducted for reasonable cause.

Based upon the contents of the DMC certification standards procedures, a re-certification process specific to DMC does exist. However, the SUD program historically has not fully implemented it. The events described that would warrant issuance of a new certificate do not lead to what one would consider a full re-certification where the providers' credentials are fully reassessed to ensure they continue to meet standards of participation. Only the details of the specific event reported are reviewed and, if verified, a new certificate for participation would be issued.

While DHCS has had statutory authority to revalidate Medi-Cal Fee-For-Service program providers at any time when warranted, SUD management stated that the DMC program has not had similar

authority and therefore has been limited in its ability to require a provider to be re-certified. SUD management also stated that even if the authority had existed in the past, the former ADP was not adequately staffed, nor funded to pursue regular re-certifications. Using its broader Medi-Cal provider enrollment authority, DHCS is currently recertifying all DMC providers in the State.

The one-time certification and the lack of program monitoring for compliance (which will be discussed in the next section of this report) has exposed the program to financial and legal risks because it has not allowed for consistent updating of new provider information and rechecking the Federal Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) database to identify exclusions and reinstatements of existing DMC providers. SUD personnel acknowledged the fact that provider information/data (e.g., relocations, sponsor/ownership changes, scope of service changes) may not be current and accurate and that there are no means to determine changes to provider information unless the provider communicates the changes as required. As noted above, these events are supposed to trigger a re-certification, but historically they did not.

The Patient Protection and Affordable Care Act (ACA) requires revalidation of enrollment information at least every five years. Re-validation or re-certification would equate to the submission of a new DMC provider certification application and all associated documentation required to continue participation in the DMC program. Receipt of a completed application will initiate the screening process.

Recommendation #3 – To ensure DMC providers continue to meet certification standards, the Department should implement a full DMC provider re-certification process at least once every five years in accordance with the new requirements of the ACA.

SUD management also acknowledged that DMC certification standards need to be strengthened. Current DMC certification standards are less stringent than current Medi-Cal Fee-for-Service provider standards and are too easy to meet thus increasing the risk of allowing substandard providers to participate in the DMC program. Current DMC standards contain provisions related to the following categories:

- Fire Safety
- Use Permits
- Accessibility of Service
- Physical Plant
- PSPP Utilization Review (UR)
- Patient Health Records
- Administrative Policies
- Health Records
- Drugs
- Basic Services
- Staffing

Limited Quality Requirements and Performance Measures for Provider Medical Staff

Two areas of particular concern that should be re-evaluated are quality requirements and performance measures for DMC outpatient drug-free clinic staff. The medical responsibilities as laid out in the *Drug Medi-Cal Certification Standards For Substance Abuse Clinics* procedures, effective July 1, 2004, are less than three paragraphs in length and are relatively basic in nature. Performance expectations for other provider staff are also very basic. Overall, the current standards

associated with staffing only include minimum requirements for a Medical Director and his or her medical responsibilities, Clinic Director, Substance Abuse Professionals and Clinic Staff.

Certification standards gaps identified by SUD management and recently confirmed by provider site visits conducted by A&I and SUD personnel include the following:

- Currently, there is no limit on the number of programs a Medical Director can oversee. Establishing minimum and maximum program caseload (e.g., number of facilities, programs and patient caseload) per Medical Director should be considered to minimize the risk of fraud, waste, and abuse as well as patient harm due to sub-standard care.
- Current medical responsibilities standards require the Medical Director to "be available on a regularly scheduled basis and otherwise on call." It was noted in recent site visits that Medical Director availability was an issue. Suggestions to address this gap include a requirement that Medical Directors post the hours that they are regularly scheduled to be present at the provider facility.
- In some circumstances, multiple providers are providing the same and/or a variety of services at the same address, or school site, thus increasing the risk of fraud, waste and abuse.

Key Observation #2
More clearly defined quality requirements and performance measures for medical directors and staff are needed.

Recommendation #4 – To ensure that only qualified and legally compliant providers are authorized to participate in the DMC program, the Department should strengthen its DMC certification standards, with a specific focus on the responsibilities and performance measures of the facility Medical Director and other provider personnel.

Recommendation #5 – To reduce the risk of fraud, waste and abuse, the Department should limit the number of DMC providers at one physical location or address to a single provider.

One benefit of transitioning the DMC programs to DHCS is the ability to leverage the existing resources and expertise within DHCS to improve the DMC programs. The following recommendation is being provided with this in mind.

Recommendation #6 – To streamline the re-certification process and take advantage of the Department's strict provider enrollment standards, the Department should consider formally aligning the DMC certification process with policies and procedures utilized by the Provider Enrollment Division for enrollment of Medi-Cal Fee-For-Service providers.

According to the Provider Enrollment Division (PED) management, the DMC business model, while different, has many of the same elements. The PED regulations are not a "perfect fit," but with some modifications to accommodate DMC requirements, alignment with PED processes is feasible and would be helpful to strengthen enforcement.

Recommendation #7 – To comply with CMS policy regarding the screening of excluded providers, the Department should conduct monthly checks against the Medicare Exclusion Database (MED) or the OIG List of Excluded Individuals/Entities database to identify exclusions and reinstatements of existing DMC providers. All identified excluded DMC providers should be suspended from the DMC program.

Much of the data used to process both AOD and DMC certification are similar, yet the data often is scattered among the various SUD units involved with the certification process. Because of this, SUD personnel expressed a desire to centralize the data to increase the effectiveness and efficiency of the certification process and to ensure that certification conclusions are appropriate and accurate.

To ensure the effectiveness of the certification process, the Department should centralize all data associated with the DMC and non-DMC AOD certification process into a single database. See recommendation #2 on page 10 regarding enhancement of the PRIME system.

Inactive Providers

During our review, we were made aware that providers are often certified for participation in the DMC program, but remain inactive for lengthy periods of time. We were informed that some providers have had certificates for years without the ability to use them. There was consensus that this is ineffective and should be addressed.

Recommendation #8 – To enhance program integrity and decrease the risk of fraud, waste and abuse, the Department should de-certify all providers that have not billed the program for over 12 months. Re-certification should then be required if the provider wishes to resume participation in the program.

As part of the Department's current re-assessment of the DMC program as a whole, implementation of the above recommendation is currently underway.

Monitoring and Compliance

Background

Provider Monitoring

Provider Monitoring and compliance activities are carried out by both the State and counties. The Licensing and Certification Branch (LCB) is charged with the responsibility to monitor alcohol and other drug (AOD) residential, detoxification, and outpatient programs. Biennial onsite reviews are conducted to ensure ongoing compliance with federal and State laws, regulations and AOD program certification standards.

As of the date of this report, field visits include the monitoring of 819 adult residential, non-medical AOD treatment facilities that also includes AOD certified (voluntary) residential facilities. Monitoring is also conducted for 845 non-residential programs that have voluntary AOD certification. Within the 845 non-residential programs are 31 certified group homes licensed by the Department of Social Services and five chemical dependency recovery hospitals licensed by the Department of Public Health that provide AOD medical treatment services to their clients. The LCB's goal is to review all facilities once every two years. While this goal has been consistently achieved for the adult residential, non-medical AOD treatment facilities, other competing priorities have affected the LCB's ability to fully meet this goal for the non-residential programs.

The Narcotic Treatment Programs (NTP) Unit is responsible for monitoring NTPs. Annual site inspections are conducted to ensure compliance with federal and State laws and regulations. The NTP Unit works closely with the federal Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as the federal Drug Enforcement Administration (DEA). The NTP Unit monitors these clinics and programs, and ensures federal DEA requirements are met. The State may revoke the license of any NTP which fails to comply with any statutory requirement or regulation.

County Monitoring

The County Monitoring Unit (CMU) within the SUD Prevention, Treatment and Recovery Services (PTRS) Division's Performance Management Branch conducts county reviews focused on programmatic oversight of prevention, treatment and recovery services supported through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG). This is accomplished through an annual review of each county which satisfies the minimum legal and regulatory requirements for contract compliance in the Code of Federal Regulations (CFR) 42 and 45.

The county monitoring process is designed to operate in a three-year cycle, conducting alternating site and desk reviews to ensure counties' adherence with the terms of the SAPT BG and the State-county contract requirements, as well as other programmatic areas the Department deems necessary to oversee. The county monitoring instrument is revised annually to encompass different

components of the SAPT BG and State-county contract requirements. Based on compliance rates or emphasis areas, some components may be reviewed annually rather than once in a three-year cycle. However, at the minimum, all requirements are monitored and reviewed at least once during the three-year time period.

Throughout the fiscal year, county monitoring analysts conduct a combination of site and desk reviews and qualitative responses are collected via the monitoring instrument from county administrators and their staff who directly oversee the provision of SUD services at the local level. All counties are reviewed annually. CMU conducts an analysis of programmatic strengths, as well as areas of deficiency or concern. Once a county review has been completed, a report is issued identifying compliance deficiencies, advisory recommendations, required follow-up, necessary technical assistance and in some instances selected programmatic highlights.

County monitoring analysts will contact the county administrator if there is non-performance or non-compliance with program requirements as indicated during the review. The analyst will request specific information and provide suggested actions to resolve compliance deficiencies. The county will have two weeks to resolve the compliance deficiencies; the analyst will document any remaining unaddressed compliance deficiencies in the county monitoring report. Once the monitoring report has been sent to the county, they will have 30 days to submit a corrective action plan (CAP), either electronically or by US mail on county letterhead with the county administrator's signature, which identifies how the county will resolve the compliance deficiency, the person(s) responsible for implementing the CAP, and the timeframe for implementation. The county will have six months to implement this plan.

Lastly, at the end of the monitoring year a county Monitoring Annual Report is developed based on the information collected during the fiscal year. It presents aggregated information about accomplishments across program areas, addresses compliance and programmatic issues, and serves as the basis for continuous quality improvement efforts.

The CMU has a county monitoring tool that is updated annually built off the requirements associated with the administration of SAPT BG program. The monitoring tool has been reviewed, approved, and applauded by the Department's federal partners for being a model of State oversight. In addition to BG monitoring, SUD had also begun to add during the last few years hot topics, and areas of interest that has allowed the Branch to better tailor its technical assistance (TA) to the needs of the county.

Observations

Limited DMC Provider Monitoring

While both the AOD and NTP programs are monitored regularly for compliance and performance, there has been limited monitoring and site inspections for the DMC program to ensure compliance with DMC standards.

As previously stated, the LCB's monitoring activities have focused primarily on AOD providers only. In terms of DMC provider monitoring, utilization reviews (URs) performed by the DMC PSPP Unit

Key Observation #3

DMC monitoring activities are very limited at this time.

within the Performance Management Branch of the PTRS Division have periodically addressed some of the DMC Certification Standards that would be normally reviewed during a provider monitoring engagement. However, the limited DMC standards compliance testing performed by the PSPP Unit falls well short of what one would expect to

ensure full compliance with DMC standards.

The DMC Certification Standards contain general requirements that must be complied with in order to obtain DMC certification and continue to participate in the DMC program. These requirements include, but are not limited to:

- **Fire Safety** - State Fire Marshall Requirements
- **Use Permits** - compliance with local agency building use permit requirements
- **Accessibility of Services** - Services shall be accessible to the disabled
- **Physical Plant** - Clinic shall be clean, sanitary and in good repair at all times
- **Patient Health Records** - maintenance of patient health records
- **Administrative Policies** - Written operational policies and procedures
- **Staffing Requirements** - Medical Director responsibilities, minimum staffing requirements

While there is consensus among SUD management staff that a more robust DMC provider monitoring function is needed to ensure full and ongoing compliance with DMC standards requirements, identifying the unit best suited to perform the monitoring function has not yet been determined. While the PSPP Unit has partially addressed the monitoring needs in the past, there are still questions whether the PSPP Unit should be the unit solely responsible for full DMC provider monitoring since its primary responsibility lies with Title 22 URs. One can argue that the LCB is best positioned to conduct the regular provider monitoring activities since it already oversees AOD provider monitoring plus it has historically been responsible for DMC certification. Regardless of which unit ultimately assumes responsibility for the task, the DMC program will continue to be exposed to increased risk of fraud, waste and abuse as well as patient harm unless full monitoring is established.

Recommendation #9 – To enhance program integrity, the Department should establish ongoing and periodic program compliance monitoring activities for the DMC Program. The monitoring activities should be coordinated with existing PSPP utilization reviews and other DHCS conducted county monitoring activities to ensure DMC certification standards are complied with. Additionally, consider enhanced / expanded roles for counties in the monitoring efforts. State/county collaboration needs to be strengthened to avoid duplication and maximize enforcement capacity.

