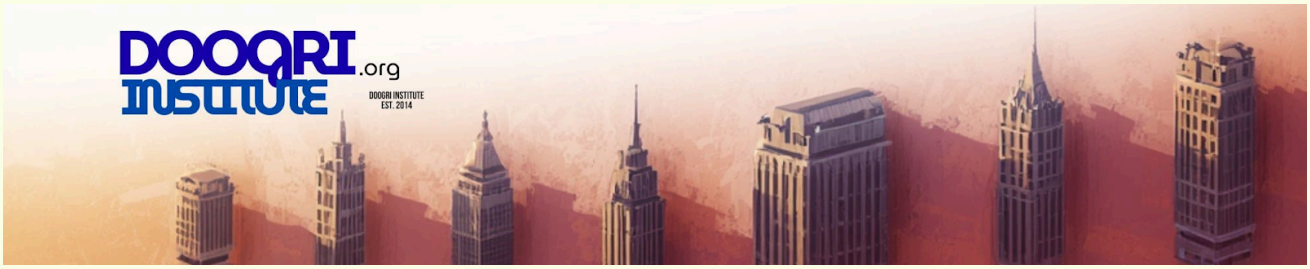


TO:	**Dr. T. March Bell** Inspector General Office of Inspector General (OIG) U.S. Department of Health and Human Services (HHS) Washington, DC **CC:** **Dr. Mehmet Oz** Administrator Centers for Medicare & Medicaid Services (CMS) U.S. Department of Health and Human Services (HHS) **The Honorable Robert F. Kennedy, Jr.** Secretary U.S. Department of Health and Human Services (HHS)
FROM:	**Dr. Henny Kupferstein, Policy Analyst, Doogri Institute**
DATE:	**March 9, 2026**
SUBJECT:	**Pilot Audit Findings:** **Medicaid Autism Services Billing in San Diego County**
RE:	**Request for Federal Scrutiny of California's Medi-Cal ABA Program**

Submission to the Office of the Committee for Senate Health and Senate Human Services: Medi-Cal Program Integrity and Patient Safety Oversight

This submission accompanies a pilot audit report on Medicaid-funded ABA services associated with provider NPIs registered in San Diego County. It relies on the HHS Medicaid Provider Spending dataset, derived from CMS T-MSIS claims data, together with provider registry analysis to identify patterns in registration, billing structure, and claims activity that may indicate program-integrity and patient-safety concerns. The report package includes an executive summary, pilot audit report, and technical appendix, and is based entirely on public data without use of protected health information. Although the dataset was later removed from the public portal pending review, archived copies were used as the basis for the underlying analysis.

The memorandum explains that the California State Senate has clear oversight interests because Medi-Cal is a major state program involving expenditure review, fraud and abuse safeguards, and protection of vulnerable patients, especially children receiving autism services. It also notes that Medicaid oversight is shared with federal authorities, including CMS, HHS-OIG, the FBI, and the Department of Justice, making referral and coordination appropriate where significant billing anomalies are identified. The San Diego pilot is presented not only as a local warning sign—showing address concentration, concentrated payment flows, and billing patterns warranting claims-level verification—but also as a replicable audit model that could be applied across California and other state Medicaid programs.

= $961.54 per hour

This inquiry examines the financial and operational structure of a typical small business reporting approximately **$2 million in annual profits**. Is the revenue level consistent with the business's staffing model, service capacity, and documented hours of work? Assuming a conventional **40-hour workweek across 52 weeks (2,080 hours annually)**, such earnings correspond to an effective revenue generation rate of **approximately $961.54 per hour**. In the context of autism service delivery, often structured around treatment schedules involving approximately **20 children receiving intensive weekly services**—this classic revenue level raises questions about whether the volume of billed services, supervisory capacity, and documented service delivery align with the claims submitted, warranting verification of the underlying service volume and billing practices.

Request for Federal Scrutiny of Medicaid-Funded Autism Service Industry in California

This report urges the **Centers for Medicare & Medicaid Services (CMS)** to designate California as the next state for focused federal scrutiny of Medicaid-funded autism services. Consistent with HHS-OIG Work Plan SRS-A-25-029, particular attention should be directed to **Applied Behavior Analysis (ABA)** and related billing structures. The evidence presented here suggests that California is not facing a narrow compliance problem correctable through incremental industry standardization. Rather, the state illustrates a broader structural failure in federal autism policy: stakeholder-driven insurance and Medicaid mandates transformed a controversial and weakly evidenced intervention model into a reimbursable health benefit, creating a large and durable payment stream now associated with indicators of **waste, abuse, neglect, and potential fraud**.

