DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 17, 2026

TO: Daniel Brillman
Deputy Administrator and Director
Center for Medicaid and CHIP Services

FROM: /Tamara Lilly/
Acting Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership With the State of Rhode Island, Office of the Auditor General: Auditor General's Report, *Provider Compliance with Opioid Treatment Program Requirements* (OAS-24-01-003)

This memo transmits the findings of the State of Rhode Island, Office of the Auditor General (Auditor General) audit report *Provider Compliance with Opioid Treatment Program Requirements*, issued October 7, 2026. The Auditor General performs a variety of auditing functions for the State of Rhode Island's departments and agencies. The Auditor General's financial and performance audits provide information to General Assembly members on the operations of State government. The Auditor General's Medicaid performance audits are conducted to determine whether agencies are carrying out their functions efficiently and effectively and are using their resources in compliance with applicable laws and regulations.

The objective of the Auditor General's audit was to determine whether the Rhode Island Executive Office of Health and Human Services (EOHHS) and the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) provided reasonable assurance that Medicaid opioid treatment program (OTP) services complied with certain Federal and State requirements for the period January 1, 2023, through December 31, 2024. EOHHS is the State agency responsible for administering the Medicaid program in Rhode Island, and BHDDH is the State agency responsible for the oversight of OTP providers.

As part of the U.S. Department of Health and Human Services Office of the Inspector General's (HHS OIG's) efforts to partner with State auditors and expand oversight coverage of the Medicaid program, HHS OIG assisted the Auditor General with its audit by:

- Matching Medicaid claims from the Centers for Medicare & Medicaid Services' (CMS's) Transformed Medicaid Statistical Information System to identify OTP services provided for individuals enrolled in the Medicaid program

- Providing the resulting Medicaid matches to the Auditor General
- Assessing the reliability of select Medicaid claims data
- Developing a statistically valid methodology for the Auditor General and evaluating the results of the sample
- Providing a separate list of claims for OTP services that were paid by managed care organizations (MCOs) daily instead of the required weekly bundled rate
- Meeting routinely with the Auditor General auditors to discuss audit work
- Monitoring the progress of the Auditor General's audit

To accomplish its audit objective, the Auditor General reviewed a stratified random sample of 100 OTP service claims, conducted site visits at all 5 OTP providers in Rhode Island, reviewed OTP provider clinical records, and assessed BHDDH's monitoring activities. In addition, the Auditor General separately examined the OTP services that were paid by MCOs on a daily basis instead of a weekly bundled rate as required. These services were not included in the sampling frame.

The Auditor General determined that BHDDH's oversight and monitoring did not ensure that OTP providers consistently complied with Federal and State requirements for delivering and documenting OTP services. Specifically, all 100 sampled OTP services did not fully meet Federal and State requirements. These deficiencies involved inadequate or missing documentation in critical areas such as biopsychosocial assessments, person-centered treatment plans, counseling services, toxicology screenings, annual assessments, medical examinations, and care coordination. Accordingly, the Auditor General estimated that OTP services totaling at least $24.9 million did not meet all Federal and State requirements during the audit period.

The Auditor General stated that the deficiencies occurred because biennial audits performed by BHDDH's Licensing and Regulatory Compliance did not effectively ensure OTP provider compliance with Federal and State requirements. Moreover, BHDDH did not compile and evaluate OTP provider results in a manner sufficient to determine whether its monitoring procedures were effectively ensuring compliance. As a result, BHDDH lacked assurance that OTP services provided to Medicaid enrollees were properly documented and monitored and compliant with Federal and State regulations.

The Auditor General also reported an "other reportable matter" to EOHHS that was not specifically related to its objective of evaluating BHDDH's oversight of OTP services. Specifically, the Auditor General identified and validated 6,347 OTP claims with which the MCOs improperly reimbursed OTP providers for methadone treatment on a daily basis instead of a weekly bundled rate, resulting in $875,696 ($656,919 Federal share) in potential overpayments.

The Auditor General stated that the causes of the improper payments were noncompliance with the required weekly bundled billing methodology and inadequate system controls within EOHHS's Medicaid systems to detect and prevent improper billing by OTP providers.

The Auditor General made seven recommendations to BHDDH, including four to improve clinical processes and documentation requirements, two to improve service delivery, and one to monitor OTP providers with recurring deficiencies. In addition, the Auditor General made four recommendations to EOHHS regarding the other reportable matter, including one to recover the total amount of the improper payments and return the Federal share to the Federal Government, one to implement system edits to ensure that no more than one weekly bundled rate is paid per week, one to strengthen OTP provider education and issue updated billing guidance, and one to implement postpayment monitoring and periodic audits. The full recommendations are in the report. In its comments on the Auditor General's report, both BHDDH and EOHHS agreed with the recommendations and described actions that they planned to take.

The Auditor General is responsible for the attached audit report and the conclusions expressed in it. The Auditor General agreed to conduct the audit in accordance with Generally Accepted Government Auditing Standards and provided us with documentation to support the independence, objectivity, and qualifications of the Auditor General staff assigned to this audit. We are not expressing an opinion on the report or its results; however, we encourage CMS to consider this report and its results, and to work with State Medicaid agencies to improve oversight and monitoring of OTP services in the future.

This memo and the Auditor General report, including BHDDH and EOHHS written comments, will be posted on the OIG website.

If you have any questions or comments about this memo, please do not hesitate to contact John Hagg, Assistant Inspector General for Audit Services, at John.Hagg@oig.hhs.gov. Please refer to report number OAS-24-01-003 in all correspondence.

Attachment

cc:

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STATE OF RHODE ISLAND

PROVIDER COMPLIANCE WITH OPIOID TREATMENT PROGRAM REQUIREMENTS

AUDIT PERIOD: JANUARY 1, 2023 THROUGH DECEMBER 31, 2024

REPORT DATE: OCTOBER 7, 2026

David A. Bergantino, CPA, CFE

Auditor General

State of Rhode Island

General Assembly

Office of the Auditor General

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October 7, 2026

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Richard Leclerc, Director, Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

In collaboration with the Office of Inspector General's (OIG) Boston Office, U.S. Department of Health and Human Services (HHS), we provide this report on our performance audit of the Department of Behavioral Healthcare, Developmental Disabilities & Hospitals' (BHDDH) oversight and monitoring of provider compliance with Opioid Treatment Program (OTP) requirements for the period January 1, 2023 through December 31, 2024. The objective of this performance audit was to determine whether BHDDH's oversight and monitoring policies and procedures provided reasonable assurance that OTP services billed to the Medicaid program complied with certain federal and state requirements.

Our audit was performed in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The recommendations detailed in this report illustrate the importance of strengthening oversight and improving clinical recordkeeping systems within Opioid Treatment Programs by identifying noncompliance issues that could endanger client health and well-being and the allowability of Medicaid reimbursement for services provided. This audit specifically highlights the need for improved controls over BHDDH's provider oversight and monitoring. As required by *Government Auditing Standards*, we have obtained management responses to our audit findings and have included those in this report.

Sincerely,

David A. Bergantino, CPA, CFE
Auditor General

STATE OF RHODE ISLAND
GENERAL ASSEMBLY
OFFICE OF THE AUDITOR GENERAL

PROVIDER COMPLIANCE WITH OPIOID TREATMENT PROGRAM REQUIREMENTS

AUDIT PERIOD: JANUARY 1, 2023 THROUGH DECEMBER 31, 2024

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LIST OF ABBREVIATIONS, ACRONYMS AND DEFINITIONS

Federal programs and regulations utilize a vocabulary of abbreviations and acronyms when referring to specific entities or data sources involved in the operation of federal health and human services programs. This report also uses terminology and acronyms that we have defined below to facilitate the readers' understanding. The table below includes explanations of abbreviations, acronyms and key terms defined in this report.

Abbreviation / Acronym / Terminology		Entity Title, Description, or Definition
Biopsychosocial (BPS) Assessment		A comprehensive assessment that includes a medical evaluation and physical exam, documentation of current physiological opioid dependence, toxicology testing, mental health and behavioral assessment, social functioning review and verification of diagnosis and treatment appropriateness.
BHDDH		Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals. State agency responsible for licensing, oversight, and clinical standards for Opioid Treatment Programs (OTP).
Comprehensive Person-Centered Treatment Plan		This is a baseline care plan for each client that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. The plan is required to be completed within 30 days of admission and must contain long-term recovery goals, counseling frequency and type, medical and psychiatric needs, social service and case management needs, relapse-prevention planning and required signatures.
Discharge Summary		A discharge summary documents the reason for discharge, final dosage, patient progress, referral recommendations, and aftercare planning.
Diversion Control Plan		A diversion control plan is a required OTP policy that outlines how the program prevents methadone or other opioid-treatment medications from being diverted to illicit use.
EOHHS		RI Executive Office of Health and Human Services, State Medicaid Agency
HHS		U.S. Department of Health and Human Services
Managed Care Organization (MCO)		Health care plans contracted with Rhode Island Medicaid to administer health coverage for eligible individuals. These plans process the majority of OTP service claims reimbursed by Medicaid.
Medication-Assisted Treatment for Opioid Use Disorder (MAT)		Medication-Assisted Treatment for Opioid Use Disorder is an evidence-based clinical intervention that integrates the use of FDA-approved pharmacologic treatments—such as methadone, buprenorphine, and naltrexone—with structured counseling and behavioral therapies.
Medicaid State Plan		The formal agreement between a state and the federal government submitted in accordance with 42 CFR 431.10 describing how that state administers its Medicaid program.

ABBREVIATIONS, ACRONYMS AND DEFINITIONS (Continued)		
Abbreviation / Acronym / Terminology		**Entity Title, Description, or Definition**
Medical Services Care and Coordination		Organizational policies and procedures that guide clinical assessments, treatment planning, medication management, care transitions, provider communication, and documentation to ensure safe, compliant, and coordinated care.
OIG		Office of Inspector General, Boston Office
Opioid Use Disorder (OUD)		A chronic medical condition defined by problematic opioid use leading to clinically significant impairment or distress. An OUD diagnosis is required for OTP admission under both federal law and Rhode Island OTP regulations.
Opioid Treatment Program (OTP)		A federally certified and Rhode Island-licensed program authorized to dispense methadone and provide medication, counseling, medical evaluation, and recovery support for individuals with OUD.
Preliminary Treatment Plan		A plan developed at admission based on the initial assessment; it sets immediate goals, safety measures, and required services that guide care during the first 30 days.
Progress Notes		Documentation of each service provided, including clinical status, counseling sessions, and treatment progress.
Recordkeeping System		OTPs must maintain comprehensive clinical documentation that includes assessments, treatment plans, dosing records, counseling notes, toxicology results and discharge summaries.
RI Code of Regulations (RICR)		All state regulations relating to behavioral healthcare organizations which include OTP providers included in Title 212, Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations. State regulation references included in this report refer to this section of the RI Code of Regulations.
RI Medicaid		RI Medical Assistance Program
SAMHSA		Substance Abuse and Mental Health Services Administration, an agency of the U.S. Department of Health and Human Services
Toxicology Screening / Drug Testing		Required at admission and periodically thereafter, but not fewer than eight (8) tests per year.
T-MSIS		Transformed Medicaid Statistical Information System
Treatment Plan Review		A Treatment Plan Review is a required clinical update at least every six (6) months in which the OTP reassesses the patient's goals, needs, and progress and then updates the treatment plan accordingly.