Coordination of Monitoring Activities

As previously stated, both the AOD and NTP programs are regularly monitored for compliance and performance. The AOD residential, detoxification, and outpatient programs are inspected biennially while NTPs are inspected annually. While such inspections appear to be satisfactory in terms of ensuring compliance with AOD and NTP specific program criteria (e.g., the health and safety of clients), it seemed unusual that past AOD inspections in particular have not revealed some of the

suspect and potentially fraudulent activities being uncovered by targeted reviews of DMC providers. While details of the targeted reviews cannot be disclosed at this time due to open and ongoing criminal investigations, example of general areas of concern include, but are not limited to, the potential for services provided that are not medically necessary, billings for fictitious ghost clients, payment for services that were not performed and sub-standard care.

While we understand that the scope of the AOD and NTP site visits are not focused on the above areas of concerns and issues associated with billing, funding, utilization, etc., we believe basic observations regarding facility activities would help to identify potential concerns.

For those DMC providers that have been temporarily suspended as part of recent site visits, the A&I requested that SUD Compliance Division management revisit past AOD and NTP inspection results to determine if anything was overlooked.

In terms of the NTPs, we were informed that they are heavily regulated by both the State and federal government as reflected by annual inspections of the facilities. As a result, there has been a general conclusion by some parties that the NTPs are not a significant concern in terms of potential non-compliance and risk to the Department. However, per our discussions with SUD management and a review of NTP monitoring activities, we concluded that the annual NTP inspections are very focused in nature and do not adequately address all areas of potential risks. The annual inspections focus strictly on the following pursuant to Health & Safety Code (HSC) §11839.3(a)(2):

- Operations and records
- Compliance with State and federal laws/regulations
- Evaluation of input from local law enforcement and local governments
- Exit interview and report to program
- Corrective Action Plan (CAP) from program to State
- Approval of CAP

Review of the above areas ensure that NTPs are not mismanaging their controlled substances, that their facilities meet State and federal requirements, and that NTPs are appropriately dosing clients.

Key Observation #4
While AOD and NTP programs are monitored regularly, the primary areas of focus are not associated with DMC certification standards. Therefore, current AOD and NTP monitoring may be creating a false sense of security in terms of current DMC compliance levels by DMC certified AOD and NTP facilities.

The annual reviews do not include DMC Title 22 requirements, nor financial related matters. NTP licensing staff routinely refer questions they receive related to DMC compliance requirements to the PSPPP staff because it is not an area they are familiar with. For NTPs that offer outpatient drug free services, it is particularly important to ensure that counseling services for which the State is being billed for are legitimate and necessary. The majority of DMC services being billed to the State (approximately 40 percent to 60 percent of the total DMC program; range reflects ongoing assessment of appropriate billings in the DMC program) are

provided by DMC certified NTPs. Therefore, it is critical that all DMC providers (AOD and NTPs) are diligently monitored and audited for compliance with DMC certification standards, Title 22 and other financial related requirements.

It is important to emphasize that coordination and communication between the SUD LCB, NTP Licensing/Monitoring Unit, DMC PSPP Units and A&I Alcohol and Drug Program Audit Unit is absolutely critical to effective program monitoring. All units working in unison with one another, sharing information and offering cross-training opportunities should be an ongoing goal and objective.

Recommendation #10 – To enhance the effectiveness and value of AOD and NTP on-site provider visits and because DMC providers are also often AOD and NTP certified, SUD management should expand AOD and NTP site visit procedures to include *basic* observations about the surroundings and activities of a provider location to identify potential fraud, waste or abuse.

While the State shares with the counties the outcomes of its provider monitoring activities and PSPP URs for purposes of obtaining corrective action plans from the counties, we were informed that the counties do not reciprocate by regularly sharing the results of their monitoring activities and PSPP URs with the State. SUD management informed us that the results of county monitoring activities and PSPP URs are only shared with the State upon specific request by the state when a particularly area of concern with a provider is identified. To increase the effectiveness of county and State monitoring and compliance activities in the future, it is crucial that the counties fully share with the state the outcomes of their local provider monitoring and PSPP UR activities.

Recommendation #11 – To increase the effectiveness and efficiency of program integrity efforts, DMC program monitoring should be fully coordinated with the biennial AOD, annual NTP and local county-conducted monitoring activities. There should also be full data sharing between all parties to ensure identified compliance issues are fully communicated to avoid duplication of efforts and executing the various monitoring and auditing activities in a vacuum.

Recommendation #12 – To ensure activities are coordinated and staff are knowledgeable about the various program integrity efforts and objectives across the entire SUD program, SUD management should provide internal cross-training on the topics of AOD monitoring, NTP monitoring, DMC monitoring and PSPP utilization reviews.

A&I is the Program Integrity Unit for the State's Medi-Cal program as designated by the Center for Medicare and Medicaid Services (CMS). As such, A&I is responsible for the intake of all fraud complaints associated with the Medi-Cal program from all sources. During our review, we identified several instances where fraud complaints investigated by A&I's Investigations Branch (IB) were incorrectly assessed thus leading to the pre-mature closing of the respective cases. Details of this finding are discussed in greater detail in the Complaint Intake and Referral Process section of this report on page 54.

Medical Director Responsibilities

Another area that would benefit greatly from enhanced program monitoring are Medical Director responsibilities. In the Title 22 regulations specific to the DMC program, there is no requirement for a Medical Director. The regulations are specific to the requirement for a licensed physician. Within the DMC Certification Standards there is a requirement for a Medical Director. The Medical Director

responsibilities as spelled out in Section IV, Subsection A of the Certification Standards are, acting alone or through an organized medical staff:

- Establishing, reviewing, and maintaining medical policies and standards.
- Assuring the quality of medical services given to all patients.
- Assuring that at least one physician practicing at the clinic shall have admitting privileges to a general acute care hospital or a plan, as approved by DHCS, for ensuring needed hospital services. For NTPs, this requirement is the responsibility of the program sponsor and shall be met by the program sponsor entering into an agreement with a hospital official to provide general medical care in accordance with Title 9, CCR, Section 10340.
- Assuring that a physician has assumed medical responsibility for all patients treated by the clinic (Title 9, CCR, Section 10110).
- Documentation of assumption of medical responsibility shall include, but not be limited to, written approval of the treatment plan in accordance with Title 22, CCR, Section 51341.1(h)(2)(A), or for NTPs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 51341.1(h)(2)(B).

Key Observation #5

There are currently no checks and balances on the physician's sole decisions through any type of utilization review that includes his/her peers (other physicians or medical personnel).

The Title 22 regulations (CCR Section 51341.1) governing the DMC program are established based on the physician having authority and discretion to determine medical and treatment issues for beneficiaries. The physician accomplishes this through his/her signature on the treatment plan (which is typically completed by a counselor) signifying the physician's prescription of treatment as the necessary course to treat the beneficiaries' substance use disorder.

A physical exam is required or the physician's signature on a physical exam waiver specifying the basis for not requiring the physical exam.

The widespread practice in the DMC program is a physical exam waiver signed by the physician for all beneficiaries, even for those individuals that have substance use disorders for co-occurring health conditions (e.g., communicable diseases, hypertension, liver disease, certain cancers, dental diseases, etc.). Per our discussion SUD management and A&I clinical staff, a physical examination would likely be warranted in these situations. This routine practice of granting waivers to the physical examination limits interaction between the physician and beneficiary. While there are currently no limits or prohibitions to this practice, it does call into question whether the services being billed to the DMC program are medically necessary. SUD management and program staff concurred that providers and their medical staff appear to be abusing this option and therefore should be reassessed. The exception to the physical exam waiver practice resides in the NTP program where a physical exam is required for all clients pursuant to Title 9.

If the counselor determines that a beneficiary requires continuing services beyond six months, the physician is required to verify the medical necessity of continuing treatment for the beneficiary by signing a continuing services justification that identifies the prognosis if treatment is to be continued. The physician is not required to see the beneficiary face to face at any point of the treatment episode, but rather makes decisions based on the review of the various documents

required (i.e., medical history, substance abuse history, personal history, physical exam, treatment plans, progress notes).

Through experience from PSPP reviews of client charts, the medical oversight of DMC beneficiaries' SUD treatment, including the assessment (establishing medical necessity), ensuring physical health of clients, and development of treatment plans (which is the physician's prescription of treatment and contains the diagnosis), is an area that allows the physician sole discretion of treatment decisions through his/her signature on various documents. There are currently no checks and balances on the physician's sole decisions through any type of URs that includes his/her peers (other physicians or medical personnel).

The system that is set up in regulations relative to the physician's medical oversight responsibility essentially requires the physician's signature on three documents. This system makes it easy for fraudulent providers and unethical physicians to bypass the medical oversight intent of the regulations and simply pre-sign blank documents or sign completed documents without any real assessment of the beneficiaries' needs.

Recommendation #13 – To increase program integrity and decrease the risk of fraud, waste and abuse in the DMC program, the Department should consider revisions to Title 22 regulations specific to the physician/medical director's role and responsibilities as it relates to beneficiary contact and involvement in patient care. Consultation from appropriate clinical personnel should be obtained to determine what those standards should be.

County Monitoring

Historically, county monitoring by the State has been solely a federal block grant activity ensuring compliance with the SAPT BG requirements. Inclusion of a DMC contract monitoring component into the CMU county monitoring tool was completed last year in fiscal year 2012-13 and is now an ongoing component of the county monitoring process. The county monitors were formally trained on the new DMC State-county contract monitoring procedures prior to deployment and regularly receive refresher training in all program areas that are contained in the monitoring instrument. The fiscal year 2013-14 county monitoring will be important in getting the counties further acclimated to the CMU monitoring county compliance with the provisions contained in the DMC State-county contract.

2011 Realignment Base – Financial Impact

Counties currently receive 2011 Realignment funds based on their most recent expenditures. DHCS will need to recommend how to adjust the allocation of the 2011 Realignment funding to the counties for DMC to recognize the reduced activity based on temporarily suspended providers no longer participating in the program.

Recommendation #14 – To ensure counties are not overpaid due to inflated base rates, the Department should work with the DOF to ensure adjustments are made to back out identified fraudulent billings or false claims from existing levels of service in developing county allocation schedules.

Post-Service Post-Payment Utilization Reviews

Background

The DMC Post-Service Post-Payment (PSPP) Unit³ within the Performance Management Branch of the SUD Prevention, Treatment and Recovery Services (PTRS) Division performs PSPP utilization reviews (URs) to monitor providers and ensure compliance with Title 22 regulations governing DMC utilization review and ensure DMC billings accurately reflect the services delivered to DMC beneficiaries.

As established within CCR, Title 22, Section 51341.1 (k) the State is charged with responsibility for conducting PSPP URs of DMC SUD services. In the course of this review, PSPP unit staff:

1. Verify that individual patient record documentation requirements pursuant to Section 51341.1 (i) are met.
2. Verify that each beneficiary meets the admission criteria, including the use of an appropriate Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic code, and medical necessity for services is established pursuant to Section 51341.1 (h)(1)(D).
3. Verify that a treatment plan exists for each beneficiary and that the provider rendered services claimed for reimbursement in accordance with the requirements set forth in Section 51341.1 (h).
4. Establish the basis for recovery of payments in accordance with Section 51341.1 (m).

Prior to the implementation of the current PSPP UR process, the counties were responsible for URs in the DMC program, with the exception of DMC direct provider contracts with the State, which overall was limited in number. In most cases, counties conducted monthly UR committees (comprised of county and provider staff and clinicians) to provide clinical oversight and review of charts (medical necessity, timeliness of documents, appropriateness of treatment plan goals and progress notes, etc.). State staff mirrored this process for DMC direct provider contracts.

In the early 2000's, counties asserted that the UR committee requirement was an obligation that was not adequately reimbursed. In response to this growing sentiment from the counties, the State assumed full responsibility for UR requirement sometime between 2000 and 2002. This change in responsibilities led to the current PSPP UR process as outlined in Title 22, Section 51341.1, (k), (l), (m) and (n).

³ Statutory/Regulatory Authority for PSPP functions: State Law – Social Security Act, Title XIX, Section 1902(a)(30)(A); 42 Code of Federal Regulations, Part 456, Subpart A, Section 456.1(a); Welfare and Institutions Code Section 14133(c); and Title 22 California Code of Regulations Section 51341.1(k), (l), (m) and (n).

Secondary Role for Billing and Fraud Complaints

In addition to URs, the PSPP Unit has historically served as the primary conduit for ADP fraud referrals to DHCS and the Department of Justice (DOJ). The former ADP Complaints Unit, which now falls under DHCS SUD Compliance Division, managed the ADP complaints hot-line and intake process and was responsible for investigating all non-billing or non-fraud related counselor and facility complaints. Billing or fraud-related complaints received by the Complaints Unit were routed to the PSPP Unit for initial review and action. If PSPP staff identified any indicators of fraud, they were responsible for referring the complaints to DHCS A&I and/or the DOJ for criminal investigation. While A&I is officially the primary conduit between all Medi-Cal-related State agencies and the DOJ for fraud referrals, it is not uncommon for State agencies to make direct referrals to the DOJ, or dual referrals to both A&I and the DOJ.