The central policy error was not simply lax enforcement. It was the decision to treat **intensive behavior-modification services delivered primarily by minimally trained paraprofessionals** as a medical benefit reimbursable through Medicaid and commercial insurance. Beginning with federal coverage clarifications in 2014 and subsequent state implementation decisions, autism diagnoses became gateways to high-intensity behavioral service authorizations. In practice, these programs often operate with **limited supervision, weak outcome accountability, and expansive billing structures**. The resulting system incentivizes volume rather than clinical effectiveness: diagnoses trigger revenue, technician hours generate margin, and supervisory oversight can be reduced to documentation sufficient for billing compliance rather than direct clinical engagement.

The report The Aftermath of SB 805: An Analysis of California's ABA Regulatory and Childcare Licensure Gap was formally served to the California Senate Health Committee, chaired by Senator Akilah Weber Pierson, on February 4, 2026. The report outlined a proposed Corrective Action Plan for California to address systemic waste, fraud, abuse, and neglect within Medicaid-funded autism services. Despite advance notice, no corrective legislative action was implemented prior to the statutory deadlines for the January 2026 legislative session. Earlier warnings contained in our Boondoggle report, submitted in September to Senator Monique Limón, likewise failed to produce legislative intervention.

Our team **conducted on-site inspections** of facilities in San Diego and documented multiple childcare licensing violations within Medicaid-funded ABA service settings. These findings were reported to Assemblymember Mia Bonta, whose district includes many of the inspected operations[1]. In November, we formally requested that the California Human Services Committee amend the state Medicaid plan

[1] The California Department of Health Care Services (DHCS) Medi-Cal Fraud Complaint Intake Unit received and assigned reference # 251219663. California Department of Social Services Community Care Licensing Division Centralized Complaint and Information Bureau (CCIB) call reference is # C11410678M2N6.

to exclude high-risk ABA CPT billing codes, consistent with the mitigation strategy adopted in Idaho to reduce exposure to federal enforcement risk.

The evidence indicates that **regulatory gaps in California** have allowed Medicaid-funded childcare operations—functionally indistinguishable from daycare services and not comparable to any **EPSDT medical benefit**—to proliferate without adequate clinical oversight. The failure to enforce licensure standards and utilization controls has created conditions conducive to large-scale industry fraud exceeding $67 billion in projected exposure.

Given the absence of effective state-level corrective action, the jurisdiction for remediation now falls to the Centers for Medicare & Medicaid Services (CMS). Federal oversight must ensure that Medicaid's statutory requirements function as a federal floor of protection—not a permissive ceiling—and that clinical integrity is preserved through demonstrable medical necessity and program integrity safeguards.

Following our forensic site inspections of ABA clinics advertised to parents in Southern California, San Diego County was selected as a pilot jurisdiction to demonstrate a low-cost, replicable audit protocol using publicly available federal datasets, enabling scalable federal scrutiny nationwide. California represents an appropriate focal point for federal action for three reasons:

- First, claims-linked and provider-registry analysis in San Diego County reveals structural red flags commonly associated with program-integrity risk, including **extreme concentration of National Provider Identifiers (NPIs)** at a small number of commercial addresses, cross-state payment flows through organizational billing entities, layered subcontracting relationships, patterns of impossible or clinically implausible service hours, and substantial billing activity from entities that did not submit ABA-specific CPT codes associated with the services being reimbursed.

- Second, California has expanded behavioral-treatment coverage in ways that **lower the threshold for participation while expanding the scope of reimbursable**

services. Policy changes have removed the requirement that an autism diagnosis be a prerequisite for referral to ABA and have broadened the categories of personnel eligible to deliver billable services, effectively diluting the qualification standards for providers within the reimbursement system.

- Third, California's **scale and influence in national Medicaid policy** mean that failure to intervene here risks normalizing this model across other state programs. Without federal scrutiny, the structural incentives that drive high-volume behavioral treatment billing in California are likely to be replicated elsewhere, amplifying fiscal exposure and patient-safety risks across the Medicaid system.