Executive Summary

AUDIT CONCLUSIONS

Our audit found that BHDDH's oversight and monitoring did not ensure that Opioid Treatment Program (OTP) providers (providers) consistently complied with federal and state requirements governing the delivery and documentation of OTP services. In a review of 100 sampled claims that were associated with OTP clients, every claim failed to meet at least one compliance requirement. These deficiencies involved inadequate or missing documentation in critical areas such as biopsychosocial (BPS) assessments, person-centered treatment plans, counseling services, toxicology screenings, annual assessments, medical examinations, and care coordination.

Although BHDDH's Licensing and Regulatory Compliance Unit conducted biennial audits of the five providers included in our review, these oversight activities were not sufficient to ensure full compliance with mandatory regulatory requirements. Our audit identified widespread noncompliance in the 100 OTP sample claims (for medication assisted treatment (MAT) services) tested, including most notably:

- 99 instances of noncompliance with MAT requirements.
- 95 instances of noncompliance in biopsychosocial (BPS) assessments either at intake or on the 5-year anniversary.
- 75 instances of noncompliance in person-centered treatment plan six (6) month reviews.
- 70 instances of noncompliance in required counseling sessions.
- 51 instances of noncompliance in annual BPS reviews.
- 50 instances of noncompliance in annual person-centered treatment plans.
- 42 instances of noncompliance in annual medical examinations.
- 22 instances of noncompliance in toxicology screens.

The extent of these results demonstrates a systemic lack of compliance across multiple core service-delivery and documentation requirements. Strengthened oversight and enhanced monitoring mechanisms are needed to ensure that providers meet federal and state standards and are adequately documenting and delivering services essential to patient care and safety. In addition, based on our audit results, we estimate that 274,412 OTP MAT services provided during the audit period, totaling $24,921,184 (statistically determined), did not meet the federal and state requirements to support the allowability of the claiming to the Medicaid program.

Our audit also found that RI Medicaid made $875,696 in potentially improper payments in relation to 6,347 claims for MAT services. These overpayments occurred because providers did not follow the State-mandated weekly bundled billing methodology and continued to submit daily methadone claims that should have been consolidated into a single weekly bundled claim. RI Medicaid did not ensure that controls were in place to prevent or detect the improper payments.

The improper payments identified represent a failure to meet federal and state program-integrity requirements. Federal Medicaid law requires states to maintain efficient, economical payment methods and implement safeguards to prevent and detect improper payments. Rhode Island's Medicaid State Plan and provider regulations reinforce these obligations by requiring OTP services to be billed using a weekly bundled methodology and mandating the identification and return of overpayments.

AUDIT PURPOSE

The purpose of this audit is to evaluate whether providers are complying with applicable federal and state requirements when providing and documenting opioid treatment services for Medicaid clients. The audit aims to determine whether BHDDH has implemented effective controls to ensure that providers meet mandatory standards related to client admissions, treatment planning, service delivery, medication management, drug screening, assessments, and

required documentation. This audit is intended to identify gaps in compliance that may place clients at risk for poor treatment outcomes and to support recommendations that strengthen program integrity and quality of care.

RECOMMENDATIONS

We recommended that BHDDH:

1) Strengthen oversight to ensure providers consistently comply with all federal and state clinical documentation and service delivery requirements.
2) Require providers to implement comprehensive internal controls that track completion, timeliness, and accuracy of all required clinical documentation.
3) Develop standardized templates, checklists, and documentation guidelines for all major clinical processes and records.
4) Provide targeted training and technical assistance to provider staff and supervisors on federal and state requirements for OTP services, including clinical documentation standards.
5) Establish documentation quality expectations and require providers to conduct periodic internal audits across all areas of OTP service delivery.
6) Implement performance reporting to track OTP compliance across all required clinical and documentation categories.
7) Conduct follow-up monitoring of providers with recurring deficiencies to ensure corrective actions are implemented effectively and sustained over time.

Other Reportable Matter- Regarding the potentially improper payments for MAT services, we recommend that RI Medicaid conduct a full review of all OTP claims (billing procedure code H0020) to confirm compliance with weekly bundling requirements and identify overpayments. RI Medicaid should then notify providers so they can return overpayments in accordance with the federal 60-day rule.

RI Medicaid should also implement system edits to prevent payment of daily H0020 claims when a weekly bundled claim is required and to ensure that only one weekly bundled claim is paid per beneficiary. Additionally, RI Medicaid should strengthen provider education, update billing guidance, and enhance post-payment monitoring and audits to ensure continued compliance and prevent recurring improper billing.

REPORT SIGNIFICANCE

The United States currently faces a nationwide public health emergency due to the opioid crisis. The high potential for opioid misuse has driven alarming trends across the country, including record numbers of people developing opioid use disorders (OUDs).

Opioids are a class of natural, semi-synthetic, and synthetic drugs that include both prescription pain medications and illegal substances. They are highly addictive, and their use is a leading factor in the drug overdose crisis. In recent years, most overdose deaths have involved illicitly manufactured fentanyl and other potent synthetic opioids. Common prescription opioids include oxycodone, hydrocodone, morphine, codeine, and fentanyl.

The Centers for Disease Control and Prevention data indicates that more than 80,000 opioid-related deaths occurred in 2022, reflecting the ongoing severity of the epidemic. Within Rhode Island, the crisis manifested at a peak of 436 fatal drug overdoses in 2022. Comprehensive efforts over the last decade have resulted in decreases in emergency department visits and fatalities in recent years as illustrated in **Table 1** on page 4. OTPs play a critical role by providing evidence-based medications along with counseling and supportive services for individuals diagnosed with OUD.

MANAGEMENT RESPONSE TO REPORT

As required by *Government Auditing Standards*, we have obtained a response and corrective actions from management of BHDDH and RI Medicaid and included their response in the Auditee Response and Corrective Actions section of this report on page 27.

AUDIT SCOPE

In collaboration with the HHS Office of Inspector General, the Rhode Island Office of the Auditor General (RIOAG) conducted an audit of BHDDH's oversight and monitoring of OTP services for the period January 1, 2023 through December 31, 2024. During this period, 5 providers submitted claims to MCOs for 274,412 MAT services totaling $25,541,470 provided to Medicaid beneficiaries. We selected and reviewed a random sample of 100 OTP MAT services to determine whether the State met federal and state requirements.

Specifically, our audit reviewed BHDDH's policies and procedures relating to provider requirements and compliance monitoring. In addition, the audit team conducted a targeted review of provider documentation for the clients sampled to evaluate provider compliance with federal and state requirements. This review included confirming:

1) the presence and completeness of biopsychosocial (BPS) assessments at intake, annual and five-year reassessments;
2) whether integrated summaries and preliminary treatment plans were developed as required;
3) that person-centered treatment plans included required elements, annual updates, and six-month reviews;
4) that progress notes included documentation of patient status, service duration, and decision-making discussions;
5) that provider documentation relating to counseling services, toxicology screenings, annual medical examinations, care-coordination activities, and transition or discharge summaries met the applicable regulatory standards to determine whether providers met mandated content, timelines, signatures, and clinical-supervision requirements; and
6) overall provider compliance with service and documentation requirements for providing MAT services to clients.

AUDIT OBJECTIVE

The objective of this audit is to determine whether Rhode Island oversight through BHDDH provided reasonable assurance that Medicaid OTP services complied with certain federal and state requirements.

FEDERAL AND STATE REGULATIONS SPECIFIC TO AUDIT OBJECTIVE

BHDDH is responsible for licensing and oversight of behavioral healthcare organizations, including programs that provide mental health and substance use treatment services. As part of this oversight, BHDDH ensures that providers comply with applicable federal and state requirements related to health, safety, service delivery, and documentation. Federal regulations at 42 C.F.R. Part 8 establish standards for OTPs, including requirements to implement and maintain health, safety, and quality-of-care protections.

State regulations, 212-RICR-10-10-1, further define the licensing, operational, and safety standards that apply to BHDDH-licensed organizations, including requirements for staffing, training, clinical procedures, and compliance with federal and state law. These regulations ensure that providers meet uniform health and safety expectations and maintain service environments that support the well-being of individuals receiving care.

Providers must maintain records sufficient to fully disclose the extent of services furnished to Medicaid beneficiaries, as required by section 1902(a)(27) of the Social Security Act. Federal regulations also require that each patient admitted to an OTP be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment (42 C.F.R. § 8.12(f)(4)).

For purposes of documentation and patient confidentiality, providers must maintain a recordkeeping system adequate to monitor patient care and to meet all federal and state reporting requirements for treatment medications (42 C.F.R. § 8.12(g)). Required clinical documentation includes person-centered treatment plans (42 C.F.R.

§ 8.12(f)(4); 212-RICR-10-10-1.6.3), medical orders (212-RICR-10-10-1.6.8), and informed consent, which providers must obtain and document in accordance with federal and state regulations (42 C.F.R .§ 8.12(e)(1)) (212-RICR-10-10-1.3.1(A)(29)).

Rhode Island regulations further require providers to complete and document a medical evaluation at admission before any initial medication dose is administered. This evaluation must include evidence of current physiological dependence, a history of opioid addiction, or both, along with documentation of any approved exceptions to admission criteria (212-RICR-10-10-1.6.14(A)(6) – (7)). To evaluate provider compliance with Rhode Island's regulatory requirements, the audit team conducted a comprehensive validation of clinical, medical, and administrative documentation contained within patient treatment records.

This review also assessed provider adherence to the standards set forth in 212-RICR-10-10-1, including the required components of the BPS assessments, person-centered treatment plans, progress notes, counseling services, toxicology screening, medical examinations, medical service and care coordination, and discharge planning.

AUDIT PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

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

Table 1

Overdose Statistics - Rhode Island
Calendar Years 2021-2025

Year	Emergency Department Visits	Overdose Fatalities	Opioid-related Fatalities
2021	1,991	435	375
2022	1,853	436	358
2023	1,786	404	345
2024	1,407	329	228
2025	1,146	219	159
Total	**8,183**	**1,823**	**1,465**

Sources: RI Department of Health

MEDICAID PROGRAM

The Medicaid program provides health care and long-term care services to individuals with limited income and resources. The federal and state governments jointly fund and administer the Medicaid program. At the federal level, the Centers for Medicare & Medicaid Services administer the program. Although Rhode Island has considerable flexibility in designing and operating its Medicaid program, its system for managing Medicaid services and substance use disorder treatment involves several state agencies working together, each with distinct responsibilities. The Executive Office of Health and Human Services (EOHHS) serves as the primary state agency responsible for administering the Medicaid program. RI administers Medicaid health coverage for most eligible individuals through managed care, where contracted health plans administer health coverage on behalf of the State. Under this model, most OTP claims are adjudicated and reimbursed to providers by these health plans with the underlying claim data provided to the RI Medicaid agency for oversight and program reporting purposes.

DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES & HOSPITALS

The Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) serves as Rhode Island's primary licensing and regulatory authority for OTP providers. Providers are licensed behavioral healthcare organizations authorized to deliver MAT for opioid use disorder, including the dispensing of methadone, buprenorphine products, and naltrexone, along with required counseling, drug screening, medical services, and treatment planning oversight. Providers operate under a dual regulatory structure—federal requirements at 42 C.F.R. Part 8 and state requirements under the Rhode Island Code of Regulations, Title 212, Chapter 10—which collectively establish the clinical, safety, documentation, and operational standards that govern OTP practice.

Under 212-RICR-10-10-1.6.14, BHDDH defines the standards providers must meet to provide MAT, including patient admission criteria, initial and periodic medical evaluations, biopsychosocial assessments, person-centered treatment planning, counseling services, toxicology screening, and ongoing clinical review. These state regulations incorporate and enforce the federal OTP standards set by SAMHSA, including the requirement that qualified medical personnel perform physical evaluations, confirm physiological opioid dependence, document medical history, review laboratory studies, and oversee the safe administration of treatment medications. BHDDH requires that all OTP patients receive an annual medical examination and appropriate clinical follow-up throughout the course of treatment.

Providers licensed by BHDDH must also maintain comprehensive medication safety and diversion-control procedures, including strict adherence to federal dispensing protocols, dose documentation requirements, spill tracking, inventory controls, and DEA-compliant security measures. Take-home medication privileges must follow federal phase-based criteria, including documented clinical stability, assessment of patient safety risks, evidence of secure medication storage (such as use of a locked box), and regular reviews of patient progress before increasing take-home doses. Toxicology screening standards require providers to conduct random urine drug tests at clinical intervals sufficient to monitor safety and treatment engagement, with a minimum number of tests required annually.

Within BHDDH, the Licensing and Regulatory Compliance Unit is responsible for conducting biennial audits of providers. This oversight includes evaluating compliance with state behavioral health regulations and federal OTP requirements in areas such as biopsychosocial assessments, person-centered treatment plans, treatment plan reviews, progress note documentation, medical examinations, medication management, drug screen frequency and documentation, take-home medication criteria, and diversion-prevention measures. These biennial audits help ensure that providers maintain safe medication practices, deliver required clinical services, and uphold

documentation standards that support quality, patient safety, and regulatory alignment across the state.

OTP PROVIDER DOCUMENTATION REQUIREMENTS

Rhode Island OTP regulations require providers to maintain clinical documentation and safe operational environments to ensure the secure delivery of methadone and the effective management of opioid treatment services. These requirements establish minimum standards for both facility conditions and treatment-record documentation.

Providers must maintain:

1) Secure medication storage and strict adherence to diversion-control policies;
2) Documented disaster-response and emergency-care plans for service continuity;
3) Safe, hazard-free clinical spaces where methadone is dispensed and counseling is conducted;
4) Policies governing take-home medication safety, including locked-box requirements, written safety instructions, and child-safety considerations;
5) Clinically appropriate facilities that support private counseling, medical evaluations, and treatment-planning sessions;
6) Clean and orderly environments free of conditions that compromise medication security or client safety; and
7) Written procedures for courtesy dosing, voluntary withdrawal, and medication discontinuation.

In addition, providers are required to keep comprehensive and timely clinical documentation for their clients including:

1) Initial and 5-year biopsychosocial assessments;
2) Annual biopsychosocial reassessments and updated integrated summaries;
3) Person-centered treatment plans completed annually, with all required clinical components;
4) Six-month treatment plan reviews documenting patient progress and updated interventions;
5) Monthly counseling documentation aligned with treatment plan goals;
6) Toxicology screening results, including a minimum of eight random tests per year for individuals in maintenance treatment;
7) Annual medical examinations documenting clinical status and needed referrals;
8) Progress notes reflecting treatment events, informed-consent discussions, duration of services, status changes, and client decisions; and
9) Transition/discharge summaries, aftercare plans, and risk assessments completed within required timeframes.

BHDDH relies primarily on biennial audits of providers to identify noncompliance with federal and state regulations.

HOW THE AUDIT WAS PERFORMED

We conducted this performance audit of BHDDH's policies and procedures relating to the monitoring of OTP services for the period January 1, 2023 through December 31, 2024 in accordance with *Government Auditing Standards*.

To accomplish our objective, we:

- Reviewed applicable federal laws, State statutes, regulations, and policies and procedures for providers;
- Met with BHDDH officials to discuss how these policies and procedures operated during the audit period;
- Interviewed the Licensing and Regulatory Compliance Unit staff to understand and document BHDDH monitoring procedures;
- Developed a clinical record checklist as a guide for conducting OTP site visits;
- Conducted and documented site visits at the 5 providers selected for review;
- Reviewed clients' clinical records to determine whether providers met documentation requirements, including initial biopsychosocial assessments at intake, annual treatment plans, 6-month treatment plan reviews, counseling sessions, and drug tests;
- Discussed the results of our review with BHDDH officials.

When evaluating compliance, our audit considered documentation maintained by the providers.

DATA VALIDATION AND ANALYSIS

Using data obtained from T-MSIS, the OIG provided the RIOAG with a sample of MAT claim data to conduct validation procedures with the State's reported MCO claim encounter data. The goal of these procedures was to validate the accuracy of the T-MSIS data to ensure that it was consistent with the data provided by the MCOs to RI Medicaid. Validation procedures concluded that the T-MSIS data was consistent with the data reported to RI Medicaid.

The analysis conducted during the data validation process resulted in the identification of potential improper payments relating to certain provider MAT claims submitted. The details of potential improper payments are fully detailed in the Other Reportable Matter section of the report on page 26.

SAMPLE SELECTION AND VALIDATION

The RIOAG collaborated with the OIG to design a statistically valid sampling methodology. The OIG and RIOAG chose a sample with a 90% confidence level. The sampling criteria were designed to select a sample size large enough to provide a high level of confidence in the test results when projected to the entire population.

Based on the sampling methodology, the OIG selected a random, statistical sample of 100 medication assisted treatment (MAT) services out of a total of 274,412 services in the audit population. The sample of 100 was separated by the OIG into four strata based on the total dollar value of the encounter payments made to each of the 5 providers (represented 100% of OTP providers covering 14 provider locations). **Table 2** on page 8 details each of the four strata to which each provider was associated with for our data analysis purposes.

We conducted a review of the provider's client records during our site visits. To gain an understanding of BHDDH's operations, as they relate to OTP oversight and monitoring, we limited our review to BHDDH's internal controls as they related to our objective.

Table 2

OTP MAT Claiming Population Statistics

Stratum	OTP Provider	Sample Size	MAT Claim Count	Claim $
1	OTP Provider A	40	123,143	11,499,586
2	OTP Provider B	20	46,435	4,256,178
3	OTP Provider C	20	55,033	5,141,725
4	OTP Provider D & E	20	49,801	4,643,981
	Totals	100	274,412	25,541,470

AUDIT PROCEDURES

For the 100 MAT claims in our sample, we evaluated compliance with state regulations divided into the following 11 categories:

1) Biopsychosocial Assessment at Intake and 5-Year Reassessment;
2) Annual Biopsychosocial Assessment Review;
3) Annual Person-Centered Treatment Plan;
4) Person-Centered Treatment Plan Six (6) Month Review;
5) Progress Notes;
6) Transition/Discharge Summary and Aftercare Plan;
7) Medical Services and Care Coordination;
8) Annual Medical Examination;
9) Completed Toxicology Screens Eight (8) Times/Year;
10) Required Counseling Sessions; and
11) Medication Assisted Treatment (MAT) Requirements.

A complete listing of provider regulations evaluated during our audit with the compliance results determined by our audit procedures are included in Appendix A of this report.

OTP PROVIDER COMPLIANCE RESULTS

The State's oversight during the audit period did not ensure that OTP MAT services provided to Medicaid beneficiaries met federal and state requirements. Of the 100 OTP Medication Assisted Treatment (MAT) services we sampled, all 100 did not fully meet applicable federal and state requirements. **Table 3** summarizes compliance results by the compliance regulation areas for the 100 sampled OTP MAT services.

These deficiencies occurred because biennial audits performed by BHDDH's Licensing and Regulatory Compliance Unit were not effectively ensuring provider compliance with federal and state requirements. BHDDH did not compile and evaluate provider results in a manner sufficient to determine if its monitoring procedures were effectively ensuring compliance. As a result, BHDDH lacked assurance that OTP services provided to Medicaid beneficiaries were properly documented, monitored, and compliant with federal and state regulations.

Provider oversight and compliance monitoring are critical controls that ensure that services are delivered safely and effectively while also ensuring the allowability of such costs for federal reimbursement. On the basis of our sample results, we estimated that 274,412 OTP MAT services provided during the audit period, totaling $24,921,184, did not meet all federal and state requirements. This amount represents the lower amount in the range of potentially unallowable costs estimated by the HHS OIG based on the audit confidence level.

Appendix A summarizes provider compliance percentages for each regulation evaluated in conjunction with our audit procedures. Significant noncompliance was considered as compliance percentages less than 90%. These regulations, covering 88 OTP federal and state requirements for each of the 100 MAT sample claims, were evaluated for each of the 5 OTP providers visited. Our review identified at least

Table 3

Testing Results
Summary of Results (%) by Compliance Requirement

Compliance Requirement		Compliant	Non-compliant	Partially Compliant	Total
1) Initial or 5-year BPS Assessment		5%	17%	78%	100%
2) Annual BPS Assessment Review	(1)	48%	46%	6%	100%
3) Annual Treatment Plan		50%	9%	41%	100%
4) Annual Treatment Plan - 6-month Review	(1)	23%	24%	53%	100%
5) Progress Notes		95%	5%	0%	100%
6) Transition/Discharge Summary and Aftercare Plan	(1)	22%	0%	78%	100%
7) Medical Services and Care Coordination		95%	5%	0%	100%
8) Annual Medical Examinations		58%	13%	29%	100%
9) Toxicology Screenings		78%	7%	15%	100%
10) Required Counseling Sessions		30%	41%	29%	100%
11) Medication Assisted Treatment Requirements		1%	0%	99%	100%

(1) Compliance percentages are based on reviewed cases in which the requirements were applicable. Annual BPS Review requirements were not applicable to 3 sampled items. Annual Treatment Plan Review requirements were not applicable to 3 sampled items. Transition/Discharge Summary requirements were not applicable to 91 sampled items; program discharge, in particular, was not applicable to the large majority of sampled items during the audit period.

two instances of noncompliance in all claims sampled, resulting in a total of 1,729 deficiencies.

To categorize compliance criteria where multiple compliance criteria are applicable or when the requirement was mandated to be met multiple times during the 2-year audit period, we categorized criteria as "noncompliant" or "partially compliant". For result reporting, we utilized "noncompliant" for instances when no documentation of compliance was found during the audit period. The assignment of "partially compliant" meant that the provider documented compliance for less than the mandated frequency required or did not document all elements required by the program regulations.