Several years ago, the integrity of this important function was tarnished by the actions of a former chief of the PSPP Unit. These actions called into question the reliability of the PSPP Unit's past effectiveness.

Former PSPP Chief Convicted of Extortion and Bribery

In January 2011, a former Chief of the PSPP Unit, was sentenced to 41 months in federal prison after being convicted on federal corruption charges for demanding more than \$100,000 in bribes from the owners of two drug rehabilitation clinics.⁴

The employee pled guilty to four counts of extortion and two counts of bribery. In addition to the prison term he received, the employee was ordered to repay the bribes he received during the FBI's undercover investigation of his corrupt activities. During his sentencing, United States District Judge Gary A. Feess, stated that the employee's conduct was "essentially a shakedown of those...over whom he has authority and the ability to control."⁴

The employee was arrested on July 9, 2009, by special agents with the FBI as he was leaving a meeting where he accepted a \$3,500 cash payment that was part of a \$10,000 bribe he had negotiated. The employee subsequently pled guilty to having solicited and accepted bribes from rehabilitation facility owners in exchange for his promises of approvals and other benefits. In a plea agreement filed in this case, the employee admitted that he told a clinic owner that he could help the owner obtain certifications that would allow the owner to expand service offerings to include mental health treatment. The employee admitted having promised that, in exchange for cash bribery payments, he could "guarantee" that the owner's clinics would obtain certification to provide mental health treatment services. The employee demanded \$92,000 in bribery payments from the owner.⁴

Key Observation #6

Criminal conviction of a former ADP employee responsible for fraud referrals to outside agencies highlights the importance of enhanced "checks and balances" going forward.

⁴ Source: FBI January 10, 2011 press release - <http://www.fbi.gov/losangeles/press-releases/2011/la011011a.htm>

In relation to another facility, the employee revealed to the owner that the clinic was being investigated by the California DOJ, but, in exchange for a cash bribe, the employee could “help” the clinic owner by providing confidential information about the subjects and progress of the investigation, as well as steering the DOJ away from the clinic. The employee demanded \$10,000 in bribe payments from the owner of this facility.⁴

Recommendation #15 – To ensure appropriate investigation and fraud referral by the PSPP Unit to the appropriate law enforcement authorities, the complaint intake function should be segregated from personnel responsible for deciding whether an investigation and fraud referral to law enforcement is warranted.

PSPP Management's Current Objectives

Over the past several years, there has been relatively high turnover of management and supervisory positions within the unit. According to SUD program management, this has led to constant change in management direction. This challenge coupled with the impact of the employee conviction on the Unit's reputation have led to an environment of instability and inconsistency in operational focus.

Key Observation #7

Current PSPP Unit management is working diligently to restore the reputation of the Unit and ensure adequate checks and balances.

In mid-March 2012, the PSPP unit was transferred and relocated from the Licensing and Certification Division (now DHCS SUD Compliance Division) to the Program Services Division (now DHCS SUD Prevention, Treatment and Recovery Services Division), under its Performance Management Branch. Since the transfer, current management has been working diligently to restore the Unit's reputation and develop a clear vision and direction

for the organization. Areas of focus continue to be assessing day to day operations to identify opportunities for improvement, instituting system checks and balances and ensuring internal controls are working effectively and efficiently, modifying previous policy decisions where warranted, and working towards changing the operating environment of the unit to one of consistency, accountability and integrity. Of course, this will be an ongoing process but many successes have occurred over the last 16 months, which will be discussed later in this report.

Observations

There seems to be a lack of clarity among SUD management and staff regarding DMC program monitoring versus DMC PSPP UR requirements. Per our review of Title 22, Section 51341.1, and *DMC Certification Standards For Substance Abuse Clinics*, there are key differences between the two distinct functions.

⁴ Source: FBI January 10, 2011 press release - <http://www.fbi.gov/losangeles/press-releases/2011/la011011a.htm>

DMC PSPP utilization reviews include the following areas of focus:

- See four primary areas of focus for URs listed on page 30 pursuant to Title 22, Section 51341.1 (k). Since DMC services rendered must be approved by a physician as medically necessary, URs are to a great extent clinical in nature.
- In determining compliance and demand for recovery of payment actions, ADP shall base its findings on a sampling of beneficiary records and other records of the provider. Title 22, Section 51341.1 (l).
- Recover overpayments to providers for the reasons listed in Title 22, Section 51341.1 (m). Examples of reasons that warrant overpayment recovery include claimed reimbursement for services not rendered, services at an uncertified location and use of erroneous, incorrect, or fraudulent multiple billing codes.
- The Department shall utilize the procedures contained in Title 22, Section 51458.2 (provisions regarding statistical extrapolation) to determine the amount of the demand for recovery of payment. Title 22, Section 51341.1 (n).

As discussed in the Monitoring and Compliance Section of this report, DMC provider monitoring should focus on compliance with the DMC Certification Standards. These standards contain general requirements that must be complied with in order to obtain DMC certification and continue to participate in the DMC program. The requirements include, but are not limited to:

Key Observation #8
Confusion has existed in the past regarding DMC provider monitoring versus PSPP utilization review objectives.

- **Fire Safety** - State Fire Marshall Requirements
- **Use Permits** - Compliance with local agency building use permit requirements
- **Accessibility of Services** - Services shall be accessible to the disabled
- **Physical Plant** - Clinic shall be clean, sanitary and in good repair at all times
- **Patient Health Records** - Maintenance of patient health records
- **Administrative Policies** - Written operational policies and procedures
- **Staffing Requirements** - Medical Director responsibilities, minimum staffing requirements

Per our discussions with SUD management, the two areas of responsibilities have historically been blurred. Depending on who was managing the PSPP Unit at the time, the focus of field reviews between UR and monitoring elements would change. While the focus of the PSPP Unit will always be URs, it remains unclear to what extent monitoring responsibilities should be included in the PSPP Unit's future scope of work.

Recommendation #16 – To effectively implement DMC provider monitoring as previously recommended, SUD management should clearly delineate DMC PSPP utilization review requirements from DMC monitoring requirements. Once completed, SUD management should identify the SUD unit best suited to assume responsibility for ongoing DMC program monitoring. If there are inadequate personnel resources to address monitoring responsibilities, SUD management should pursue additional resources and request the needed positions.

Clinical and Audit Expertise

The PSPP UR process does not provide adequate utilization controls. At the time of the shift of UR responsibilities from the county to the State in the early 2000's as previously discussed, staffing classifications within the PSPP Unit were not enhanced to coincide with the new responsibilities. No clinical staff have historically been part of the unit's staffing. All PSPP monitors have been at the Associate Governmental Program Analyst (AGPA) or Staff Services Analyst (SSA) classifications until recently. The PSPP Unit now has one Nurse Evaluator II staff position on board since early 2013. Over the last year, the PSPP Unit has also consulted with the former ADP's State Medical Director, a licensed addictions specialist Psychiatrist, for clinical decisions and advice on case work of problematic providers.

The relatively recent clinical additions to the PSPP Unit have highlighted the huge gap in the area of UR expertise available within the Unit. Due to the lack of clinical staff within the PSPP Unit, it has been difficult for staff to challenge providers in the areas of medical necessity documentation or appropriateness of services when identified, since a physician is providing medical direction and oversight for the provider's treatment personnel.

In addition, the use of general analyst personnel to perform fairly complex site visit reviews places the PSPP Unit at a disadvantage and increases the risk that provider deficiencies might go unnoticed. Expecting general analysts to adequately assess billing issues and identify indicators of fraud associated with internal fraud complaints from the SUD Complaints Unit is also unrealistic.

Key Observation #9
The PSPP Unit is in need of increased clinical expertise and capacity.

Assessment of billing issues and potential fraud complaints would be more effectively handled by an auditor classification, while general analyst classification would be better suited for program monitoring work that is less complex in nature.

Recommendation #17 – To increase the effectiveness of the PSPP Unit, SUD management should enhance/increase clinical expertise and capacity within the Unit. SUD management should also consider leveraging A&I's clinical resources and expertise to assist with aspects of its PSPP utilization reviews.

Recommendation #18 – In light of the 2011 Realignment, the Department should determine what enhanced role the counties might play regarding future utilization reviews. Once determined, the Department should amend the State-county contract to reflect the modified roles and responsibilities.

Training of staff is another critical component of ensuring that staff possess the competencies and desired approach to PSPP reviews that reflect a high standard of integrity and accountability. Current training of staff consists of teaming new staff with an experienced staff member for on the job training, reading regulations and documented policies, and unit case conferencing meetings. The unit supervisor will observe staff in the field and reviews all reports. Besides the State-mandated ethics training, there is no other formal training provided to staff in this area.

Recommendation #19 – To increase the effectiveness of PSPP utilization reviews, SUD management should build and implement a comprehensive core training program for PSPP Unit staff.

PSPP Scope of Work

Below is an overview of the UR process.

- Reviews/Reports – PSPP site reviews and subsequent development/issuance of PSPP reports, as well as the review and approval/denial of corrective action plans submitted by providers. State scope and authority for performing PSPP reviews is outlined in Title 22 Section 51341.1.
- Tracking/Fiscal Management and Accountability Branch (FMAB) linkages – tracking of overpayments identified through PSPP reviews and referral of overpayment/recovery data to FMAB for recovery via invoice or cost settlement process.
- Policy, Procedures, and Protocol Development – drafting/proposing recommended changes to regulations dealing with DMC program requirements;
- Provide updates to the SUD field regarding compliance concerns, trends or important changes in program requirements; ongoing improvement to efficiency and effectiveness of PSPP business processes and corresponding updates/development of procedures.
- Audit and Investigation Referrals – when indicators of fraud are encountered.
- Training – technical assistance and training to the field on DMC program requirements.
- Appeals – tracking and drafting proposed responses to appeals to DMC PSPP findings.
- Legal Service Requests – when clarification regarding regulatory intent/authority is needed for DMC program oversight.

The PSPP Unit maintains a list of all billing DMC providers (the Active DMC Provider list) from which it establishes its schedule of PSPP UR for the upcoming fiscal year. The PSPP Unit's goal is to conduct URs of every provider once within a three-year cycle, the order of which is influenced by the following factors:

- date the provider last received a UR review
- whether the provider has closed since last UR review (unit must review records while available and ensure records are appropriately transferred to the State or county)
- dollar amount billed during the fiscal year (providers with billings over a certain dollar threshold per fiscal year are scheduled for annual reviews as opposed to the cyclical schedule of one UR within a three-year period.
- whether the provider has ever received a UR review (newly certified programs that have not yet received a UR review).

Selected providers are then divided among the eight PSPP analysts for onsite review during the fiscal year.

Key Observation #10

The goal of conducting a utilization review of every provider once within a three-year cycle is more appropriate for routine compliance reviews such as provider monitoring. PSPP reviews should be driven by risk analysis and data mining that identify potential fraud indicators.

Prior to performing the onsite review, the PSPP analyst downloads billing lines for the selected provider and identifies ten beneficiaries whose client records will be reviewed during the onsite review. The provider and county administrator are contacted approximately a week before the review and are informed of the review date and time. The list of beneficiaries whose records will be assessed is not provided until the analyst arrives onsite the morning of the review.

During the PSPP UR, the analyst reviews the ten beneficiary records to assess the program's compliance with DMC program requirements, as established in Title 22 Sections 51341.1, 51490.1, 51516.1, 51458.1 and Title 9 CCR.

Deficiencies identified are noted and discussed with the provider during the exit conference. Onsite URs typically take two to three days to perform.

Upon return to the office, the PSPP analyst develops a report which describes the deficiencies and overpayments identified. The report goes through a peer and management review process before being issued to the county and/or service provider (for providers that contract directly with the State, the county is not provided a copy of the report). The report informs the county/direct service provider that a corrective action plan must be submitted within 60 days and that an appeal of the findings may be submitted within 90 days.

As outlined in Title 22 Section 51341.1(q), a provider and/or county may appeal a DMC disposition concerning demands for recovery of payment and/or programmatic deficiencies via a first and second level appeal process. First level appeals are submitted to, and responded to by, the Assistant Chief of the DMC Division. Second level appeals are submitted to, and responded to by, the Deputy Director of the Mental Health and Substance Use Disorder Services Division. Providers dissatisfied with the first and second level appeal decision may file a petition of writ of mandate pursuant to Section 1085 of the Code of Civil Procedures in the superior court.