California represents a **high-priority jurisdiction for targeted federal audit activity** under existing CMS and HHS-OIG program-integrity authorities. This report does **not** recommend that CMS encourage states to further standardize or stabilize the ABA industry. The problem is not that the industry lacks enough rules. The problem is that the industry, as currently constituted, is not recognizable as a legitimate health benefit deserving preservation through technical correction. The evidence now includes both **program-integrity improprieties and documented harms to autistic people**.

Under these conditions, the proper federal response is not rehabilitation of the industry, but containment. The corrective action plan is therefore **not industry repair**. It is **federal interruption, financial containment, and recovery**. Accordingly, this report recommends that CMS pursue a phased federal response centered on:

1. Targeted California audit action,
2. Immediate claims and billing scrutiny,
3. Deferment or suspension of suspect payment streams where authorized,
4. Federal freezes or enhanced prepayment review where warranted,
5. Recovery of improper federal payments, and
6. broader reexamination of ABA embedded in Medicaid design is a public benefit.

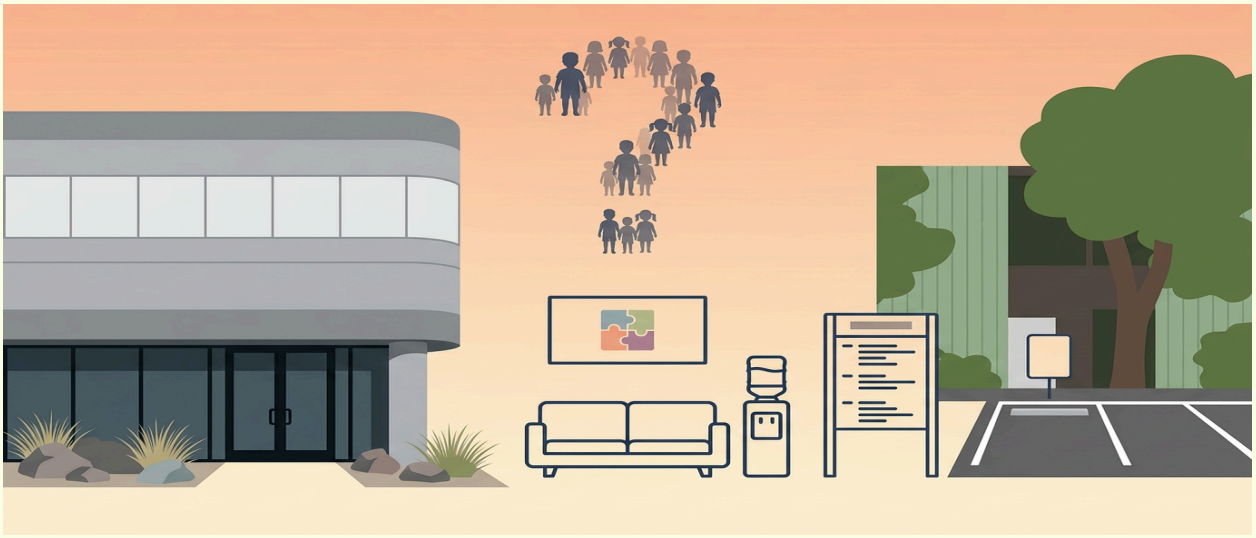
I. Purpose of This Report

This report is submitted to request that CMS initiate heightened scrutiny of California's Medicaid ABA billing and consider California for inclusion in the next phase of federal audit and oversight activity concerning autism-related Medicaid services. The specific purposes are:

1. To present **San Diego County as a pilot audit region** demonstrating scalable indicators of improper billing and structural oversight failure.
2. To explain why California's ABA model presents not only **fraud risk**, but also **waste, abuse, and neglect** risk under established federal oversight taxonomy.
3. To argue that California should not be treated as a jurisdiction needing mere industry standardization, but as a case in which the **benefit design** itself may be unsound.

4. To recommend a federal response centered on **following the money, suspending expansion, freezing suspect payment streams where authorized, and pursuing clawbacks where improper claims are established**.

This report is therefore not limited to a request for claims review. It is also a warning: California should be treated as a **cautionary case study** in what happens when stakeholder activity persuades states to recognize a harmful conversion-oriented intervention model as a health benefit for a vulnerable population.