Of the eleven specific compliance areas evaluated during our audit, providers obtained 95% compliance with two federal and state requirements related to progress notes and medical services and care coordination.

For the other nine compliance areas evaluated during our audit, we noted significant noncompliance where complete or partial noncompliance exceeded 10% in the client cases reviewed. Compliance results for initial or 5-year BPS assessment, annual treatment plan 6-month reviews, medication assisted treatment requirements, and required counseling sessions were notably deficient with complete or partial noncompliance noted in most sampled client cases.

Our evaluation of MAT services (client methadone treatment), which is detailed in finding 11 on page 24, summarizes the cumulative evaluation of federal and state requirements for providers to continue clients on methadone treatment. As shown in **Table 3** on page 9, providers were unable to document compliance with the required elements in 99% of the sampled clients tested.

Detailed compliance findings and results for all 11 compliance areas are included in the audit findings section of this report.

Table 4 below illustrates compliance results by provider. Improved controls over compliance will require BHDDH to maintain similar data in conjunction with its compliance monitoring going forward. Such information is critical to inform decisions on increased monitoring or training at the provider level.

Our results noted clear differences in compliance between individual providers. Very low compliance may signal operational or compliance issues at specific providers, which the regulatory agency should be aware of and may need to follow up on.

Table 4

Testing Results
Summary of Compliance Results by Provider

		Number of Federal and State Requirements:			
OTP Provider	Claims Sampled (#)	Compliant	Not Compliant	Noncompliance Avg. Per Sample Item	Compliance (%)
OTP Provider A	40	1,766	744	18.60	70%
OTP Provider B	20	953	334	16.70	74%
OTP Provider C	20	992	267	13.35	79%
OTP Provider D	15	784	160	10.67	83%
OTP Provider E	5	96	224	44.80	30%
Totals	100	4,591	1,729		

Note: Total Compliance Requirements Evaluated Per Sample Item totaled 88 individual requirements if all were applicable.

Finding #1: BPS assessments at intake or on the 5-year anniversary were not completed in accordance with federal and state regulations.

Background: A BPS assessment is a comprehensive clinical evaluation completed at intake to determine a client's treatment needs within an OTP. It gathers information across three main areas:

1) biological factors such as medical and health history, substance-use patterns (current and past), physical and medication needs, and risk behaviors impacting health;
2) psychological factors including mental status and mood, psychiatric history and care, coping skills and stress management, and other behavioral health concerns; and
3) social factors such as family involvement, social supports, living situation, employment, and environmental stressors.

A complete BPS also integrates these findings into a structured summary that identifies the client's strengths, treatment priorities, diagnostic impressions (inclusive of Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) diagnosis codes and American Society of Addiction Medicine (ASAM) patient placement criteria), and recommendations aligned with ASAM criteria. The assessment forms the foundation for the 30-day preliminary treatment plan and guides the development of the person-centered plan that follows.

Criteria: Under 42 CFR § 8.12(f)(4), providers must conduct a comprehensive initial psychosocial assessment and periodic clinical evaluations to determine the most appropriate combination of services and medication-assisted treatment.

Furthermore, 42 CFR § 8.12(f)(4)(i) mandates that all medical and psychosocial services, including initial and updated assessments, must be delivered exclusively by appropriately licensed, credentialed, and qualified healthcare personnel. Rhode Island behavioral healthcare regulations (212-RICR-10-10-1 § 1.6.2(A)–(H)) require a comprehensive assessment of physical, psychological, and social functioning at intake, alongside updates or complete reassessments on its 5-year anniversary to justify ongoing medical necessity. The regulations explicitly dictate that the clinical evaluation must identify the client's current status, determine the explicit need for specialized medical or psychological evaluations (§ 1.6.2(A)(1)(c)), and include an integrated summary (§ 1.6.2(B)) that analyzes and synthesizes the findings to form the foundation of the 30-day preliminary treatment plan (§ 1.6.2(E)). Additionally, § 1.6.2(I) mandates that these evaluations be conducted solely by staff members meeting minimum state qualification and credentialing standards.

Condition: For 95 of the 100 sampled MAT service claims, providers did not maintain documentation in accordance with these requirements as detailed in **Table 5** on page 12. Our testing did not find BPS assessments, as required by federal and state regulations, for 17 of the clients included in our sample. In addition, 78 of the sampled clients had an incomplete BPS documented, however, the assessment was missing one or more areas of required information.

Cause: BHDDH monitoring procedures did not ensure that providers consistently follow federal and state requirements governing the completion and documentation of BPS assessments. A contributing factor may include a lack of internal controls to ensure assessments and integrated summaries are completed, updated, and properly retained.

Effect: Missing or poorly documented BPS assessments undermine the provider's ability to determine appropriate treatment needs, evaluate medical necessity, and ensure safe, effective, and individualized care.

Recommendations: See summary of audit recommendations on page 25.

Table 5

Finding 1 Results - BPS Assessments

Total Population: 100
Total Sample Items with at least one BPS Deficiency: 95
Percentage of sample items deemed noncompliant: 95%

Description of BPS Noncompliance	Compliance Result	Sample Exceptions (#)	Deficiency %
Intake or 5-Year Assessments not performed or not documented.	Noncompliance	17	17%
Deficiencies deemed partial noncompliance (see note):			
Assessment of the client's physical and psychological status, including the type and level of treatment and any specialized needs not completed.	Partial Noncompliance	27	27%
Integrated summary synthesizing assessment findings not completed.	Partial Noncompliance	50	50%
Preliminary treatment plan and integrated summary not completed.	Partial Noncompliance	9	9%
Assessment conducted by unqualified personnel.	Partial Noncompliance	20	20%

Note: Several sample items had multiple instances of partial noncompliance cited.

Finding #2: Annual BPS assessment reviews were not completed in accordance with federal and state regulations.

Background: An annual biopsychosocial assessment review is a mandatory face-to-face evaluation of a patient's physical, psychological, and social functioning conducted every twelve months. This interview updates the patient's strengths, active DSM/ICD codes, and ASAM criteria to recommend substance use care levels. A clinical supervisor must sign and validate the update within fourteen days of completion, unless it is drafted by licensed clinical staff. This yearly review directly informs a new annual person-centered treatment plan. This is important to ensure that life circumstances and changes in the client's physical and mental health can be addressed in an updated treatment plan.

Criteria: Under 42 CFR § 8.12(f)(4), providers must conduct periodic physical and behavioral health assessments, performed only by licensed and credentialed personnel as specified by § 8.12(d). Rhode Island regulations (212-RICR-10-10-1 § 1.6.2(F)) require that each client's biopsychosocial assessment be reviewed and updated at least every 12 months, including the integrated summary. Annual updates must be completed face-to-face (§ 1.6.2(G)) and validated by a clinical supervisor within 14 days, unless completed by independently licensed clinical staff.

Condition: Our testing did not find an annual BPS assessment review as required by federal and state regulations for 45 clients included in our sample. In addition, another 6 sampled clients received only 1 annual review in the 2-year audit period instead of the required two annual reviews.

Cause: BHDDH monitoring procedures did not ensure that providers conducted and documented timely annual BPS assessment reviews as required by federal and state regulations.

Effect: Missing or incomplete annual BPS assessment reviews hinder the ability to demonstrate ongoing medical necessity, continuity of care, and compliance with federal and state requirements. This increases clinical risk, weakens care planning, and could expose the program to future compliance findings and potential recoupment.

Recommendations: See summary of audit recommendations on page 25.

Finding #3: Annual person-centered treatment plans were either not consistently completed or adequately documented.

Background: An annual person-centered treatment plan is a mandatory master care plan developed every twelve months. Driven by the annual biopsychosocial assessment, it outlines the patient's strengths, goals, measurable objectives, and specific clinical interventions for the upcoming year. The plan details the type, frequency, and duration of services while prioritizing individual choice. It requires documented input from both the patient and the multidisciplinary team, along with clinical signatures for compliance.

Criteria: Under 42 CFR § 8.12, providers must maintain individualized, patient-centered care plans based on psychosocial and behavioral health assessments, created and updated by licensed and credentialed personnel and reflecting treatment needs, treatment response, and changes in medical, psychiatric, social, and psychological circumstances. Under 212-RICR-10-10-1 § 1.6.3(C), a new person-centered treatment plan must be completed at least every 12 months, including individualized goals, DSM/ICD diagnoses, measurable interventions, responsible staff, service frequency, timeframes, and incorporation of assessment findings and the integrated summary.

Condition: Our testing did not find a completed annual person-centered treatment plan during our audit period as required by federal and state regulations for 9 clients included in our sample. In addition, treatment plans for 41 clients had one or more instances of noncompliance with plan requirements. The specific compliance deficiencies are summarized in **Table 6** on page 15.

Cause: BHDDH monitoring procedures did not ensure completed annual person-centered treatment plans for clients in accordance with federal and state regulations. Oversight activities did not detect and correct deficiencies in compliance with regulations relating to the completion and timeliness of treatment plans for OTP clients.

Effect: BHDDH monitoring did not ensure that providers maintained effective controls, resulting in frequent delays or omissions in person-centered treatment plans and annual assessment reviews. These deficiencies led to non-compliance with federal and state mandated requirements, reduced the ability to demonstrate both initial and ongoing medical necessity, and weakened continuity and quality of care. As a result, clinical risk increased, care planning was compromised, and both providers and the state oversight agency were exposed to heightened regulatory, financial, and compliance risk, including the potential for recoupment.

Recommendations: See summary of audit recommendations on page 25.

Table 6

Finding 3 Results - Annual Person-Centered Treatment Plans

Total Population: 100
Total Sample Items with at least one treatment plan deficiency: 50
Percentage of sample items deemed noncompliant: 9%

Description of Annual Treatment Plan Noncompliance	Compliance Result	Sample Exceptions (#)	Deficiency %
Annual person-centered treatment plans were not performed or not documented.	Noncompliance	9	9%
Deficiencies deemed partial noncompliance (see note):			
Supervisor validation completed outside the required two-week period.	Partial Noncompliance	19	19%
Client, provider, and/or supervisor signatures absent.	Partial Noncompliance	18	18%
Individualized narrative section missing.	Partial Noncompliance	16	16%
No written statement of issues to be addressed.	Partial Noncompliance	16	16%
Goals not stated or not measurable/observable.	Partial Noncompliance	16	16%
Required interventions not documented.	Partial Noncompliance	16	16%
Timing/frequency of interventions not documented.	Partial Noncompliance	16	16%
Plan did not identify responsible personnel for each intervention.	Partial Noncompliance	16	16%
Timeframes for achieving or reviewing goals not documented.	Partial Noncompliance	16	16%
Required identification of qualified clinician oversight missing.	Partial Noncompliance	16	16%
Written and coded diagnostic information absent.	Partial Noncompliance	14	14%

Note: Several sample items had multiple instances of partial noncompliance cited.

Finding #4: Missing and incomplete person-centered treatment plan six-month reviews.

Background: Six-month reviews provide a mid-year check on a client's progress and ensure the annual treatment plan still reflects current needs. These reviews document progress toward goals, note any needed changes to interventions, and update the plan based on changes in medical, psychiatric, social, or behavioral circumstances.