On a quarterly basis (recently changed from annual cycle), the PSPP unit creates and submits to the Fiscal Management and Accounting Branch (FMAB) a report of disallowances that have been identified for recovery. The report only includes disallowance totals for programs that did not appeal the overpayment/deficiencies identified in the PSPP UR report within the 90 days allowed by regulation. The overpayment is recovered either through the cost settlement process (handled by the FMAB and used in instances when the cost settlement process has not already occurred for the fiscal year in which deficiencies are identified) or by invoice (handled by DHCS accounting in instances when cost settlement has already taken place).

Three-Year Cycle for Utilization Reviews

Based on approximately 1,000 DMC facilities that currently exist, each analyst would have to complete approximately 42 URs per year to achieve full coverage within each three year period. This did not appear to be feasible given the PSPP Unit's limited staffing. According to PSPP Unit

management, the goal of achieving full coverage within a three-year-period is currently not feasible. Hence, management has been considering modification of its cyclical based approach to URs.

According to PSPP Unit management, incorporating a risk assessment model as a component of the selection criteria for provider reviews has been discussed but has not yet been implemented. Criteria under consideration are lower dollar thresholds that would be subject to a more in-depth and frequent review than in the past, providers that have had a prior temporary suspension or other sanction (until they receive a good review), or providers that increase their billings by more than a specified percentage in any given year. A more targeted way to assess risk and focus limited resources to those areas determined to be highest risk needs to be developed and implemented.

We agree that pursuing a risk-based approach to URs is the logical path to take. The focus of URs should be based upon the areas of greatest exposure to fraud, waste and abuse as stated. This conclusion is supported by the business model used by A&I Medical Review Branch (MRB). MRB, who is the designated anti-fraud unit for DHCS, performs data mining of paid claims data to identify red flags and aberrant billing trends, spikes and activities that warrant a closer review.

Recommendation #20 – To enhance the value of PSPP reviews, SUD management should modify its approach to utilization reviews by discontinuing its practice of reviewing all providers based upon a cycle (once every three years). Instead, reviews should be prioritized based upon high risk and high dollar providers as identified via analysis of paid claims data and other analysis of provider activity data. Consultation with the A&I Medical Review Branch is advised to implement the necessary structure and practices for effective data mining and case development.

Conversely, if DMC provider monitoring is ultimately implemented in parallel with risk-based PSPP URs, the monitoring/compliance reviews may appropriately be based upon a cyclical review schedule of *every* provider within a defined time-frame.

Opportunity for Collaboration

PSPP Unit management also expressed a desire to work collaboratively with the MRB as recommended to enhanced their data mining and case development efforts. They expressed the need to develop management reports and tools to assist them with identifying program trends and indicators of potential fraud. Currently data is not easily accessible to help guide program decisions. Furthermore, linkages across units are not built in relation to information sharing. There is no centralized provider database.

Statistical Extrapolation

Per Title 22 Section 51458.2, the Department shall use probability sampling to extrapolate the recoverable amount when demanding recovery of overpayments due from Medi-Cal providers when the extrapolated recovery amount exceeds the cost to the Department of doing the audit. With this in mind, statistical extrapolation of PSPP review findings has never been implemented according to PSPP management. Concerns about the resources required to conduct reviews of enough records to constitute a statistically valid sample, as well as the potential for the recovery of payments that could force the closure of some SUD programs, are reported to have been major considerations.

The current review process consists of the examination of ten DMC patient records from a single fiscal year's billings from a particular program. The sample size used provides an opportunity for PSPP staff to identify any significant problems with the program's compliance with Title 22 requirements, while allowing the review to be completed in one or two days.

PSPP management, however, has had concerns with this approach. The concerns include 1) working from a static sample size inequitably impacts smaller programs because recoupments would comprise of a larger percentage of their overall claims and 2) the total overpayment recovered never proportionately extends beyond the ten beneficiary sample, regardless of the extent/scope of deficiencies encountered, as it would with a statistical extrapolation methodology. Therefore, it is the opinion of current DMC management that the implementation of a statistical extrapolation methodology for identifying and extrapolating PSPP recoveries would do much to deter fraud and waste and improve the quality of care available within the DMC system.

While we do not disagree with PSPP management's sentiments on this matter, there are circumstances where statistical extrapolation may not be feasible due to lack of expertise to effectively perform the task. However, to the extent resources are available to effectively pursue statistical extrapolation, it should certainly be pursued due to the increased recoveries that could potentially be achieved from its use.

Recommendation #21 – To deter fraud, waste and abuse by DMC providers, SUD management should explore the feasibility of increasing the use of statistical extrapolation in its PSPP utilization reviews to increase the potential for recovery of identified overpayments and the positive effect this might have on provider compliance with DMC standards, laws and regulations.

In addition to performing PSPP URs, the PSPP unit is also responsible for providing county and provider staff with technical assistance and training to assist them in understanding and meeting Title 22 DMC program requirements. This is accomplished through the PSPP exit conference (at which time the PSPP analyst discusses deficiencies identified and responds to any questions the program may have regarding DMC requirements) and through regional and statewide trainings. Regional and statewide training are made available as needed/requested and are subject to resource limitations within the unit. In February of this year, the PSPP unit provided a statewide webinar training on the Outpatient Drug Free, Day Care Habilitative and Residential Perinatal Modalities.

Management Actions - Business Process Improvements

To ensure integrity and accountability are understood expectations, PSPP Unit management has taken the following actions:

- Instituted a code of conduct and expectations for staff
- Instituted a post-review provider survey to ascertain staff conduct while in the field and receive input for process improvements
- Required staff to complete and file a Fair Political Practices Commission (FPPC) Form 700, Statement of Economic Interests
- Instituted checklists and a peer review process for reports
- Focused hiring and recruitment of high quality diverse staff
- Required supervisor review of staff in the field
- Ensure accountability and performance measurement
- Supervisory and management modeling of appropriate behavior and policy decisions
- Focus on creating team experiences to build a cohesive team

In addition, over the last 16 months a major focus of the supervisory/management team for the PSPP unit has been the pursuit of business process improvement opportunities. Activities performed to improve the Unit's effectiveness in achieving its core responsibilities (State oversight responsibilities are described in Title 22 51341.1) include, but are not limited to, the following:

- Changing focus of review from quantity to quality. Historically staff were instructed to complete each review in one day, whereas the average review time is now two to three days for review of ten client records.
- Ongoing assessment of critical business functions
- Obtained clarity on the PSPP Unit's scope of authority and staff training/monitoring to ensure unit is performing within that scope.
- Rigorous attention given to consistency in how regulations applied among team members
- Staff training and development
- Enhanced engagement with the Office of Legal Services
- Update to FAQs and website materials
- Provider and county training
- Consulting with DHCS Medical Director on issues that require clinical perspective/direction
- Added clinical position to PSPP Unit

While there is still more work to be done, current PSPP management has performed its due diligence to move the Unit forward in a positive direction.

Financial Audits

Background

The Alcohol and Drug Program Section (ADPS) within A&I's Financial Audits Branch (FAB) performs financial and performance audits in compliance with generally accepted government auditing standards. ADPS performs detailed fiscal audits to review and analyze financial and client records to verify that reimbursements comply with laws and regulations. Audits performed by ADPS focus on provider fiscal compliance. The authority to conduct these activities is in the Welfare and Institutions Code and Code of Federal Regulations.

ADPS is responsible for:

- Performing audits of SUD programs within DHCS to ensure county and provider compliance with applicable federal and State laws, regulations, and guidelines, State General Fund (GF), and SAPT Block Grant funds;
- Auditing the expenditures of counties and subcontractors funded in whole or in part with the funds administered by SUD within DHCS; and,
- Overseeing AOD service providers' compliance with federal Office of Management and Budget (OMB) Circular A-133, which requires annual audits of providers who receive federal grant funds above a dollar threshold.

The following mandated audit activities are performed in accordance with applicable laws and regulations:

- Audits of DMC Providers: Welfare and Institutions (W&I) Code Section 14124.24
- Audits of SAPT Block Grant Providers: 45 CFR, Part 96
- Administrative Appeals Process for DMC and SAPT Block Grant Audits: W&I Code Section 14171; Health and Safety Code Section 11817.8(f)
- Personnel Liaison/Training, Coordination/Regulations, Development/Budget Tracking: Audit staff is required

Observations

Audit Procedures and Selection Process

ADPS' mandates and responsibilities remain the same under the DHCS in terms of the audit selection process and the conduct of how audits are performed. ADPS performs cost report audits, which means that all of ADPS's audits are performed in arrears. The cost report settlement process takes approximately 18 to 24 months to produce an interim settlement cost report for each county. That cost report represents a comprehensive summary of each of the contractors and their

respective county. Once the interim settlement cost report has been completed within the Department, the settled cost report is good for three years at which time it will be settled and accepted as final by the Department. The only exception to this process is that an audit would have had to begin of any contractor before that timeframe expired. Once the audit has commenced within that timeframe, the audit and/or audit appeal process would then determine final settlement.

Selection Methodology

Prior to the beginning of each fiscal year, ADPS establishes an annual audit plan of roughly 50 potential contractors to be audited by audit staff for the current fiscal year. ADPS relies primarily on two methods in establishing the audit plan. One method is through risk analysis in which the department's billing data base is utilized to determine any abnormalities such as spikes in the units billed from the prior year, unusual shifts between individual and group units-of-service, and an unusual number of denied units-of-service. Given that some of these types of activities occur routinely, it doesn't automatically mean that something is wrong. However, it does suggest that some attention is warranted.

Secondly, ADPS works closely with other parts of the Division such as the Licensing and Certification Branch, PSPP Unit and the counties themselves. All of these separate and distinct areas may have made referrals to ADPS for the audit of certain contractors. Approximately 80 percent of the selected contractors in ADPS' audit plan are determined through the risk analysis process with the remainder being picked up through the referral process. Staff then selects from the audit plan and initiates the protocol from the audit program and begins setting up the audit.

Audit Timing

Staff begins the preliminary audit procedures and establishes contact with the county and the contractor. It is at this time that the auditor can determine and establish whether a contractor is still in business. Because ADPS's audits are performed in arrears, there could be a two-year difference in time between the current fiscal year and the fiscal year being audited. It also means that data ADPS is working with is at least two years old. At this point in the audit planning, audit staff will contact the county to perform additional follow-up to verify the status of the contractor. In almost all the cases, the county is aware of the operational status of its contractors.

Key Observation #11

The Cost Report settlement process needs to be shortened to ensure audits are more current with program activities.

Recommendation #22 – To increase program integrity, the Department should explore the feasibility of placing more expectations on the counties, including fines if necessary, to notify the Department when the county becomes aware that a contractor is closing its program, or has become defunct.

Recent Audit

In March 2013, ADPS issued an audit report for one county that contained disallowances of \$1,366,696 for fiscal year 2006-07 and \$2,320,711 for fiscal year 2007-08. ADPS staff followed the normal process for selection of contractors for testing and contacting the county to obtain

Key Observation #12
There needs to be greater collaboration between the County and State auditing branches for greater coverage and tracking.

supporting documentation for audit testing purposes. It was during this stage of the audit that staff identified a pattern with a number of the contractors being reviewed. Audit testing revealed that a significant number of contract providers reviewed were no longer in business, or were on the verge of going out of business. Audit staff also performed test work to verify the accuracy of the records and documentation the county claimed they were in possession of. The audit later confirmed that the county only had documentation for one of

the contractors in question. For the remainder of contractors reviewed, adjustments were made to disallow all reimbursed costs associated with these contractors for lack of supporting documentation to substantiate the costs associated with DMC claims paid. A final audit report was issued by ADPS documenting the disallowances for the two fiscal years audited.

The audit staff confirmed that in all cases the county knew the status of each contractor, but failed to report the information to the State. The county was given 60 days to appeal the finding and disallowances. No appeal was filed within the given timeframe and the county was billed for the total disallowances.

The audit report was distributed within the department which was still ADP at that time. Given the sizeable disallowances for the county and contractors, additional follow-up with the county to determine the cause and extent of the problem was warranted, but never occurred.

Recommendation #23 – To ensure program integrity, SUD management and program staff should monitor and follow-up on all significant audit findings, especially those that are unusual in nature, material in dollar amounts, or may lead to financial and/or legal exposure to the Department.

Narcotic Treatment Program (NTP) Cost Reports

During the course of our review, we were informed that while DMC providers are required to submit annual cost reports to their respective counties in which they operate, NTP providers are not subject to the same requirement.

Assembly Bill 2071 (Miller, Chapter 1027, Statutes of 1996), eliminated the requirement for NTPs to submit annual cost reports to the State. In lieu of a cost report, NTPs are instead required to submit an annual performance report, the format of which was to be agreed upon by the former ADP, the county Alcohol and Drug Program Administrators Association of California and representatives of the NTPs.

Key Observation #13

While compliance reviews of NTPs are performed annually by both the State and federal government, financial audits of NTPs have been non-existent since the implementation of AB 2071.