II. Core Thesis

The principal problem in California is not simply noncompliance within an otherwise legitimate therapy model. The deeper problem is that ABA, as operationalized through Medicaid, appears to have evolved into a billing-driven service architecture in which:

- diagnosis triggers high-hour authorizations,
- technicians generate the bulk of reimbursable volume,
- supervisors function as sparse billable overlays rather than consistent clinical presences,
- multiple provider layers obscure accountability, and
- the child becomes the revenue-generating node through which technician time, supervision time, assessment time, and caregiver training time are all monetized.

This structure creates conditions under which:

- **waste** can occur through overutilization even absent explicit deception,
- **abuse** can occur through coding practices inconsistent with sound clinical standards,
- **neglect** can occur when supervision is nominal rather than real, and

- **fraud** may occur when hours, roles, or service categories are fabricated or misrepresented.

The San Diego findings suggest that these are not isolated defects. They appear to be features of the business model.

III. Why California Merits Immediate Federal Scrutiny

California is a particularly urgent jurisdiction for three reasons.

1. Scale

California operates the nation's **largest Medicaid program**. If serious ABA billing irregularities are present in one county at the levels identified in San Diego, statewide exposure may be substantial.

2. Benefit Design

California's policy choices expanded access to behavioral intervention in ways that appear to have widened the billing surface area. This includes a framework in which children may be funneled into high-intensity behavioral services under broad medical-necessity logic and delivered care by large paraprofessional workforces.

3. Prior Notice and Failed State Corrective Pathways

Formal notice has already been provided at the state level. After exhaustion of legislative timelines and bill deadlines, the present request proceeds on the premise that **state-by-state correction is no longer adequate**. Federal review is now necessary because the problem is not only local administration, but the federally supported continuation of a benefit category that may be causing both fiscal and human harm.

IV. San Diego Pilot Findings

A. Provider Registry Concentration

The San Diego provider registry contains approximately **7,660 behavior technician NPIs** associated with San Diego County. Over **54 percent** of these NPIs are concentrated at ten addresses, including major concentrations at:

- 501 W Broadway Ste 800
- 4719 Viewridge Ave Ste 100
- 5333 Mission Center Rd Ste 110
- 11650 Iberia Pl Ste 130

These are not, on their face, facilities capable of housing the provider volumes reflected by the registry. Site inspection evidence already submitted in this region supports the

conclusion that many such addresses operate primarily as administrative or paper registration points.

Claims linked to these San Diego NPIs account for approximately **$326.1 million in Medicaid payments** during the study period. These payments were traced to 10 billing entities, most of which are not headquartered in San Diego. More than **$175 million** was associated with **out-of-state entitie**s, including organizations in Oregon, Alaska, Ohio, and Florida.

Four entities triggered the highest-risk screening results in the pilot review:

- **ABS Kids** — approximately **$84.6 million** linked to San Diego NPIs, with impossible-hours findings and high per-beneficiary spending.
- **Easter Seals Southern California** — approximately **$49.4 million**, including multiple rendering entities with impossible-hours patterns, one reaching **329.9 hours in a single day-equivalent billing period**.
- **Positive Behavior Supports Corporation** — approximately **$26.4 million**, including impossible-hours findings and predominant use of generic behavioral codes rather than ABA-specific codes.
- **Blue Sprig / Florida Autism Center** — approximately **$8.6 million**, including rapid growth and weak apparent supervision ratios.

The review also identified **six entities receiving a combined $157.1 million** that billed zero ABA-specific CPT codes despite their connection to San Diego behavior technician NPIs. The largest of these, **Central City Concern**, an Oregon FQHC, received approximately **$94.9 million**. This coding pattern does not by itself establish fraud, but it raises substantial questions about service classification, billing structure, and oversight.

B. Medicaid Payment Flows

Claims-linked analysis identified approximately **$326 million in Medicaid payments** associated with these San Diego NPIs. Those funds flow through a limited set of billing entities, including several headquartered outside California.

The significance of this pattern is not simply geographic oddity. It indicates that the nominal local care workforce may actually be embedded in **remote or layered billing** structures that complicate supervision, responsibility, and verification of actual service delivery.