Criteria: Under 42 CFR § 8.12(f), providers must conduct periodic clinical evaluations and update treatment plans to reflect the patient's current status, treatment response, and service needs. All updates must be completed by appropriately licensed and credentialed clinical staff. Rhode Island regulations (212-RICR-10-10-1 § 1.6.4) require providers to complete and document a treatment plan review every six months, or sooner if clinically indicated. Each review must reassess goals, update interventions based on the patient's condition, and be properly signed and validated in accordance with § 1.6.3.

Condition: Our testing did not find required 6-month reviews of a client's annual person-centered treatment plan for 24% of the clients where it was required by federal and state regulations during our audit period. In addition, 1 of the 2 required reviews were not completed for 26% of the clients included in our sample. Treatment reviews were conducted for 27% of the clients sampled; however, certain required elements of the review were not completed. Only 23% of the clients were found to have annual treatment plan reviews that fully complied with OTP requirements.

Cause: BHDDH monitoring procedures did not ensure that required 6-month reviews of treatment plans were conducted for OTP clients in accordance with federal and state regulations. Oversight activities were not effective in detecting and addressing noncompliance with federal and state regulations for treatment plan reviews.

Effect: Not performing person-centered treatment plan six-month reviews can increase the risk of treatment plans becoming outdated or no longer reflecting the client's needs, leading to ineffective treatment, which could potentially lead to client harm.

Recommendations: See summary of audit recommendations on page 25.

Finding #5 Progress notes were not always adequately documented regarding opioid treatment services.

Background: Progress notes are the required written documentation of services provided within an OTP, including counseling encounters. They are not themselves a clinical service but serve as the official record of what occurred during treatment. Progress notes track a client's status, document progress toward treatment-plan goals, record relevant events during care, and capture decisions made by the client. They must also include the duration of the service delivered and reflect any canceled or missed appointments. When completed consistently and accurately, progress notes form the ongoing narrative of treatment, support informed decision-making, and ensure continuity of care. Importantly, progress notes describe the service—they are not the therapeutic intervention itself.

Criteria: Under 42 CFR § 8.12, providers must maintain a recordkeeping system adequate to document and monitor patient care, including assessments, treatment responses, and clinically relevant events. Providers must also document informed consent discussions and treatment decisions as part of patient-centered care planning. Rhode Island regulations (212-RICR-10-10-1 § 1.6.5(A)–(D)) require progress notes to document the patient's current status, relevant treatment events, duration of services, informed decision-making discussions, and patient decisions, following a standard charting format.

Condition: Clinical files for five (5) sampled clients did not contain progress notes for either year of the audit period. In general, most client cases reviewed did include progress notes and the documentation, when completed, was found to materially comply with federal and state requirements.

Cause: BHDDH monitoring procedures did not ensure that providers maintained or retained required clinical documentation for all clients in accordance with federal and state requirements.

Effect: Without progress notes in the clinical files, providers are unable to demonstrate patient progress, support clinical decision making, or verify that required therapeutic services were provided. The omission of progress notes from a client's records can also jeopardize care coordination when several practitioners are providing treatment or if providers experience staff turnover.

Recommendations: See summary of audit recommendations on page 25.

Finding #6 Inadequate documentation of client transition, aftercare, and discharge processes.

Background: Client transition and discharge documentation is a critical component of care within OTPs. A complete discharge process ensures continuity of treatment, supports safe transitions, and provides essential information to future providers. Before discharge, staff should work collaboratively with the client to develop an aftercare plan that identifies follow-up services, recovery support, and steps to maintain progress. A discharge summary must then be completed to document the client's course of treatment, progress, recommendations, and any identified risks. When properly documented, these elements help safeguard clients during a vulnerable period, reduce relapses and overdose risk, and promote coordinated care across service providers.

Criteria: Federal regulations under 42 CFR §8.12 require providers to maintain complete and accurate clinical records that support patient care, treatment progress, and continuity of services. Rhode Island regulations at 212-RICR-10-10-1.6.6 require providers to develop an aftercare plan collaboratively with the client before discharge, ensure the plan identifies post-discharge services, activities to sustain progress, and a crisis plan when needed, and complete a discharge summary within fifteen working days. The discharge summary must document the treatment course, outcomes, recommendations, and include a risk assessment describing the course of treatment prior to discharge.

Condition: Our testing found that, of the 9 clients who discharged or transitioned from the program during the audit period, providers documented discharge in all cases, however, did not complete the required aftercare plan in 3 (33%) of the discharge instances. In addition, certain required elements of the discharge documentation and aftercare plans were noted to be incomplete in 7 cases reviewed. Complete details of the documentation deficiencies are summarized in **Table 7** on page 19.

Cause: BHDDH monitoring procedures did not ensure that providers consistently adhered to discharge documentation requirements, including timely completion and inclusion of mandatory aftercare and risk-assessment elements.

Effect: An incomplete transition/discharge plan can break medication continuity and deprive future providers of essential diagnostic data, affecting the person-centered model, leaving the client vulnerable to relapse, overdose, or immediate re-hospitalization.

Recommendations: See summary of audit recommendations on page 25.

Table 7

Finding 6 Results - Transition / Discharge Documentation and Aftercare Plans

Total Population: 9 (Number of sample cases where program discharge / transition documentation and aftercare plans were applicable)
Total Sample Items with at least one deficiency in required documentation was noted: 7
Percentage of sample items deemed noncompliant: 78%

Description of Noncompliance	Compliance Result	Sample Exceptions (#)	Deficiency %
Deficiencies deemed partial noncompliance (see note):			
Discharge summary did not include risk assessment.	Partial Noncompliance	6	67%
Discharge summary was not completed within 15 working days.	Partial Noncompliance	2	22%
Discharge summary did not include DSM/ICD diagnoses	Partial Noncompliance	2	22%
Discharge summary did not include significant findings.	Partial Noncompliance	1	11%
Discharge summary did not include treatment course.	Partial Noncompliance	1	11%
Discharge summary did not include treatment outcomes.	Partial Noncompliance	1	11%
Aftercare plan did not include post-discharge services.	Partial Noncompliance	4	44%
Aftercare plan did not include activities to sustain progress.	Partial Noncompliance	4	44%
Aftercare plan did not include a crisis plan.	Partial Noncompliance	4	44%
Aftercare plan was not developed with the individual before discharge.	Partial Noncompliance	3	33%

Note: Several sample items had multiple instances of partial noncompliance cited.

Finding #7 Required sessions for counseling services were not provided for methadone maintenance.

Background: Counseling sessions are clinical services delivered directly to individuals receiving opioid treatment, such as individual, group, or family counseling. These sessions provide therapeutic intervention, address goals identified in the person-centered treatment plan, and support recovery through evidence-based practices. Counseling is a core component of treatment programs, including OTPs, where regular counseling is required—such as monthly individual sessions during the first year of methadone maintenance.

Criteria: Federal regulations require that adequate counseling and rehabilitative services be provided as part of maintenance treatment. Under 42 CFR § 8.12(f)(5)(i), each patient must receive counseling services that are "clinically appropriate and meet the patient's needs," including regularly scheduled sessions provided by qualified counseling staff. Rhode Island regulations establish specific minimum counseling requirements. State regulations (212-RICR-10-10-1 § 1.6.14(A)(10)(d)-(e)) require that (1) the type and number of counseling sessions received by each individual in the program shall be based on a clinical assessment of the person's service needs and goals as formulated in the person's plan and (2) Rehabilitative counseling services (individual, group, and family) shall be provided by OTP staff and shall be consistent with the individual's person- centered plan. A minimum of one (1) session per month is required.

Condition: As shown in **Table 8** below, for 70 of the 100 claims sampled, clients did not receive the required number of counseling sessions (1 per month - 24 per 2-year period) during the two-year audit period. We also noted that in 29 cases reviewed, certain clients had no documented counseling services within one of the calendar years reviewed.

Cause: BHDDH monitoring procedures did not ensure that providers were complying with counseling session mandates for MAT clients.

Effect: Providing fewer counseling services may limit clinical oversight, impede treatment progress, and reduce the likelihood of successful recovery outcomes.

Recommendations: See summary of audit recommendations on page 25.

Table 8
OTP Counseling Frequency
Sample Size - 100 Claims
Regulation Requirement - Minimum Monthly
12 Per Year (24 for 2-Year Period)

Counseling Visits Documented	Number of Sampled Claims	Percentage of Sample
All Required	30	30%
19-23	22	22%
15-18	19	19%
10-14	18	18%
5-9	7	7%
4 or Less	4	4%
Total	100	

Note: 4 sample clients were not enrolled in an OTP for the entire 2-year period thus required a prorated number of counseling visits.

Finding #8 Medical services and care coordination were not always adequately documented regarding opioid treatment services.

Background: At admission, patients must be provided with essential information about how treatment works with provider documentation that the patient received and acknowledged it. This includes medical service and care-coordination instructions such as safety expectations for take-home medication, child-safety and storage requirements, the use of OTP-approved lock boxes, the program's disaster-response procedures, and how to access courtesy dosing at another clinic if needed. Patients must also be informed of how withdrawal from opioid-replacement medication is managed, including the need for physician approval and individualized taper schedules. Providing this information at admission ensures patients understand how to safely manage their medication, what to do in an emergency, and how key components of their treatment will be coordinated.

Criteria: Federal regulation 42 CFR § 8.12(i)(1)-(4) requires providers to base take-home medication decisions on clinical safety factors and to provide patients with education on secure storage, safe handling, and transportation of medication to prevent diversion. Providers must document the rationale for take-home approvals and maintain procedures that minimize misuse of medication. Rhode Island regulation 212-RICR-10-10-1 § 1.6.14.11(a)-(j) requires providers to maintain diversion-control policies, and confirmation of patient receipt of safety and child-protection instructions and locked storage for take-home doses.

Condition: For 5 out of the 100 sampled MAT service claims, providers did not maintain medical services and care coordination documentation required by federal and state regulations. This noncompliance was specific to one provider where the required documentation could not be located. Compliance was 100% at the other 4 providers evaluated.

Cause: BHDDH's monitoring did not ensure that all providers consistently implemented or enforced required medical-service and care-coordination procedures under 212-RICR-10-10-1 § 1.6.14.11(a)-(j). Oversight tools did not verify whether providers documented essential patient-safety information, diversion-control protocols, take-home requirements, disaster-response procedures, courtesy-dosing processes, and opioid-withdrawal management steps. Additionally, one provider specifically lacked internal controls to ensure these medical-service elements were communicated at admission, properly documented, and incorporated into the patient's treatment record.

Effect: Incomplete documentation of required medical-service and care-coordination elements limits a provider's ability to demonstrate safe medication management, regulatory compliance, and proper patient education. Missing information—such as diversion-control plans, take-home medication safety instructions, child-safety requirements, lock-box use, disaster-response procedures, courtesy-dosing arrangements, and withdrawal-schedule approvals—creates significant clinical and safety risks. Without this documentation, patients may not receive critical guidance needed to store medication safely, manage emergencies, prevent diversion, or navigate withdrawal. These gaps can lead to unsafe medication practices, increased risk of overdose, improper discontinuation of treatment, and weakened continuity of care.