The performance report provision, however, only applies to those NTPs that exclusively receive DMC reimbursements for services rendered. NTPs that receive negotiated net amount (NNA) funds, a combination of NNA and DMC funds, and/or provides other treatment modalities at the same location as the certified NTP must still submit a cost report to the State for the expenditure of all funds. Per our discussion with SUD management and ADPS audit personnel, NTPs that fall under this category do submit cost reports as required. However, financial audits of NTPs, including those that continue to submit cost reports, have not been performed since AB 2071

was codified into State law. We were informed that in the mid 1990's discriminatory billing by NTPs was a significant issue that was being addressed quite aggressively by the former ADP Audit Services Branch. AB 2071 was then introduced sometime thereafter and all of the audit activities, recoupment of identified overpayments and corrective action plans ceased to exist.

Recommendation #24 – To ensure program integrity, the Department should resume financial audits of NTPs that submit cost reports to ensure that operating costs reported to the State are accurate and in sufficient detail to support payments made for services rendered to beneficiaries.

ADP Bulletin 97-39, issued on June 27, 1997, served as a NTP audit bulletin to provide clarification regarding implementation and enforcement aspects of changes brought about by AB 2071. More specifically, it addressed the more significant potential audit issues associated with NTPs that were still required to submit cost reports in order to assist counties and providers in maintaining operating, accounting and filing systems to allow for full compliance and to reduce the risk of audit findings. Highlights of the bulletin are summarized below:

- Any DMC reimbursements in excess of the customary charge will be subject to audit recoupment. In short, discriminatory billing is prohibited.
- Inequitable cost allocations to funding sources which reimburse for actual costs are prohibited and will be subject to audit adjustments if identified via review of cost reports.
- While NTP rates are fixed, cost data may be utilized for future rate development.
- NTPs that offer other treatment modalities (i.e., Outpatient Drug Free and Day Care Habilitative) at the same location as the certified NTP are required to submit a cost report.
- The Department (formerly ADP) will review claim documentation during audits and PSPP utilization reviews (URs) to identify potential fraud associated with services claimed but not supported.
- Any findings related to services claimed but not supported may result in a referral to DHCS or DOJ Bureau of Medi-Cal Fraud.

The audit and program integrity measures outlined in ADP Bulletin 97-39 were very thorough and well intentioned in our opinion. The only problem was that the planned actions were only minimally executed. Per our discussion with SUD management, the aforementioned financial audits of NTPs that are required to submit cost reports have not been performed while post-service, post-payment

URs of NTPs have only been limited. As a result, the risk of overpayments to NTPs associated with fraud, waste and abuse continues to exist as long as financial audits and PSPP reviews are not addressed to the extent necessary.

Key Observation #14

Annual monitoring reviews by both the State and federal governments for licensing and certification purposes is providing a false sense of security regarding steps being taken to minimize the risks of fraud, waste and abuse.

As previously mentioned in the Monitoring and Compliance Section, we were regularly informed during our review that NTPs are highly regulated by both the State and the federal government and therefore present lower risks to the program. Because the scope of the annual monitoring reviews only focus on licensing and certification requirements, it is quite different from what the scope would be in a financial audit and PSPP review. As a result, we believe the current annual reviews are providing a false sense of security.

ADP Bulletin 98-26, issued on May 5, 1998, provided further implementation guidance regarding performance reports for NTPs pursuant to provisions of Chapter 1027, Section 11758.46(j) of the Health and Safety Code. Per our review of the bulletin, the following statement stood out:

Performance reports are different from cost reports in that they are a summary of information generated from DMC claims. Because ADP collects and maintains this information, NTP providers will not be required to submit performance reports or any additional data. Attached is a sample of the two-page performance report planned to be used by the Department and a sample report with actual data reflected.

The data contained in the performance reports will be used as supporting information by ADP for budget hearings, rate development, and other special data requests. Performance reports will not be used as an accountability tool. Accountability will be measured through auditing/monitoring reviews.

The statement and procedures in the bulletin present several concerns as follows:

- Accepting the responsibility to compile performance report data on behalf of the NTPs from DMC claim data received defeats the purpose of independently obtaining the data directly from the NTPs. This lack of segregation of duties exposes the State since it is assuming the responsibility of preparing accurate information on behalf of the NTPs.
- Claims data is not a substitute for cost data. Solely utilizing claims data for budget hearings and rate development, which both rely on accurate cost data, may lead to ill-informed decisions and unsupported rates that could be inflated.
- This approach does not hold the NTPs accountable for their financial statistics and figures. The performance reports are the responsibility of NTP management, not the State.

Recommendation #25 – To ensure proper segregation of duties and accountability from NTP providers, SUD management should discontinue its role in preparing the required Performance Report on behalf of NTPs to be consistent with the statutory reporting requirement. The Performance Report should be independently prepared and remitted by the NTPs to the State as required by law. Provider bulletins should also be updated accordingly to ensure expectations of the counties and providers are clear.

Per our discussion with SUD management, it was agreed upon that the Department would generate the performance report based on DMC billing data. So the Fiscal Management and Accountability Branch (FMAB) generated the performance reports and mailed them out annually to either the county or the direct contract provider. The FMAB performed this task for several years. However, due to various factors such as workload issues and the fact that county and providers did not want them, the FMAB stopped issuing them out annually about five to six years ago. The FMAB gave the counties and NTP providers an opportunity to request copies of the reports if they wanted one, but no request were ever made.

Per our review of a sample Performance Report and discussion with ADPS audit personnel, the data contained in the report was highly summarized and therefore would be of little benefit to a financial audit engagement.

We were informed that all NTPs that are subject to the Performance Report requirement must submit an expenditure report so the FMAB can include all final DMC expenditures with the county cost report. Direct contract providers also submit an expenditure report so the FMAB can finalize their expenditures as well. Similar to the Performance Report, the expenditure report contains summarized data and would not be very useful for a financial audit of the NTPs.

The bulletin stated that audit and monitoring reviews of NTPs subject to the Performance Report requirement will take place to ensure accountability. Per our discussion with SUD management, these measures have been limited or non-existent which presents the risk of overpayments for activities and services that are ineligible for reimbursement and potentially associated with fraud, waste and abuse. Similar to NTPs subject to cost reporting requirements, NTPs subject to the Performance Report requirement have not been subject to a financial audit since the implementation of AB 2071.

Per our discussion with SUD management, some PSPP reviews of NTPs were performed in the past, but such reviews ceased after the two PSPP employees dedicated to the NTP reviews retired. We were informed that when current PSPP management took over the PSPP URs approximately a year ago, they questioned the quality of work performed by the staff assigned to the PSPP URs of NTPs.

Recommendation #26 – To ensure the integrity of past PSPP URs, SUD management should perform a cursory assessment of past reviews for reasonableness, accuracy and completeness. Any identified anomalies or red flags should be investigated and addressed as necessary.

It must be stressed that absent any direct evidence of wrong-doing by internal employees, the best approach to address future concerns regarding the integrity of internal staff and minimize the risk of inappropriate actions is to implement an effective internal control structure.

While there are a host of different definitions for internal controls depending upon the business sector or industry involved, we chose to focus on the internal control framework developed by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), a nationally recognized organization formed in 1985 to provide guidance on business ethics, internal control, risk management, fraud and other topics.⁵

An entity's *internal control structure* is comprised of five interrelated components, which are summarized below:

1. Control environment - Management's attitude towards, awareness of, and actions concerning its internal control structure.
2. Risk Assessment - The identification and analysis of relevant risks to achievement of the organization's objectives.
3. Control procedures - Policies and procedures established by management to provide reasonable assurance that specific objectives of the entity will be achieved.
4. Information and Communication - The identification, capture and communication of pertinent internal and external information in a form and timeframe that enables people to carry out their responsibilities and make informed decisions.
5. Monitoring - Internal monitoring of the organization's control structure to assess the system's performance over time and address identified deficiencies.

An effective internal control structure begins with a sound control environment as promulgated by the organization's leadership. COSO's definition of the control environment clearly articulates the importance of this control and the impact it has on the organization as a whole:

The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure. Control environment factors include the integrity, ethical values and competence of the entity's people; management's philosophy and operating style; the way management assigns authority and responsibility, and organizes and develops its people; and the attention and direction provided by the board of directors.⁶

Recommendation #27 – To ensure the integrity and effectiveness of its organization, SUD management should work diligently to improve its internal control structure.

⁵ Source: <http://www.coso.org>

Below are two examples of control procedures that should be effectively implemented within the DMC program on a go-forward basis.

- Transaction authorization - all transactions should be authorized by responsible personnel acting within the scope of their prescribed authority and responsibility.
- Segregation of duties - segregation of functional responsibilities should be in place to prevent any one employee, acting alone, from committing and concealing irregularities or illegal acts. However, it is important to note that no system of policies and procedures can prevent collusion, an irregularity or illegal act committed by two or more employees, each of whom is necessary to complete the fraudulent scheme.

Complaint and Fraud Referral Process

Background

The Complaints and Counselor Certification Branch (CCCB) within the SUD Compliance Division is responsible for investigating DMC program facility complaints against California's AOD recovery and treatment programs. Through complaint investigations, the CCCB ensures the provision of quality treatment through the enforcement of standards for professional and safe treatment.

The CCCB also investigates violations of the code of conduct of registered or certified AOD counselors. AOD Recovery or Treatment Facilities licensed or certified by SUD are required to report counselor misconduct to SUD within 24 hours of the violation. Title 9, California Code of Regulations, Section 13065 states the following:

Within 24 hours of the time an alleged violation of the code of conduct specified in Section 13060 by a registrant or a certified AOD counselor becomes known to an AOD program, the program shall report it to the Department and to the registrant or counselor's certifying organization. Such report may be made by contacting the Department and the certifying organization in person, by telephone, in writing, or by any automated or electronic means, such as email or fax.

Complaints may be received from a variety of sources such as clients, staff and former staff, other State agencies, and the general public via telephone, letter, facsimile, email, or in person.

Facility and counselor complaints which are received by SUD specific to licensed, unlicensed or certified programs as well as inappropriate conduct by counselors and registrants are investigated to determine whether laws and regulations have been violated. The complaint staff receives approximately 300 complaints annually. In FY 2011-12 545 complaints were received, 266 total complaints were received in FY 2012-13. Complaints are processed for investigation based on the seriousness of the offense. Allegations involving immediate health and safety threats are also given highest priority. Examples of health and safety concerns of residents that would be given priority include, but are not limited to, the following:

Facility Related Complaints

- Deaths
- Unlicensed residential facilities
- Provision of medical services in residential facilities
- Fire hazards
- Plumbing/heating problems
- Cleanliness of the facility
- Moldy food
- Pest infestations

- Any other condition presenting an immediate danger or threat of danger to a resident's well-being

Counselor Related Complaints

- Sexual misconduct
- Physical abuse
- Drugs on the premises
- Misuse of medication

Reports generated by a facility to notify the Department of special incidents, as required by CCR Section 10561, such as deaths or injury, outbreak of disease, personnel changes, structural changes, and other information of a critical or emergency nature are not considered complaints. Although these reports may indicate a range of problems with the facility and may require special inquiry, investigation, or evaluation, the information is an admission by facility personnel that an event did, in fact, occur and therefore is not appropriate for investigation as a complaint allegation.

42 CFR Part 455, Subpart A requires that complaints be investigated by SUD prior to referral to law enforcement. The field staff investigate complaints by interviewing witnesses and performing site visits as needed. Single complaints can contain multiple allegations, which range from sexual abuse to verbal harassment. If an allegation is substantiated, the field staff contacts the certifying organizations informing them of the Department's proposed sanction or penalty against the counselor/registrant. If evidence has been gathered that a crime has been committed, the matter is referred to local law enforcement.

For facility complaints, the standard form for documenting the investigation is the Program Investigative Report (PIR). The PIR is used for recording the Complaint Analyst findings, and serves as the Notice of Deficiency. It must include due dates for submission of the corrections.

For counselor complaints, the Complaint Analyst prepares a Counselor Investigative Report, Form ADP 6015L, after completing the investigation. If deficiencies are found, the Complaint Analyst will provide the licensee/designee with ADP 6015L at the end of the visit, or ADP 6015L will later be delivered by certified mail. If mailed, the Notice of Deficiency must be postmarked within ten (10) working days of completion of the complaint investigation, except for Class A deficiencies which require an ADP 6015L to be left with the licensee/designee before the complaint analyst leaves the facility. A Class A deficiency is issued when there is an immediate health and safety risk that must be remedied immediately.

If an allegation is substantiated, a Notice of Deficiency must be issued. The notice must identify the title and number of the code section, the class of the deficiency, a code section excerpt or entire section, a description of how the regulation was violated, the particular place or area of the facility in which it occurred, the civil penalty notice, and the due date for submission of corrections and/or corrective action plan.