C. High-Risk Entity Patterns

Among the entities linked to San Diego NPIs, several showed patterns consistent with elevated program-integrity concern, including:

- high-volume paraprofessional billing,

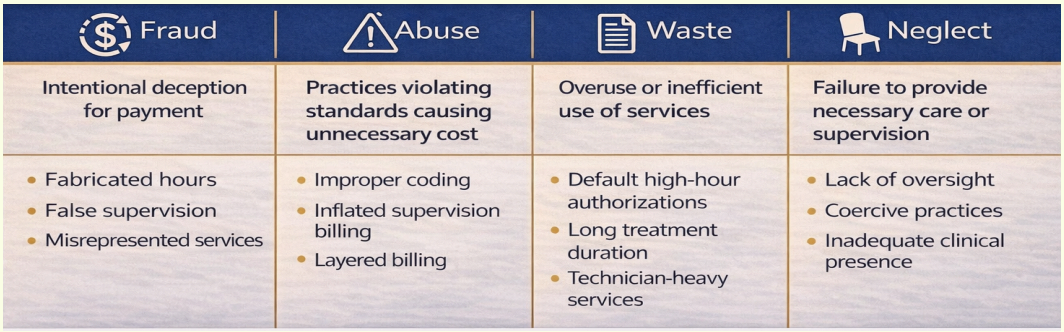
- nominal supervision,
- opaque provider layering,
- overutilization incentives,
- documented harm concerns,
- and repeated signals of impropriety

D. Network Structure

Network analysis identified a large interconnected provider cluster, indicating that many apparently separate providers may in fact operate through overlapping administrative and billing infrastructure. This is relevant because it suggests that what appears as a dispersed service market may function as a small number of coordinated reimbursement systems.

V. Oversight Taxonomy: Waste, Fraud, Abuse, and Neglect

Federal oversight frameworks distinguish between four categories. The most important point for CMS is that **California ABA may implicate all four categories at once**. This is not a case where only fraud matters. Even where fraudulent intent is not immediately provable, the service model can still generate large-scale waste and neglect. That matters because CMS does not need to wait for criminal findings before addressing a structurally unsound reimbursement category.



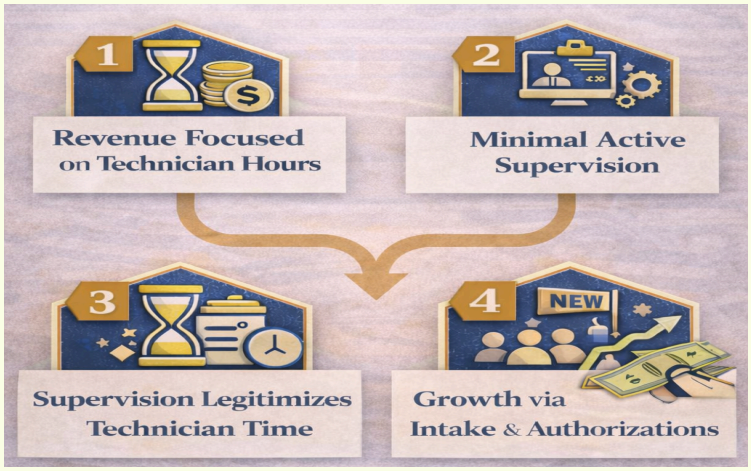
VI. The Ponzi Structure of Supervision

A central structural feature of the current ABA industry is what this report describes as a **Ponzi-like supervision model**. Technician-delivered services generate the majority of billable hours, while supervision is documented through billing codes submitted under a supervising BCBA's NPI. In practice, the presence of these codes can serve primarily as

administrative evidence that supervision occurred, regardless of the extent of direct clinical involvement.

This billing documentation also functions as **proof of Medicaid reimbursement viability for private investors**. Private equity and franchise operators increasingly rely on Medicaid claims data demonstrating technician billing under supervisory NPIs to justify expansion capital. In effect, technician billing tied to a supervisor's credential not only legitimizes reimbursement but also **signals to investment markets that additional BCBAs should be funded to scale new franchise locations**, further expanding the technician-based service model.

For purposes of federal oversight, the key point is not the metaphor itself but the operational consequence: **supervision appears to be the mechanism by which massive volumes of lower-cost labor are converted into reimbursable medical claims**. If that supervisory layer is thin, nominal, or retrospective, the entire benefit structure becomes unstable.



VII. Why This Report Does Not Recommend "Industry Standardization"

This report does not recommend that California respond by further standardizing or legitimizing ABA through more detailed state regulation alone.

That approach would be inadequate for three reasons.

1. It assumes the benefit is fundamentally sound

Standardization presumes that ABA is a stable health service whose defects lie in administration. The evidence summarized here raises a more basic question: whether the intervention, as scaled through Medicaid, is appropriately classifiable as a medical benefit at all.