Recommendations: See summary of audit recommendations on page 25.

Finding #9 Annual medical examinations were not completed or adequately documented.

Background: Annual medical examinations are a core clinical requirement within OTPs and serve as a comprehensive health check to ensure that ongoing medication-assisted treatment remains safe, medically appropriate, and responsive to changes in the client's physical condition. These examinations evaluate the client's overall health status, review current medications, assess any new or worsening medical issues, and identify risks that may affect treatment. Annual exams also help providers adjust dosing, identify contraindications, coordinate care with other medical providers, and ensure that the client's medical needs are integrated into the broader person-centered treatment plan. Consistent and well-documented annual medical examinations support patient safety, continuity of care, and compliance with regulatory expectations for ongoing medical oversight.

Criteria: Under 42 CFR § 8.12(f)(4)(i), providers must ensure that each patient receives a comprehensive physical and behavioral health assessment within 14 days of admission and periodically thereafter. Federal guidelines for OTPs clarify that this periodic assessment must occur at least once annually. Rhode Island's OTP regulations require that all patients receive a medical examination at least annually, and that the medical staff must record the results of this annual medical examination in the patient's record (212-RICR-10-10-1 § 1.6.14(A)(11)(g)-(i)).

Condition: Our testing found that 13 client cases reviewed did not have documentation of a required annual medical examination in either year of the 2-year audit period. Further, another 29 client cases reviewed had only 1 of the 2 required medical examinations documented in the client record. Collectively, providers failed to comply with the requirement for annual medical examinations in 42% of the client cases reviewed.

Cause: BHDDH monitoring procedures did not ensure providers consistently implemented or enforced policies and procedures to ensure that annual medical examinations were performed and properly documented.

Effect: Not performing annual medical examinations can increase the risk of undetected and unmanaged medical conditions (physical and behavioral), which could potentially lead to patient harm.

Recommendations: See summary of audit recommendations on page 25.

Finding #10 Toxicology tests were not properly documented.

Background: Toxicology testing is a core safety and clinical-monitoring requirement within OTPs. These tests help providers identify ongoing substance use, evaluate treatment effectiveness, and adjust care plans to maintain patient safety. Toxicology screens—typically urine tests—must be conducted randomly and frequently enough to detect illicit drug use, medication interactions, or emerging clinical risks. Results must be documented in the client's treatment record so providers can track patterns over time, support informed clinical decisions, and intervene when necessary.

Consistent toxicology monitoring is especially critical for patients receiving methadone, as combining methadone with substances such as fentanyl or other opioids significantly increases the risk of respiratory depression, overdose, or death. Proper documentation of test results ensures continuity of care, supports responsible medical oversight, and helps safeguard patients during treatment.

Criteria: Federal regulations require providers to conduct adequate testing for opioids and other illicit drugs, including a minimum of eight random drug tests per year for each patient in maintenance treatment (42 CFR § 8.12(f)(6)). State regulations require providers to maintain written toxicology screening policies and ensure that all urine toxicology screen results are documented in the individual's treatment record. Rhode Island further requires that random urine toxicology screens be conducted as clinically indicated, but no less than eight times per year while an individual remains in treatment (212-RICR-10-10-1 § 1.6.14(A)(14)).

Condition: For 22 of the client cases reviewed, the providers did not meet the minimum annual toxicology test requirement (minimum 8 random toxicology tests per year). Providers could not document any toxicology tests performed for 7 of the cases reviewed.

Cause: BHDDH monitoring procedures did not ensure providers consistently follow or enforce required toxicology screening policies or documentation practices, resulting in incomplete or missing toxicology test records.

Effect: Without complete toxicology documentation, providers may be unable to effectively monitor patient progress, identify continued substance use, or adjust treatment plans appropriately to ensure patient safety and clinical effectiveness. Combining potent substances like methadone and fentanyl increases the risk of severe respiratory depression, which can lead to a fatal overdose or permanent brain damage.

Recommendations: See summary of audit recommendations on page 25.

Finding #11 Non-compliance with MAT service requirements.

Background: MAT requirements are mandated as critical components to provide the behavioral-health foundation that supports pharmacologic treatment for individuals with opioid use disorder. In accordance with State regulations, the continuation of MAT services (client methadone treatment) requires the performance and documentation of the criteria detailed below, all of which were individually evaluated during our audit.

Criteria: Rhode Island MAT regulations require OTP compliance with all elements under §1.6.14(A)(10)–(14), including:

1) complete an initial person-centered treatment plan (1.6.14(A)(10)(a));
2) update the treatment plan every six months (1.6.14(A)(10)(b));
3) maintain a diversion control plan (1.6.14(A)(11)(a));
4) provide counseling—at least one session per month in year one (1.6.14(A)(10)(e)) and adjusted intervals thereafter (1.6.14(A)(10)(e)(5)-(6));
5) random drug testing to be conducted as clinically indicated, but no less than eight (8) times/year while an individual remains in treatment (1.6.14(A)(14)); and
6) all patients receive a medical examination at least annually (1.6.14(A)(11)(g)).

Condition: Our testing found that 99 out of 100 MAT claims reviewed did not have documentation supporting at least 1 of the requirements mandated for the provision of methadone treatments to clients. As shown in **Table 9**, more than 68% of the client cases had noted deficiencies in 3 or more of the requirements for client methadone treatment. Such noncompliance does not meet the standard of care required by federal and state requirements of the MAT program and further could be deemed unallowable for federal reimbursement if scrutinized by a federal audit. The critical importance of the MAT requirements necessitates improved monitoring by BHDDH to identify and ensure corrective action of noncompliance found.

Cause: BHDDH monitoring procedures did not ensure that MAT planning and counseling requirements were performed by providers in accordance with federal and state regulations. Oversight activities were not effective in detecting and addressing noncompliance with federal and state regulations for planning and counseling requirements.

Effect: The high rate of incomplete and non-compliant treatment records reduces the effectiveness of MAT and creates a direct risk to patient safety. Without complete, updated, and aligned treatment plans, providers cannot reliably monitor progress, identify relapse risks, or adjust care. These gaps weaken MAT services and increase the likelihood of treatment disengagement or adverse outcomes. Noncompliance with collective MAT service requirements can impact the allowability of claiming to the Medicaid program.

Recommendations: See summary of audit recommendations on page 25.

Table 9
MAT Requirement Deficiencies
Sample Size - 100 Claims
Total Requirements - 7

Number of Deficiencies	Number of Sampled Claims	Percentage of Sample
None	1	1%
1-2	31	31%
3-4	51	51%
5-6	15	15%
7	2	2%
Total	100	

RECOMMENDATIONS

In response to our findings relating to compliance with requirements for:

- Initial and 5-year BPS assessments;
- Annual BPS assessment reviews;
- Annual person-centered treatment plans;
- Treatment plan 6-month reviews;
- Treatment progress notes;
- Client Transition/Discharge Summary and Aftercare Plan;
- Medical services and care coordination;
- Annual client medical exams;
- Toxicology screenings;
- Counseling sessions; and
- Medication Assisted Treatment requirements.

We recommend that BHDDH:

1) Strengthen oversight to ensure providers consistently comply with all federal and state clinical documentation and service delivery requirements.
2) Require providers to implement comprehensive internal controls that track completion, timeliness, and accuracy of all required clinical documentation.
3) Develop standardized templates, checklists, and documentation guidelines for all major clinical processes and records.
4) Provide targeted training and technical assistance to provider staff and supervisors on federal and state requirements for OTP services, including clinical documentation standards.
5) Establish documentation quality expectations and require providers to conduct periodic internal audits across all areas of OTP service delivery.
6) Implement performance reporting to track OTP compliance across all required clinical and documentation categories.
7) Conduct follow-up monitoring of providers with recurring deficiencies to ensure corrective actions are implemented effectively and sustained over time.

OTHER REPORTABLE MATTER – RI MEDICAID PROGRAM DISBURSED $875,696 IN POTENTIAL IMPROPER PAYMENTS FOR OPIOID-USE-DISORDER TREATMENT SERVICES FURNISHED BY OPIOID TREATMENT PROGRAMS

Government Auditing Standards require auditors to communicate control deficiencies and/or noncompliance that are not significant within the context of the specific audit objectives if the auditor, in their judgment, believes that the deficiencies warrant the attention of those charged with governance.

Background: The Medicaid State Plan establishes a weekly bundled payment methodology for OTP services, under which providers must submit a single weekly bundled claim that includes all covered services. Daily billing of H0020 encounters is not authorized. Collectively, these criteria require that OTP services be billed as a weekly bundle rather than as multiple daily encounters.

Criteria: Federal regulations, specifically 42 U.S.C. § 1396a(a)(30)(A), require states to administer their programs in a manner that ensures payments are economical, efficient, and free from unnecessary utilization. Provider regulations at 210-RICR-20-00-1 require Medicaid providers to comply with all billing rules and methodologies set by EOHHS, while R.I. Gen. Laws §40-8.2-22 requires providers to return overpayments.

Condition: In a joint audit with the federal HHS OIG, we identified and validated 6,347 potential OTP claims where the Medicaid program reimbursed providers for daily methadone encounters instead of the required weekly bundled methadone claim (H0020). We independently verified the claim data provided by the OIG was consistent with encounter data submitted by the respective managed care providers (from data provided by EOHHS), resulting in $875,696 (federal share - $656,919) in potential overpayments. In many instances, providers submitted five to seven daily methadone claims for the same beneficiary within a single week, causing the State to pay several times more than the established weekly bundled rate.

While not specifically related to our objective of evaluating BHDDH's oversight and monitoring of provider compliance with federal and state regulations, this matter required reporting to State management under *Government Auditing Standards.* In addition, we communicated this issue in the State's recently submitted *Single Audit Report* as required by federal Uniform Guidance requirements in relation to the audit of the Medicaid Program.

Cause: The primary causes of these improper payments were provider noncompliance with the required weekly bundled billing methodology and the absence of adequate system controls within Medicaid systems (lack of edits on MCO and State encounter data systems) to detect and prevent provider billing noncompliance.

Effect: Noncompliance with Medicaid billing policies resulting in improper payments by the Medicaid program.

Recommendations:

1. Conduct a full review of all OTP H0020 claims—both adjudicated and pending—to determine compliance with the weekly bundled methodology and calculate the total amount of overpayments. Recover amounts from providers determined to be improper payments and return the federal share of those payments to the federal government.
2. Implement system edits within Medicaid systems to prevent payment of daily H0020 claims when a weekly bundled claim is required and ensure that no more than one weekly bundled claim is paid per beneficiary per week.
3. EOHHS should strengthen provider education and issue updated billing guidance to reinforce weekly bundling requirements for OTP services.
4. Implement enhanced post-payment monitoring and periodic audits to ensure ongoing compliance and prevent recurrence of improper billing.

BHDDH Corrective Action Plan – Provider Oversight and Monitoring

BHDDH recognizes the importance of the joint Audit by the Rhode Island Office of the Auditor General (OAG) and the U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG). The Department has focused its response to address each of the Audit's recommendations.