The following terms shall be used when determining the resolution for each allegation:

- Substantiated - An allegation is substantiated if it has been determined to be valid and the facility is cited.

- Not Substantiated - Investigation could not substantiate that the alleged facts occurred or violated policy or law.

At the completion of the site investigation, the complaint analyst may conduct an exit interview with the licensee/designee to discuss the progress of the investigation. If the Complaint Analyst does not conduct a face-to-face exit interview, he/she may conduct a telephone exit interview with the licensee or his/her designee as soon as possible upon the conclusion of the site investigation. Upon resolution of the complaint, the specific allegations must be shared with the provider by recording them on the Notice of Deficiency.

The complaint is considered ready for closure when the licensee has corrected cited deficiencies, or submitted a corrective action plan. The complaint analyst will then complete the summary on the reverse side of the complaint form and forward all materials related to the complaint investigation to the section supervisor, including the complaint form with Part 3 completed, for closure.

Death Investigations

The CCCB is also responsible for death Investigations. Departmental policy directs providers to notify the CCCB within 24-hours of a death. On average, SUD receives 18 death reports annually. Once notified about a death, the matter is immediately assigned to an analyst and investigated. At the conclusion of the investigation, a death meeting is held among the complaint analyst, complaint supervisor, field analyst, field supervisor, Licensing and Certification managers and legal staff to discuss the findings and recommended course of action. Data is collected on all of the deaths and quarterly meetings are held to review the death investigation policy.

The CCCB's overall responsibilities are summarized below.

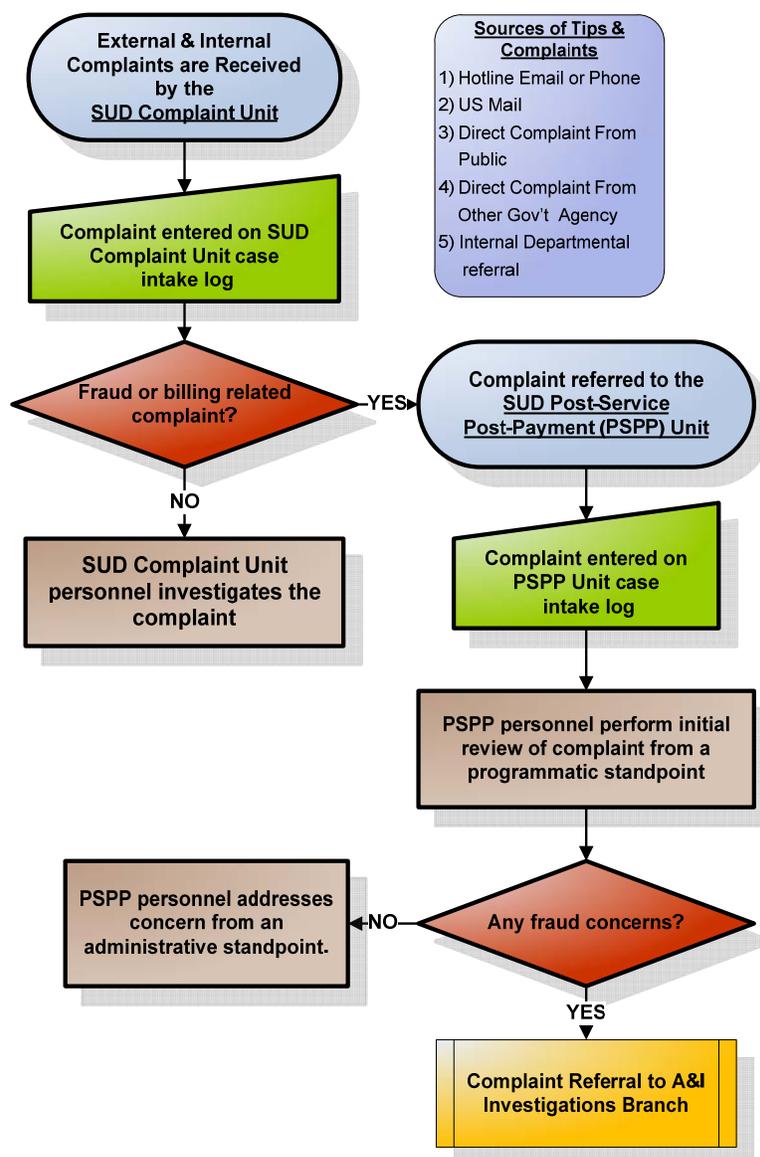
- Investigate complaints regarding licensed and/or certified facilities (CCR, Title 9, Chapter 5, Section 10543)
- Investigate complaints regarding unlicensed facilities (CCR, Title 9, Chapter 5, Section 10542)
- Investigate any deaths that occur in a licensed and/or certified facility
- Investigate any complaints regarding registered or certified AOD counselors working in licensed and/or certified facilities
- Monitor and collaborate with six different counselor certifying organizations
- Issue temporary suspensions and/or revocations to facilities
- Perform work associated with sanctions imposed (e.g., documentation, testifying, court hearings, etc.)
- Refer DMC billing complaints to the PSPP Unit

Observations

SUD Program

Complaints referred to the SUD CCCB can be made anonymously via its toll free hotline at (877) 685-8333, via email at DHCSLCB@dhcs.ca.gov, or by faxing a completed complaint form to (916) 455-5084. Because of the recent transition of the former ADP to DHCS, the SUD program is still in the process of posting the information onto DHCS' website. The general complaint process flow is shown below.

FIGURE 4 – Substance Use Disorder Services Complaint Intake Process



When the Complaints Unit and PSPP Unit were both housed within the former ADP Licensing and Certification Division, a single complaint intake log was utilized. Now that the PSPP has been relocated to the Performance Management Branch of the SUD PTRS, two complaint intake logs now exist. While the two logs are related to two different types of complaints (i.e., facility and counselor complaints versus billing and fraud complaints), it is important that both units coordinate their efforts and compare complaint logs on a regular basis to ensure all complaints are being addressed by the appropriate unit and in a timely fashion.

Recommendation #28 – To ensure all complaints received within the SUD program are being addressed by the appropriate unit and in a timely fashion, the SUD Complaint Unit and PSPP Unit should coordinate their efforts and compare complaint logs details on a regular basis.

Audits & Investigations Division

As mentioned in the Monitoring and Compliance section of this report, A&I is the Program Integrity Unit (PIU) for the State's Medi-Cal program as designated by the Center for Medicare and Medicaid Services (CMS) and pursuant to CFR 42 Part 455. As such, A&I is responsible for the intake of all fraud complaints associated with the Medi-Cal program from all sources.

More specifically, A&I's Investigations Branch (IB), comprised of sworn peace officers, is responsible for the complaint intake system and preliminary investigation of fraud referrals received. IB also serves as the primary liaison with the Department of Justice's (DOJ) Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA), which is California's designated Medicaid Fraud Control Unit (MFCU) responsible for criminal investigation and prosecution of Medi-Cal fraud cases pursuant to CFR 42, Part 1007.

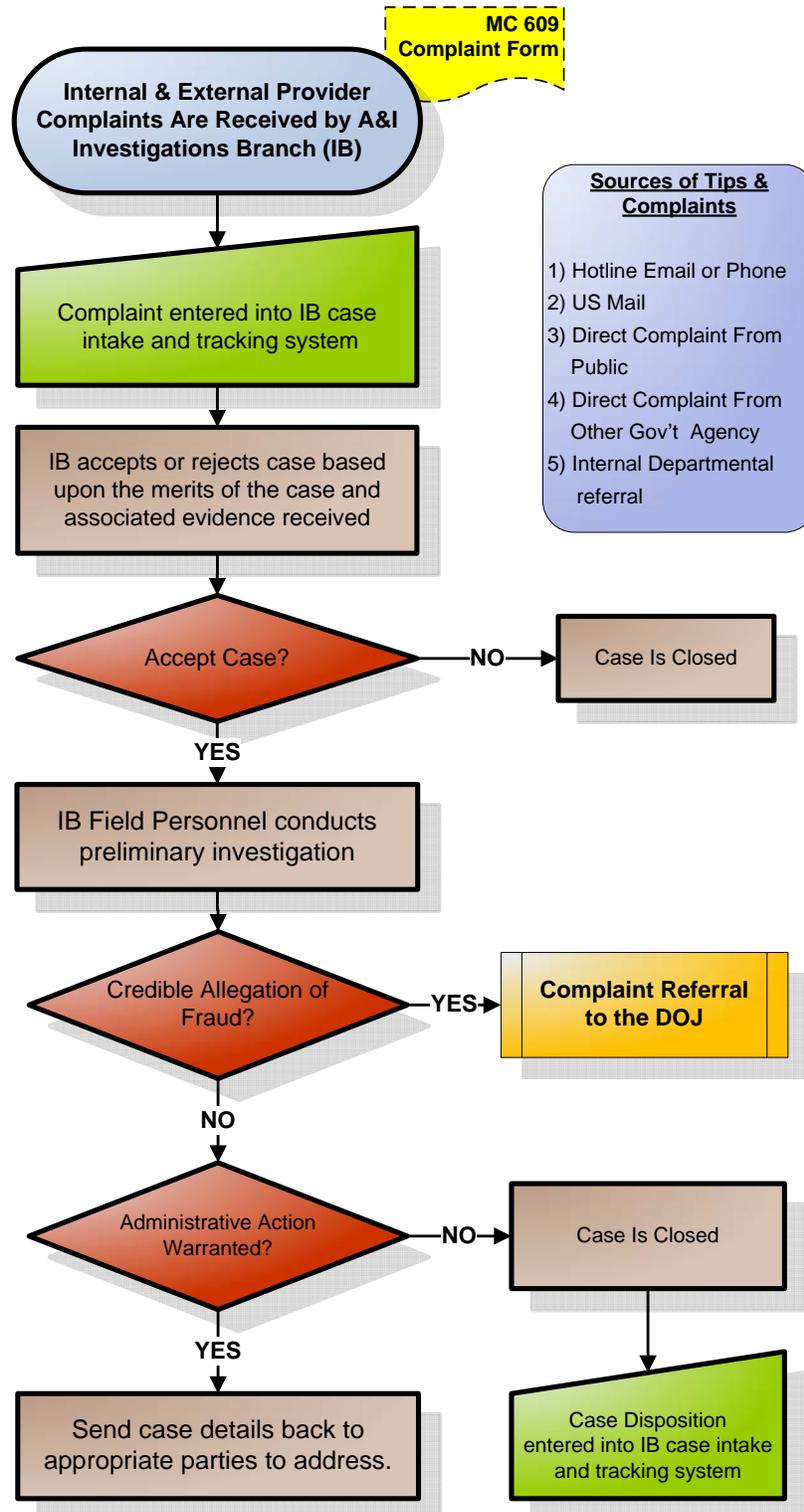
Federal regulations require cooperation and collaboration between the PIU and MFCU to combat provider fraud and abuse. With this in mind, A&I and the DOJ's BMFEA do collaborate with one another on a regular basis.

Medi-Cal fraud complaints referred to A&I can be made via DHCS' Medi-Cal Fraud Hotline at (877) 685-8333, via email at stopmedicalfraud@dhcs.ca.gov, or via A&I's online complaint form. The recorded message on DHCS' toll-free hotline may be heard in English and four other languages: Spanish, Vietnamese, Cambodian and Russian. The call is free and the caller may remain anonymous. Information regarding these reporting options may be obtained at <http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx>.

The DOJ's BMFEA also offers a fraud complaint hotline (800-722-0432) and online complaint form for Medi-Cal fraud referrals. As such, it is not uncommon for reporting parties to make dual referrals to both A&I and the DOJ.

The general complaint process and investigation flow within A&I is depicted in Figure 5 on the following page.

FIGURE 5 – Audits & Investigations Complaint Intake Process



During our review, we identified past DMC-related fraud complaints referred to A&I. During the period between July 2009 and May 2013, A&I received a total of 20 complaints from all sources, including the former ADP. We were not able to obtain complaints details from A&I before July 2009 because prior to July 2009, A&I IB complaints and case tracking processes were manual with minimal querying capabilities. We further did not review complaints received after May 2013 because they are currently part of the Department's targeted sweeps of DMC outpatient drug-free clinics statewide. An analysis and assessment of the statewide targeted sweeps project will be conducted at the conclusion of that project. A summary of the complaints received are shown below.

Table 2 - Fraud Complaints Referred to A&I Between July 2009 and May 2013

No. of Complaints Received	Disposition of the Case
4	Referred Case to the DOJ / BMFEA
7	Currently an Open and Ongoing Preliminary Investigation by the A&I IB
8	Case Closed by the IB
1	Case Returned to ADP
20	Total

Of the 20 complaints received, seven were received from the former ADP, six were from anonymous sources, four were from members of the public, one was from Los Angeles County, one from the DOJ/BMFEA, and one from a managed care plan.