2. It risks entrenching a harmful structure

Where the underlying service model is coercive, compliance-focused, technician-heavy, and associated with substantial reports of harm from autistic people, additional regulation may simply stabilize the revenue model rather than protect patients.

3. It places too much burden on state legislatures

The record in multiple states suggests that lawmakers are vulnerable to stakeholder pressure, provider lobbying, and insurance-mandate narratives that present ABA as the unquestioned standard of care. The result has been expansion first, oversight later.

In other words, this is no longer just a matter of correcting an industry. It is a matter of deciding whether federal Medicaid should continue underwriting it in its present form.

VIII. Patient Safety and Human Harm

This report is not limited to billing anomalies. It also proceeds from the position that **program integrity and patient safety are linked**. The current ABA structure raises patient-safety concerns because:

- autistic people have reported trauma, coercion, and long-term psychological harm associated with intensive behavioral conditioning,
- young children cannot meaningfully consent to high-intensity compliance-based treatment,
- family pressure and institutional norms often frame refusal of ABA as neglect, and
- outcome systems rarely capture harms such as masking, distress, loss of autonomy, or mental-health deterioration.

CMS need not resolve every debate about ABA outcomes to recognize that a benefit associated with both **credible reports of harm** and **credible indicators of billing impropriety** warrants a more protective federal stance. This is especially true where the vulnerable population is children and where the services are publicly financed.

IX. California as a Cautionary Federal Case

California should be treated as a cautionary example of what happens when:

- stakeholder advocacy compels insurance recognition of a contested intervention,
- policymakers frame that intervention as medically necessary without robust safety architecture,
- federal Medicaid pathways support expansion, and
- oversight arrives only after harms and financial irregularities are already embedded.

From that perspective, California is not merely another state to audit. It is a case study in how federal programming, state benefit design, and commercial-professional interests can together build a durable channel for both **financial extraction and coercive intervention**.

X. Recommended Federal Actions

This report recommends a phased federal response centered on financial containment and recovery, not industry repair. CMS, in coordination with OIG and other relevant authorities, shall consider the following actions.

1. **Designate California for immediate heightened scrutiny of Medicaid ABA billing.** California should be named as the next jurisdiction for focused review of Medicaid ABA billing integrity, with San Diego County serving as an initial pilot region.
2. **Conduct claims-level audit and validation.** Review should include: actual service delivery verification, rendering-versus-billing entity analysis, supervision verification, code-pairing and concurrency review, cross-service overlap review, and medical-necessity review for high-hour authorization patterns.
3. **Freeze expansionary assumptions**. CMS should not encourage California to merely expand or normalize ABA infrastructure while these concerns remain unresolved.
4. **Consider deferment or federal payment controls where authorized**. Where federal law and program authority permit, CMS should consider targeted deferment, suspension, or heightened prepayment review mechanisms for high-risk billing streams pending validation.
5. **Pursue clawback review**. Improper federal financial participation should be identified and recouped where warranted.
6. **Reassess the benefit category itself.** CMS should examine whether diagnosis-triggered, high-volume ABA reimbursement as presently structured remains appropriate for federal support, especially where the intervention's evidentiary and safety foundations are contested.

XI. Replicability of the San Diego Protocol

The San Diego pilot is not merely evidentiary; it is methodological. The protocol used here can be applied to any ZIP code or state using:

- NPI registry analysis,
- Medicaid spending data,
- address normalization,
- network mapping,
- concurrency and utilization screens, and
- targeted site inspection.

This means California is both an urgent case and a scalable model for broader federal oversight. The complainant intends to continue submitting region-specific patterned analyses using the San Diego pilot structure. But the central request of this report is that CMS not wait for piecemeal state correction. The available evidence now supports direct federal intervention.

XII. Closing Position

The question before CMS is no longer whether ABA billing can be made somewhat cleaner around the edges. The question is whether federal Medicaid should continue supporting a service architecture that appears to combine high-volume paraprofessional billing, nominal supervision, opaque provider layering, overutilization incentives, documented harm concerns, and repeated signals of impropriety.

This report submits that ***the answer should be no***. The appropriate corrective action at this stage is not industry stabilization, but **federal scrutiny, targeted restraint, and financial recovery where warranted**.

California should be next.

Supporting materials: Full complaint, methodology summary, and source documentation available upon request. No PHI was accessed. All cited figures are sourced to public datasets and source records identified in the appendix.

[End of Report]