Recommendation 1: Strengthen oversight to ensure providers consistently comply with all federal and state clinical documentation and service delivery requirements.

Management Response: BHDDH will maintain its established biennial audit protocol, while expanding follow-up and monitoring processes.

Specifically, BHDDH will:

- Conduct routine unannounced visits through its Quality Management Unit, which includes both Adult Protective Services and the Office of Licensure and Standards. This will provide a three-tier system of oversight that includes routine biennial licensing audits, post audit six-month reviews, and unannounced visits, including but not limited to those triggered by serious reportable incidents or health and safety issues.
- Require Opioid Treatment Program providers to share with BHDDH a randomized clinical documentation sample. The sample will include progress notes, biopsychosocial assessments, initial and annual treatment plans, annual medical examinations, and care coordination activities, encompassing areas covered by the 11 Findings identified in the Audit.
- Continue to review, through its Licensing office and its Division of Behavioral Health, oversight findings prior to biennial audits, six-month post-audit follow-up visits, and quality unannounced visits.

Recommendation 2: Require providers to implement comprehensive internal controls that track completion, timeliness, and accuracy of all required clinical documentation.

Management Response: BHDDH will:

- Require each of the five Opioid Treatment Program providers to maintain internal documentation tracking controls, using a standardized mechanism that requires providers to systematically track, at a minimum, the completion, accuracy, and timeliness for core clinical compliance areas, including but not limited to biopsychosocial assessment due dates, treatment plan reviews, counseling sessions, and toxicology screens. Providers will be required to conduct these internal self-audits at a minimum of every six months.

Recommendation 3: Develop standardized templates, checklists, and documentation guidelines for all major clinical processes and records.

Management Response: BHDDH will:

- Develop and distribute standardized documentation templates for biopsychosocial assessments, person-centered treatment plans, post-audit six-month reviews, discharge and aftercare plans, and Medication Assisted Treatment, and share these with providers with the expectation that these templates be used when providers conduct internal audits.
- Develop a standardized Medication Assisted Treatment documentation checklist for providers that addresses the requirements under The Rhode Island Code of Regulations section 1.6.14(A)(10)-(14), and ensure that any standardized templates, locked Excel tracking tools, and reporting checklists directly mirror and integrate with the internal documentation tracking controls under Audit Requirement 2.

Recommendation 4: Provide targeted training and technical assistance to provider staff and supervisors on federal and state requirements for OTP services, including clinical documentation standards.

Management Response: BHDDH will:

- Provide mandatory training to clinical staff and supervisors at all five Opioid Treatment Program providers on applicable federal (42 CFR Part 8) and state (212-RICR-10-10-1) documentation requirements. The training will address biopsychosocial assessments, treatment planning, counseling frequency, and Medication Assisted Treatment documentation standards, with an emphasis on areas identified in the Audit.
- Track provider participation and completion of required training and offer recurring technical-assistance office hours to address provider questions and implementation issues.

Recommendation 5: Establish documentation quality expectations and require providers to conduct periodic internal audits across all areas of OTP service delivery.

Management Response: BHDDH will:

- Establish a minimum compliance threshold (e.g., 90%), using a severity scale developed by BHDDH. As noted in the response to Recommendation 2, each OTP will be required to conduct and submit to BHDDH internal audit results every six months covering applicable Opioid Treatment Program service delivery and documentation requirements.
- Establish corrective-action expectations for providers whose self-audit results fall below the established threshold.
- Incorporate provider self-audit results into the provider's overall compliance record and risk profile.
- Communicate through training and other opportunities a clear, transparent understanding of BHDDH regulatory standards and the Plan of Correction process.
- Review Plans of Correction and reject them if deemed insufficient and require providers to submit an amended Plan of Correction within 10 days. If a provider remains deficient after an amended Plan of Correction, the provider may qualify for neutral monitoring and oversight.

Recommendation 6: Implement performance reporting to track OTP compliance across all required clinical and documentation categories.

Management Response: BHDDH will:

- Develop a centralized compliance dashboard and reporting tool that tracks compliance percentages by provider across all requirement categories, modeled directly on Table 3 and Table 4 in the Audit. The Department will ensure that the dashboard identifies compliant, non-compliant, and partially compliant classifications, where applicable, providing a true-to-life reflection of documentation quality. The dashboard will be updated on a recurring basis, at least quarterly, using data from BHDDH oversight reviews and provider self-audits.
- Use identified compliance trends, risk profiles, and performance gaps to strategically prioritize and deploy department resources, including targeted training, technical assistance, office hours, and follow-up monitoring.

Recommendation 7: Conduct follow-up monitoring of providers with recurring deficiencies to ensure corrective actions are implemented effectively and sustained over time.

Management Response: BHDDH will:

- Communicate with and educate providers about regulatory oversight, enforcement, and monitoring mechanisms established by the Department through regulations, and address concerns with providers exhibiting recurring or significant deficiencies. This will give providers an opportunity to fully understand the expectations BHDDH has for them as the regulatory authority.
- Require providers that fall below the established compliance threshold — or those flagged with significant or recurring deficiencies — to submit a Plan of Correction detailing specific remedial steps, designated responsible parties, and strict timeframes.
- Implement risk-based follow-up site visits at providers that fall below the established compliance threshold, including providers with significant or recurring deficiencies.
- Conduct focused re-audits and file reviews, as appropriate, to verify that corrective actions outlined in approved Plans of Correction have been fully implemented, integrated into daily workflows, and sustained over time.
- Address continued provider noncompliance with regulatory and licensing actions — including conditional licensing, consent agreements, or formal administrative penalties — consistent with applicable requirements and BHDDH statutory authority.

EOHHS Corrective Action Plan - Other Reportable Matter

Recommendation 1: Conduct a full review of all OTP H0020 claims - both adjudicated and pending - to determine compliance with the weekly bundled methodology and calculate the total amount of overpayments. Recover amounts from OTP providers determined to be improper payments and return the federal share of those payments to the federal government.

Management Response: EOHHS will establish a systemwide audit cycle of this service to ensure the providers are appropriately billing. A thorough investigation and data analysis of the OTP H0020 code was completed. Corrective action plans that include recoupments are in the process of being reviewed.

Recommendation 2: Implement system edits within the MMIS to prevent payment of daily H0020 claims when a weekly bundled claim is required and ensure that no more than one weekly OTP bundled claim is paid per beneficiary per week.

Management Response: EOHHS is actively reassessing the current MMIS system configuration and operational processes. In collaboration with Gainwell Technologies, a dedicated project is underway to strengthen controls and implement guardrails designed to prevent this from occurring in the future. Several potential solutions are currently being evaluated and developed, with the goal of enhancing the system, oversight, and compliance. We are in the process of confirming with Gainwell that a system correction was implemented in 2024. We will ask for system testing to ensure that this error will not occur again.

Recommendation 3: EOHHS should strengthen provider education and issue updated billing guidance to reinforce weekly bundling requirements for OTP services.

Management Response: EOHHS is actively reassessing the current provider Billing Manual to ensure the billing requirements for all bundled services is clear and that it is also clear that the unbundling of the rates is not allowed and may cause recoups for the services billed. All OTP vendors will receive corrective action plans with instructions on proper billing for the OTP H0020 code. EOHHS is in the process of updating the OTP Billing manual and this will include clarification as to which services are included in the bundled OTP rate.

Recommendation 4: Implement enhanced post-payment monitoring and periodic audits to ensure ongoing compliance and prevent recurrence of improper billing.

Management Response: EOHHS will establish a systemwide audit cycle of this service to ensure the providers are appropriately billing. EOHHS will begin quarterly surveillance and monitoring of the OTP's utilization of this code through CMS and State data analytic tools. The data generated from these reports will inform Medicaid and may result in an audit, updates to the transportation provider's corrective action plans, enrollment issues, further recoupments and possibly a Credible Allegation of Fraud (CAF) referral to the Rhode Island Medicaid Fraud Control Unit (MFCU).

Appendix A

State Opioid Treatment Program Regulations with Audit Results

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Biopsychosocial Assessment	1.6.2	Biopsychosocial Assessment	5%
		A. An assessment of the individual's physical and psychological status and social functioning shall be conducted for each person who is evaluated for admission to the organization.	56%
		1. The following shall be determined and documented through the assessment process:	
		a. The treatment needs and expectations identified by the person served;	81%
		b. The type and level of treatment to be provided;	71%
		c. The need for specialized medical or psychological evaluations;	63%
		d. The need for the participation of the family or other support persons;	78%
		e. Psychological characteristics and mental status exam;	81%
		f. History of and current behaviors associated with risk taking and life-threatening ideation and actions; and	80%
		g. History of and current behaviors associated with alcohol and illicit substance use, or other behavioral health disorders.	82%
		B. Each biopsychosocial assessment shall include an integrated summary that analyzes and synthesizes the findings of the assessment. Formulation of the integrated summary shall include:	30%
		1. A description of the person that includes his or her strengths, aspirations, and concerns related to the proposed treatment;	77%
		2. Formulation and prioritization of the issues for the treatment and a description of the factors that contribute to each issue;	80%
		3. Clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes;	74%
		4. Current multiaxial Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and International Classification of Diseases (ICD) codes, both written and coded; and	35%
		5. For persons assessed in need of substance abuse services, the assessment summary shall include recommendations for a level and type of service based on current American Society of Addiction Medicine's patient placement criteria (ASAM-PPC) criteria.	79%

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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Biopsychosocial Assessment (continued)	1.6.2	C. The preliminary treatment plan and integrated summary shall be developed that includes, at a minimum, the following:	21%
		1. Individualized goals and service needs with consideration of the individual's expectations and desires; and	37%
		2. Identification of preliminary treatment goals and interventions.	23%
		D. The person responsible and the date to be completed shall be documented for each intervention.	23%
		E. The preliminary treatment plan shall be formulated as part of the assessment and shall suffice up to thirty (30) days after the assessment unless other requirements are designated for a specific program.	25%
		F. At least once every twelve (12) months, a review and update of the assessment information and the integrated summary shall be documented. This review/update must be reviewed and validated with the signature of the clinical supervisor within fourteen (14) days of completion. This validation is not required for documents created by licensed clinical staff.	47%
		G. Assessment reviews and updates shall be conducted in face-to face interviews with the individual.	47%
		H. The biopsychosocial assessment shall be rewritten in its entirety, at least every sixty (60) months. This reassessment must be reviewed and validated with the signature of the clinical supervisor within fourteen (14) days of completion. This validation is not required for documents created by licensed clinical staff.	56%
		I. Unless specified otherwise in this Part, staff conducting initial biopsychosocial assessments shall, at a minimum, have the following qualifications with education and experience relevant to the service they are providing:	63%
		1. Licensed Independent Practitioner; or	
		2. Master's Degree with license to provide relevant behavioral health service or with one (1) year post Master's Degree full-time experience providing behavioral health services; or	
		3. Advanced Practice Registered Nurse (APRN) as defined in § 1.3.1(A)(3) of this Part above; or a Registered nurse with either ANCC certification as a Psychiatric and Mental Health Nurse or with one (1) year post RN license full-time experience providing behavioral health services; or Certified Addictions Registered Nurse (CARN); or	