Based upon our review of the eight closed cases noted above, we revealed that four of the cases were prematurely closed based upon an inaccurate assessment of the details involved. IB investigators incorrectly concluded that four cases did not have a Medi-Cal nexus because the providers in question were not identified as Medi-Cal enrolled providers. What the investigators did not realize was the fact that DMC provider details do not reside within the Medi-Cal Fee-For-Service (FFS) Provider Master File (PMF), nor does DMC paid claims data reside within the FFS paid claims data processed by the Department's Fiscal Intermediary.

Key Observation #15
Four DMC fraud cases were prematurely closed due to incorrect conclusions that the providers in question were not affiliated with the Medi-Cal program.

The Short-Doyle Medi-Cal system (SD/MC), which processes health care claims submitted by counties and direct providers for Mental Health and Substance Use Disorder Services, is separately administered by the Department's Information Technology Services Division (ITSD) and outside contractors. SD/MC data and Medi-Cal FFS data reside in separate databases that are not cross-referenced.

A&I management fully acknowledged the mistake it made with the four cases referenced and stated that efforts will be made to provide additional and ongoing training to investigative personnel to ensure they fully understand the DMC program, its programmatic requirements, and the part the program plays in the Medi-Cal program as a whole. Furthermore, the four cases will be revisited to determine if the cases need to be reopened or whether the cases have been addressed in DHCS' recent targeted reviews of DMC outpatient drug-free clinics.

Recommendation #29 – To ensure the effectiveness of all future DMC fraud investigations, A&I management should collaborate with SUD management to provide detailed and ongoing DMC program training to A&I investigators and other staff that may be responsible for future investigations, audits and reviews of DMC activity and providers.

We were also informed that ITSD is already working towards merging the SD/MC into DHCS' MIS/DSS data warehouse so that all data from all programs will reside in a single data repository. This task, however, is complex and therefore will take some time to be fully implemented.

In addition to preliminary fraud investigations performed by A&I's IB, A&I's Medical Review Branch (MRB) has been involved with DMC fraud cases in the past when clinical expertise was needed. Per our discussion with A&I MRB staff who worked on a prior DMC fraud case received from the former ADP several years ago, we were informed that ADP cases were often difficult to work because access to the SD/MC data was very limited.

A&I has not historically had direct access to the SD/MC data for purposes of mining the data as it does with Medi-Cal FFS data to identify indicators of potential fraud that require review and investigation. Now that the former ADP has fully transitioned to DHCS, the SD/MC data is fully accessible by A&I for data mining, audit and investigative purposes, which is a significant step towards increasing program integrity within the DMC program.

Fiscal Management & Accountability

Background

The Fiscal Management and Accountability Branch (FMAB) within the SUD Prevention, Treatment and Recovery Services (PTRS) Division supports the DHCS by accounting for, and reporting on, the federal and State public alcohol and other drug (AOD) funds. These public funds are made available to counties via the Negotiated Net Amount (NNA) and/or DMC contracts that counties and providers for AOD treatment and prevention services. Specifically, FMAB:

1. Settles year-end cost reports for counties and direct contract providers
 - Prepares written instructions
 - Provides training and technical assistance
 - Develops internal review procedures
 - Completes reviews
2. Processes and reconciles DMC claims
 - Ensures receipt of certifications
 - Provides training and technical assistance
 - Coordinates efforts with DHCS on system modifications
 - Reconciles submission of DMC claim data for settlement of cost reports
3. Processes NNA and DMC contracts for counties and/or direct contract providers
 - Develops contract language
 - Develops various contract documents
 - Develops contract supporting documents
 - Provides technical assistance
4. Maintains Master Provider File/Provider Registry Information Management enterprise (PRIME)
 - Enter AOD provider information into database
 - Coordinate with other Department Divisions on obtaining AOD provider information
 - Coordinate with counties on obtaining AOD provider information
5. Miscellaneous Activities
 - Provide billing and payment information to DHCS and/or DOJ related to potential DMC fraud
 - Assist with the SAPT Block Grant application by providing cost report expenditure information
 - Assist with Office of Legal Services on DMC related lawsuits

Observations

DMC Provider Payment Processing

After DMC claims are adjudicated through the Short-Doyle Medi-Cal (SDMC) system, the claims data is uploaded into the Short-Doyle Medi-Cal Remediation Technology (SMART) system. Counties and direct contract providers are required to submit certification forms for all claims filed. Upon receipt of the certification form, FMAB confirms the form with the filename in the SMART system, and if there is a match, FMAB staff will enter the receipt date of the certification form. Once the receipt data is entered into the SMART system, the approved claim data is transmitted to the accounting queue for DHCS Accounting staff to process payments. DHCS Accounting prepares the payment schedule and sends it to the FMAB manager for review and approval. Upon approval, the schedule is sent to the State Controller's Office (SCO) for payment. If there are insufficient funds in the contract, payment will not be processed and a contract amendment must be prepared.

Recoveries and Offsets

While the FMAB is involved with DMC-related funding transactions, it is not involved with any decisions regarding provider recoveries and offset resulting from identified overpayments.

If a recoupment of funds is required as a result of a PSPP utilization review (UR), PSPP staff will provide the FMAB the recoupment data. FMAB enters the recoupment information into a tracking log that captures information associated with the provider, county of location, type of service, service fiscal year, and recoupment amount.

Normally the recoupment is handled through the cost report settlement process. Upon receipt of the recoupment information, the information is provided to FMAB staff to incorporate within the specific county or direct provider cost report. To confirm that it was processed, supervisors review the cost report against the tracking log and enter their initials in the tracking log. If the cost report has already been settled upon receipt of the recoupment information, FMAB will then prepare an invoice to DHCS Accounting to invoice the county/provider. This information is also identified in the tracking log (cost report or invoice).

FMAB management informed us that an automated process is being considered for the recoupment of PSPP disallowances, in which PSPP staff will have the capability of identifying which claims are disallowed in the SMART system. Once this is done, DHCS Accounting Office will receive the information to either issue an invoice, or offset a future payment. Once this process comes to fruition, the FMAB will have access to the data, but will no longer be involved with the recovery/offset process. The only time the FMAB may continue to be involved are situations involving a court ordered recovery.

Other forms of recoveries or offsets associated with activities such as financial audits are not processed by the FMAB, or even known by the FMAB. Any county or direct contractor who disagrees with financial disallowances resulting from a financial audit conducted by the Alcohol and Drug Program Section (ADPS) within A&I may request an appeal to dispute the findings. After the

audit report is issued, a Contingency Accounts Receivable form is established and routed to the Accounting Office if there are financial findings. The county or direct service provider has sixty (60) calendar days from receipt of the audit report to file a written notice of disagreement stating the issues in dispute. If the county doesn't appeal, the Accounting Office is notified to bill the county. If the county appeals, ADPS forwards the request to DHCS Office of Administrative Hearings and Appeals for DMC funds or to the Office of Administrative Hearings for disallowances regarding non-DMC funds. Audit appeals that involve any DMC funds will be conducted in accordance with Article 1.5 (commencing with Section 51016), Chapter 3, Division 3, Title 22, CCR; and all other audit appeals will be conducted in accordance with Chapter 5 (commencing with Section 11500) Part 1, Division 3, Title 2, of the Government Code. After the hearing, ADPS will prepare an Accounts Receivable form to be forwarded to the Accounting Office. The Accounting Office will then bill the county or direct service provider in accordance with the final decision.

Several gaps exist within the current processes as follows:

1. When an invoice is issued to the county, or provider for a PSPP disallowance, the FMAB is not always provided the invoice information. Therefore, it is difficult for the FMAB to monitor the receipt of the invoice. In this case, the final payment that is identified within the FMAB will not match the final payment amount as identified by the Accounting Office.
2. When a PSPP invoice is paid, the FMAB is not notified that payment was received. Therefore, the final payment amount that is identified within the FMAB will not match the final payment amount as identified by the Accounting Office.
3. The FMAB is not informed of other recovery/offset of funds. Therefore, the final approved amount will always be higher as maintained by FMAB than it would be from Accounting.

Recommendation #30 – To ensure that the all DMC recoveries and offsets are adequately tracked, SUD Financial Management and Accountability Branch should work with DHCS Accounting Office to develop a process to enhance communications and develop a tracking system for DMC recoveries and offsets.

The following summarizes the FMAB role with provider sanctions upon receipt of the suspension notification:

1. Payment Suspension
 - a. Notify county of payment suspension (as long as a confidentiality agreement is in place).
 - b. Notify DHCS Information Technology Services Division (ITSD) staff to program SMART to include a system edit so no payments are issued. A report is subsequently generated that summarizes which providers are receiving payments and confirming that the suspended providers are not within the payment schedule. Once this is confirmed, the FMAB Manager will provide approval to DHCS Accounting to schedule payment.

2. Temporary Suspension

- a. FMAB staff update PRIME/SMART by putting an end date in the specific facilities NPI field (one person enters the information and one person confirms). Once the suspension date is entered, any claims submitted for services on that date and beyond will be denied.

While DMC providers are required to maintain its records for audit purposes, it would be prudent for the county to also proactively secure records, including client files, from providers that are suspended. However, there is currently no formal process between the State and counties to ensure that records from suspended providers are secured. Similarly, there is no formal process between the State and direct providers to facilitate the retrieval of records, including client files, from direct providers that are suspended. These formal processes are important should the State wish to pursue administrative actions or criminal investigations.

Recommendation #31 – To ensure that provider records, including client/beneficiary files, are adequately preserved, SUD management should work with the counties and direct providers to develop a process to retrieve and secure relevant records after a provider is sanctioned.

Statutes and Regulations

Background

The DMC program is governed by a host of statutes, regulations, contracts, DMC certification standards, alcohol and other drugs certification standards and California's Medicaid State Plan. The table below summarizes DMC authority by key topic.

Table 3 - Drug Medi-Cal Authority Matrix by Key Topic

KEY TOPIC	W&I	H&S	GC	STATE PLAN	CONTRACT	DMC STDS	1981DRUG TX STDS	AOD CERT	TITLE 22	TITLE 9, CH 4. NTP
Authorized Services	X	X		X	X	X		X	X	X
Description of Services & Limitations (non-NTP)	X			X		X		X	X	
NTP - Description of Services & Limitations	X			X	X				X	X
State Requirements	X				X			X	X	X
County Requirements	X				X		X	X	X	X
Provider Requirements	X							X	X	X
Certification Requirements	X				X	X	X	X		
Realignment	X	X	X							
DMC Rates & Reimbursement	X	X		X	X				X	
Perinatal	X			X		X			X	X
NTP Licensure		X								X
Cost Reports	X	X		X	X					
Medical Necessity	X			X	X	X			X	X

Legend: W&I – Welfare and Institutions Code; H&S – Health and Safety Code; GC – Government Code; DMC STDS – Drug Medi-Cal Standards; Drug TX STDS – Drug Treatment Standards; AOD Cert – Alcohol and Other Drug Certification Standards

Observations

Opportunities exist to strengthen existing regulations to provide clarity, enhance oversight capability, and ensure beneficiaries receive safe and appropriate services. Below are suggested areas for revision to ensure the safety of beneficiaries and medical appropriateness of services rendered in addition to mitigating fraud, waste and abuse.

- Medical necessity - Title 22 regulations for the DMC program allow for the prescription of services for beneficiaries meeting the criteria for substance abuse (a Diagnostic and Statistical Manual of Mental Disorders (DSM) category indicating a low severity level of substance use disorder), but does not include any limitation/specific language that ensures the level of treatment prescribed is appropriate for the level of beneficiary need. As a result, the risk exist that beneficiaries are prescribed intensive treatment modalities (Day Care Habilitative intensive outpatient treatment, residential perinatal treatment) despite having little history and/or low levels of substance use. This lack of specificity in the regulation increases the risk of inappropriate prescribing and billing for units of service that are reimbursed at higher rates and rendered with increased frequency.
- Physical Exam - Despite the fact that substance abusers are an unusually high risk population in terms of physical health conditions, the vast majority of DMC programs admit beneficiaries into treatment without first performing a physical examination to determine the safety and/or appropriateness of DMC treatment services. Title 22 regulations state that an assessment of the physical condition of the beneficiary be performed within 30 days of admission. The regulations, however, allows this assessment to be performed either through a physical exam, or via the review of the beneficiaries' medical and substance abuse history and/or most recent physical exam documentation. Assessments made without the benefit of a physical exam must include a waiver which specifies the basis for not requiring a physical exam.

The allowance of a physical exam waiver has led to the commonplace practice of physicians approving high risk clients for DMC services without meeting with and physically examining the beneficiary. According to SUD management, intake and assessment of beneficiaries within the DMC program are typically performed by non-clinical counseling staff who lack clinical training and the medical expertise needed to identify medical and/or psychological conditions that would necessitate referral to a higher level of medical care.

- Age Appropriate Services – Current regulations do not require age appropriate services which means that providers can, and do, mix adolescents with adults in group counseling settings. According to SUD management, this practice can be detrimental to the youth by negatively impacting their potential for treatment and recovery and also raises safety concerns for youth during a vulnerable stage of their development and recovery from alcohol and/or drugs. Evidence based practices also support the requirement for age appropriate services.

- Day Care Rehabilitative (DCR) – The DCR treatment modality is an intensive outpatient modality requiring treatment for a minimum of three hours per day, three days a week per Title 22 regulations. As defined in regulations, “...The service shall consist of regularly assigned, structured, and supervised treatment.” Providers are reimbursed for services per day which is a minimum three hours of service. Currently, eligibility for this modality is restricted to pregnant, or 60 days postpartum, women and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) youth. With the Medi-Cal expansion benefit, eligibility for the DCR benefit will no longer be restricted, but will be available to all Medi-Cal eligible beneficiaries needing the service.

Risks associated with this modality of treatment includes the potential for the inclusion of excessive numbers of youth in group sessions (there is no limit on group size for DCR as there is for regular outpatient services), which increases the risk of ineffective treatment practices; utilizing three-hour group counseling sessions to minimally satisfy the regulatory requirements rather than tailoring the treatment to the individuals’ needs and what is clinically appropriate; and, providing only group services that appear to be prevention and education-based rather than treatment focused.

Recommendation #32 – To increase program integrity, the Department should explore options to strengthen existing regulations associated with medical necessity, age appropriate services and Day Care Rehabilitative requirements with consultation from appropriate clinical staff.

Conclusion

As discussed earlier in this report, an entity's control environment sets the tone of the organization from an internal control standpoint. It is the foundation for all other components of internal control, providing discipline and structure.

Our limited scope review of the DMC program revealed an organization that has focused more heavily on programmatic deliverables and services for DMC beneficiaries than measures associated with program integrity. Under the former ADP, management's attitude towards program integrity could have been strengthened, as evidenced by the following broad observations made during our limited scope review:

- Weak performance / certification standards for participating providers.
- No re-certification of DMC providers.
- Inconsistent monitoring of both DMC providers and counties for compliance with certification standards and State/county contract requirements, respectively.
- Lack of adequate financial oversight of Narcotic Treatment Programs.
- Minimal sanctions or penalties imposed on DMC providers in the past.
- Staff integrity issues.

Processes that are intended to serve as vital checks and balances within the program have not been effective. Until these internal control weaknesses are fully addressed, DHCS will continue to be exposed to financial and/or legal risks as well as increased risks of fraud, waste and abuse within the DMC program.

While the above challenges continue to exist, the current SUD management team continues to make significant strides towards closing the gaps identified. The SUD management staff members interviewed during this engagement appear to be both knowledgeable about the program and committed to improving the integrity, effectiveness and efficiency of the their respective SUD divisions. An abundance of suggestions for improvement were provided to us during the engagement, many of which have been included in this report.

With new SUD leadership in place and the positive steps that have been taken by current SUD management staff to address issues within both SUD divisions since transitioning to DHCS, we are encouraged that the SUD divisions are taking the steps necessary to move their program forward in a positive direction.

The former ADP's transition to DHCS offers the newly reorganized SUD divisions a tremendous opportunity to strengthen its program by leveraging DHCS' vast resources and expertise. DHCS not only offers SUD management staff an environment that will support and embrace their desire for program improvement, but a strong commitment to program integrity.

This report makes a number of recommendations that will help SUD management address identified gaps and control weaknesses in its current program. See the following page for a summary of all recommendations.

Summary of Recommendations

Immediate

State-Level Administration

- To ensure the successful implement of remedies for identified gaps and program deficiencies, Substance Use Disorder Services management should take advantage of the recent transition to DHCS and fully leverage the Department's support and resources. (Recommendation #1, Page 10)

Licensing & Certification

- To enhance program integrity and decrease the risk of fraud, waste and abuse, the Department should de-certify all providers that have not billed the program for over 12 months. Re-certification should then be required if the provider wishes to resume participation in the program. (Recommendation #8, Page 22)

Monitoring & Compliance

- To enhance the effectiveness and value of AOD and NTP on-site provider visits and because DMC providers are also often AOD and NTP certified, SUD management should expand AOD and NTP site visit procedures to include basic observations about the surroundings and activities of a provider location to identify potential fraud, waste or abuse. (Recommendation #10, Page 27)
- To increase program integrity, the Department should explore the feasibility of placing more expectations on the counties, including fines if necessary, to notify the Department when the county becomes aware that a contractor is closing its program, or has become defunct. (Recommendation #22, Page 41)

Post-Service Post-Payment Utilization Reviews

- To ensure the integrity of past PSPP URs, SUD management should perform a cursory assessment of past reviews for reasonableness, accuracy and completeness. Any identified anomalies or red flags should be investigated and addressed as necessary. (Recommendation #26, Page 45)

Financial Audits

- To ensure program integrity, SUD management and program staff should monitor and follow-up on all significant audit findings, especially those that are unusual in nature, material in dollar amounts, or may lead to financial and/or legal exposure to the Department. (Recommendation #23, Page 42)

Complaint and Fraud Referral Process

- To ensure appropriate investigation and fraud referral by the PSPP Unit to the appropriate law enforcement authorities, the complaint intake function should be segregated from personnel responsible for deciding whether an investigation and fraud referral to law enforcement is warranted. (Recommendation #15, Page 32)
- To ensure all complaints received within the SUD program are being addressed by the appropriate unit and in a timely fashion, the SUD Complaint Unit and PSPP Unit should coordinate their efforts and compare complaint logs details on a regular basis. (Recommendation #28, Page 52)
- To ensure the effectiveness of all future DMC fraud investigations, A&I management should collaborate with SUD management to provide detailed and ongoing DMC program training to A&I investigators and other staff that may be responsible for future investigations, audits and reviews of DMC activity and providers. (Recommendation #29, Page 55)

Short-Term

State-Level Administration

- To improve the effectiveness of its Provider Registry Information Management enterprise (PRIME) system, SUD management should enhance the PRIME system to accept all application, compliance, and program information (deficiencies, corrective action plans, etc) across all programs to ensure the entire universe of data is being tracked and analyzed. Data such as the non-eligible provider list(s) from the Provider Enrollment Division should also be incorporated in this effort to the extent feasible. (Recommendation #2, Page 10)
- To ensure activities are coordinated and staff are knowledgeable about the various program integrity efforts and objectives across the entire SUD program, SUD management should provide internal cross-training on the topics of AOD monitoring, NTP monitoring, DMC monitoring and PSPP utilization reviews. (Recommendation #12, Page 27)
- To effectively implement DMC provider monitoring as previously recommended, SUD management should clearly delineate DMC PSPP utilization review requirements from DMC monitoring requirements. Once completed, SUD management should identify the SUD unit best suited to assume responsibility for ongoing DMC program monitoring. If there are inadequate personnel resources to address monitoring responsibilities, SUD management should pursue additional resources and request the needed positions. (Recommendation #16, Page 33)
- In light of the 2011 Realignment, the Department should determine what enhanced role the counties might play regarding future utilization reviews. Once determined, the Department should amend the State-county contract to reflect the modified roles and responsibilities. (Recommendation #18, Page 34)

Licensing & Certification

- To ensure DMC providers continue to meet certification standards, the Department should implement a full DMC provider re-certification process at least once every five years in accordance with the new requirements of the ACA. (Recommendation #3, Page 20)
- To reduce the risk of fraud, waste and abuse, the Department should limit the number of DMC providers at one physical location or address to a single provider. (Recommendation #5, Page 21)
- To streamline the re-certification process and take advantage of the Department's strict provider enrollment standards, the Department should consider formally aligning the DMC certification process with policies and procedures utilized by the Provider Enrollment Division for enrollment of Medi-Cal Fee-For-Service providers. (Recommendation #6, Page 21)
- To comply with CMS policy regarding the screening of excluded providers, the Department should conduct monthly checks against the Medicare Exclusion Database (MED) or the OIG List of Excluded Individuals/Entities database to identify exclusions and reinstatements of existing DMC providers. All identified excluded DMC providers should be suspended from the DMC program. (Recommendation #7, Page 22)

Monitoring & Compliance

- To enhance program integrity, the Department should establish ongoing and periodic program compliance monitoring activities for the DMC Program. The monitoring activities should be coordinated with existing PSPP utilization reviews and other DHCS conducted county monitoring activities to ensure DMC certification standards are complied with. Additionally, consider enhanced / expanded roles for counties in the monitoring efforts. State/county collaboration needs to be strengthened to avoid duplication and maximize enforcement capacity. (Recommendation #9, Page 25)
- To increase the effectiveness and efficiency of program integrity efforts, DMC program monitoring should be fully coordinated with the biennial AOD, annual NTP and county monitoring activities. There should also be full data sharing between all parties to ensure identified compliance issues are fully communicated to avoid duplication of efforts and executing the various monitoring and auditing activities in a vacuum. (Recommendation #11, Page 27)

Post-Service Post-Payment Utilization Reviews

- To increase the effectiveness of the PSPP Unit, SUD management should enhance/increase clinical expertise and capacity within the Unit. SUD management should also consider leveraging A&I's clinical resources and expertise to assist with aspects of its PSPP utilization reviews. (Recommendation #17, Page 34)

Fiscal Management & Accountability

- To ensure proper segregation of duties and accountability from NTP providers, SUD management should discontinue its role in preparing the required Performance Report on behalf of NTPs to be consistent with the statutory reporting requirement. The Performance Report should be independently prepared and remitted by the NTPs to the State as required by law. Provider bulletins should also be updated accordingly to ensure expectations of the counties are clear. (Recommendation #25, Page 45)

Long-Term

State-Level Administration

- To ensure counties are not overpaid due to inflated base rates, the Department should work with the DOF to ensure adjustments are made to back out identified fraudulent billings or false claims from existing levels of service in developing county allocation schedules. (Recommendation #14, Page 29)
- To ensure the integrity and effectiveness of its organization, SUD management should work diligently to improve its internal control structure. (Recommendation #27, Page 46)

Post-Service Post-Payment Utilization Reviews

- To increase the effectiveness of PSPP utilization reviews, SUD management should build and implement a comprehensive core training program for PSPP Unit staff. (Recommendation #19, Page 35)
- To enhance the value of PSPP reviews, SUD management should modify its approach to utilization reviews by discontinuing its practice of reviewing all providers based upon a cycle (once every three years). Instead, reviews should be prioritized based upon high risk and high dollar providers as identified via analysis of paid claims data and other analysis of provider activity data. Consultation with the A&I Medical Review Branch is advised to implement the necessary structure and practices for effective data mining and case development. (Recommendation #20, Page 37)
- To deter fraud, waste and abuse by DMC providers, SUD management should explore the feasibility of increasing the use of statistical extrapolation in its PSPP utilization reviews to increase the potential for recovery of identified overpayments and the positive effect this might have on provider compliance with DMC standards, laws and regulations. (Recommendation #21, Page 38)

Financial Audits

- To ensure program integrity, the Department should resume financial audits of NTPs that submit cost reports to ensure that operating costs reported to the State are accurate and in sufficient detail to support payments made for services rendered to beneficiaries. (Recommendation #24, Page 43)

Fiscal Management & Accountability

- To ensure that the all DMC recoveries and offsets are adequately tracked, SUD Financial Management and Accountability Branch should work with DHCS Accounting Office to develop a process to enhance communications and develop a tracking system for DMC recoveries and offsets. (Recommendation #30, Page 58)
- To ensure that provider records, including client/beneficiary files, are adequately preserved, SUD management should work with the counties and direct providers to develop a process to retrieve and secure relevant records after a provider is sanctioned. (Recommendation #31, Page 59)

Statutes and Regulations

- To ensure that only qualified and legally compliant providers are authorized to participate in the DMC program, the Department should strengthen its DMC certification standards, with a specific focus on the responsibilities and performance measures of the facility Medical Director and other provider personnel. (Recommendation #4, Page 21)
- To increase program integrity and decrease the risk of fraud, waste and abuse in the DMC program, the Department should consider revisions to Title 22 regulations specific to the physician/medical director's role and responsibilities as it relates to beneficiary contact and involvement in patient care. Consultation from appropriate clinical personnel should be obtained to determine what those standards should be. (Recommendation #13, Page 29)
- To increase program integrity, the Department should explore options to strengthen existing regulations associated with medical necessity, age appropriate services and Day Care Rehabilitative requirements with consultation from appropriate clinical staff. (Recommendation #32, Page 62)