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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Biopsychosocial Assessment (continued)	1.6.2	4. Licensed Chemical Dependency Professional, Certified Co-Occurring Disorder Professional-Diplomate or Certified Alcohol and Drug Counselor; or 5. Certified Co-Occurring Disorder Professional with no less than one (1) hour of individual clinical supervision each month; or 6. Provisional Alcohol and Drug Counselor or Provisional Certified Co-Occurring Disorders Professional with no less than two (2) hours of individual clinical supervision each month; or 7. Master's Degree staff working toward licensure and individuals enrolled in Master's Degree programs working towards Provisional Alcohol and Drug Counselor, or Provisional Certified Co-Occurring Disorders Professional certification, with no less than one (1) hour of individual clinical supervision per week and additional supervision as required by their respective training or licensing programs.	
Person-Centered Treatment Plan	1.6.3	Person-Centered Treatment Plan	
		A. Based on the biopsychosocial assessment, a goal-oriented, recovery-focused individualized treatment plan shall be developed and implemented with each person served.	50%
		B. The treatment plan shall contain the following elements:	
		1. The unique needs, expectations, and characteristics of the person served into an appropriate, personalized, and comprehensive plan;	75%
		2. Written and coded multiaxial DSM diagnoses and/or ICD codes demonstrating a clear connection between the diagnoses, the data and integrated summary documented in the assessment, and the goals and interventions identified on the treatment plan	54%
		3. Written statement of each issue that needs to be addressed;	75%
		4. Observable and measurable long and short-term goals formulated by the person served;	75%
		5. Interventions, services, tasks or supports needed to attain goals:	75%
		a. When and with what frequency each intervention will occur;	75%
		b. The person(s) who will perform each intervention;	75%
		c. Timeframes based on the projected length of time to review progress or to accomplish each specific goal and intervention;	75%

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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Person-Centered Treatment Plan (Continued)	1.6.3	d. A member of the professional staff who has the clinical skills and experience to provide the indicated services must be responsible for the overall development and implementation of the treatment plan. This staff member shall be clearly identified in the plan;	75%
		e. The treatment plan shall be dated and include the signature of the person served and primary provider and, unless the primary provider meets the qualifications in § 1.6(C)(1) of this Part, shall be validated with the signature of the clinical supervisor of the specific service or program. Each staff person's credentials and the date shall be clearly documented with the signature or a statement that the person is unwilling or unable to sign.	73%
		6. Validation shall be recorded no later than two (2) weeks after completion of the plan; and	71%
		7. The treatment plans of individuals receiving services in a CMHC residential or assertive community treatment program require the signature of a psychiatrist.	N/A
		C. A new treatment plan shall be developed at least once every twelve (12) months.	50%
Person-Centered Treatment Plan Review	1.6.4	Person-Centered Treatment Plan Review	
		A. Goals and interventions indicated in the treatment plan shall be reassessed, updated and modified every six (6) months as necessary, and at each of the following events: 1. At the time of the individual's admission to a specific service or program; 2. Upon changes in the individual's condition or level of care; 3. At the time of an internal transfer between programs; 4. When an intervention is completed or a goal attained; 5. When an intervention is not helping the individual 6. Upon the individual's frequent use of crisis intervention services; 7. If an individual refuses services or makes him or herself available for services; and/or 8. At the request of the person served.	23%
		B. The results of the review must be specifically referenced in the treatment plan and shall be: 1. Documented on a supplement to the treatment plan that is clearly labeled "Treatment Plan Review," or 2. Documented in a detailed progress note that is clearly labeled "Treatment Plan Review."	29%
		C. Treatment plan reviews shall be signed and validated according to requirements specified in § 1.6.3 of this Part.	40%

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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Progress Notes	1.6.5	Progress Notes	
		A. The person's current status and progress relative to the treatment plan and the treatment process shall be documented as progress notes in the treatment record.	95%
		B. Progress notes shall be recorded according to a standard charting format.	95%
		C. Progress notes shall provide documentation of relevant events occurring during the individual's course of treatment.	95%
		D. The following shall also be recorded in progress notes:	
		1. Information about the individual's progress in the treatment process;	95%
		2. Duration of service;	95%
		3. Discussions pertinent to the informed decision-making process;	95%
		4. Decisions made by the individual served; and	95%
		5. Cancelled and missed appointments.	64%
Transition/Discharge Summary and Aftercare Plan	1.6.6	Transition/Discharge Summary and Aftercare Plan	22%
		A. An aftercare plan shall be developed in partnership with the individual before a planned discharge and he or she shall be offered a copy of the plan.	67%
		B. The aftercare plan shall include:	
		1. Services to be accessed following transition/discharge;	56%
		2. Activities to sustain the progress made during treatment; and	56%
		3. A crisis plan for the individual to follow after transition/discharge, when indicated.	56%
		C. A summary shall be formulated that records the most significant information regarding the individual's treatment from the time of first contact until services have ended at the time of the person's discharge from services.	100%
		D. The summary shall be completed no later than fifteen (15) working days after the individual's discharge from the organization.	78%
		E. The transition/discharge summary shall include the following:	
		1. Circumstances of the discharge;	100%
		2. Presenting issues;	100%
		3. Current multiaxial Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and International Classification of Diseases (ICD) codes, both written and coded;	78%
		4. All significant findings relevant to the person's treatment and recovery;	89%
		5. Course and progress of treatment;	89%
		6. Outcomes in relation to the identified issues, goals, and treatment;	89%
		7. Recommendations and referrals for further services, if indicated; and	100%
		8. A risk assessment describing the course of treatment prior to discharge.	33%

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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Transition/Discharge Summary and Aftercare Plan (Continued)	1.6.6	F. When a person served is not participating in a particular service or program, the director of such service or program may discharge the person from the program or the organization only when the following conditions have been met:	
		1. The program staff have worked with the person to resolve issues, made appropriate changes in his or her treatment plan, and have documented such efforts;	100%
		2. The program staff have assisted the person to access alternative services; and	100%
		3. The person has been given written notice of the pending discharge and has been informed of his or her right to appeal the decision.	100%
		G. Records shall remain open if it is determined that:	
		1. The individual is at risk for relapse, hospital level care, incarceration, or homelessness without services;	N/A
		2. The person is prescribed medication by the organization and has not been transitioned to new providers; and/or	N/A
		3. The individual has been receiving services through Assertive Community Treatment (ACT) or Integrated Health Homes (IHH) and is scheduled to be incarcerated for six (6) months or less	N/A
		H. When a person served does not participate in a planned discharge, the organization shall:	
		1. Provide information on how to access emergency services and the conditions, if any, of future care from the discharging organization; and	N/A
		2. Provide follow-up contacts after discharge as required by specific programs or by State law.	N/A
Medication Assisted Treatment	1.6.14	Medication Assisted Treatment	1%
		A. Opioid Treatment Program (OTP)	
		10. Person-Centered (Treatment) Planning	30%
		b. Person-centered plans shall be reviewed, revised, and updated every six (6) months.	23%
		c. A new person-centered plan shall be developed at least once every twelve (12) months.	50%
		e. Rehabilitative counseling sessions (individual, group, and family) shall be provided by OTP staff and shall be consistent with the individual's person-centered plan. A minimum of one (1) session per month is required.	30%

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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Medication Assisted Treatment (Continued)	1.6.14	11. Medical Services and Care Coordination	95%
		a. An OTP must maintain a Diversion Control Plan to ensure quality care while minimizing the diversion of an opioid replacement medication from treatment to illicit use.	95%
		b. The following shall be confirmed and documented prior to the initiation of take-home privileges:	95%
		(1) The individual shall receive instructions regarding safety;	95%
		(2) Such instructions shall include but not be limited to, child safety measures and the storage of medications; and	95%
		(3) The individual shall obtain an agency approved locked box for storage of take-home medication.	95%
		c. Each OTP is required to have a Disaster Response policy for each location which should include a coordination of emergency care plan with other OTPs and other necessary facilities to ensure medication delivery in the event of an emergency.	95%
		d. The OTP shall have a written policy describing procedures to be implemented when a person served needs "Courtesy Dosing" while enrolled in an approved treatment program.	95%
		(1) Arrangements for "Courtesy Dosing" shall be made in advance, consistent with federal standards.	95%
		e. Each OTP shall have policies and procedures regarding the discontinuation of any opioid replacement medication that include, at the minimum, the following:	95%
		(1) The OTP physician shall approve all requests for voluntary withdrawal from an opioid replacement medication.	95%
		(2) All withdrawal schedules shall be determined on an individual basis and each individual's progress shall be monitored by OTP staff.	95%
		(3) Withdrawal schedules shall adhere to proper medical guidelines without consideration of financial concerns.	95%

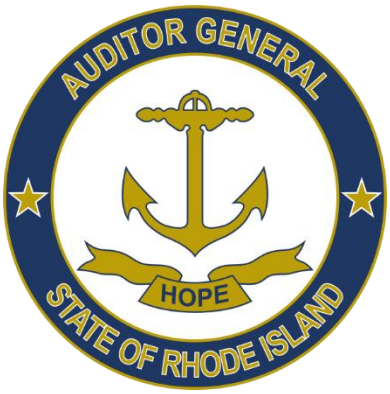
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State Opioid Treatment Program Regulations with Audit Results (Continued)

RI Regulations Title 212, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 10, Licensing and General Administration, Subchapter 10, Behavioral Healthcare Organizations, Part 01, Rules and Regulations for Behavioral Healthcare Organizations

Regulation Topic	Regulation Section	Description of Opioid Treatment Program Requirements	Compliance Percentage
Medication Assisted Treatment (Continued)	1.6.14	f. Medical care, including referral for necessary medical service, and evaluation and follow-up of patient complaints must be compatible with current and prevailing community standards of medical practice.	95%
		g. All patients must receive a medical examination at least annually.	58%
		h. All other medical procedures performed at the time of admission shall be reviewed by the medical staff on an annual basis, and all clinically indicated tests and procedures shall be repeated.	58%
		i. Medical staff shall record the results of this annual medical examination and review of patient medical records in each patient's record.	58%
		j. When an individual is transferred to another program within the organization, the individual's treatment record with completed up-to date documentation shall be transferred to the receiving program.	N/A
Toxicology Screenings	1.6.14	A. Opioid Treatment Program (OTP) 14 Random drug testing shall be conducted as clinically indicated, but no less than eight (8) times/year while an individual remains in treatment.	78%
Counseling Sessions	1.6.14	A. Opioid Treatment Program (OTP) 10. Person-Centered Treatment Planning e. Rehabilitative counseling services (individual, group, and family) shall be provided by OTP staff and shall be consistent with the individual's person- centered plan. A minimum of one (1) session per month is required.	30%

Notes to Appendix A – For OTP regulations with compliance results reported as not applicable,"N/A", the OAG was unable to evaluate the criteria based on the specific circumstances of the sampled cases reviewed.



State of Rhode Island

General Assembly

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