Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

North Dakota Comprehensive Program Integrity Review

Final Report

February 2012

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the North Dakota Medicaid Program. The MIG review team conducted the onsite portion of the review at the North Dakota Department of Human Services (DHS) offices. North Dakota does not have a Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the Medicaid Program Integrity (MPI) area within the DHS Medical Services Division (MSD), which is responsible for Medicaid program integrity activities. This report describes one noteworthy practice, thirteen regulatory compliance issues, and two vulnerabilities in the State's program integrity operations. While North Dakota has addressed many of the issues identified in MIG's 2008 review, the State's overall program integrity efforts are inadequate. CMS looks forward to helping the State strengthen its program integrity operations.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help North Dakota improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of North Dakota's Medicaid Program

The DHS MSD administers the North Dakota Medicaid program. As of January 1, 2011, the program had 63,924 beneficiaries enrolled in fee-for-service (FFS). North Dakota also has a primary care case management system and a Program of All-Inclusive Care for the Elderly serving Medicaid beneficiaries.

At the time of the review, the State had 3,901 providers participating in the FFS program. Medicaid expenditures in North Dakota for the State fiscal year (SFY) ending June 30, 2011 totaled $252,051,286.

Medicaid Program Integrity Division

The MPI Unit, within the DHS, is the organizational component dedicated to fraud and abuse activities. The MPI Unit was created on March 1, 2011, following a realignment that brought together the surveillance and utilization review subsystem (SURS), provider enrollment, and third party liability units. At the time of the review, MPI had eight authorized staff consisting of six full-time staff and two positions for temporary employees focusing on Medicaid program integrity. One of the two temporary positions was vacant at the time of the review. The table below presents the total number of investigations, administrative actions and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary & Full Investigations*	Number of State Administrative Actions or Sanctions (Approximation)	Amount of Overpayments Identified	Amount of Overpayments Collected
2007	1	0	$0	$0
2008	1	1	$19,120	$0**
2009	1	0	$0	$0**
2010	15	2	$85,739***	$64,072

*Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation. Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
** Recoveries still pending from the one case investigated in 2007.
*** The $85,739 represents the total from provider self-audits. The $64,072 was collected from one MPI provider self-audit, while $21,667 is the pending recovery from another provider self-audit.

Methodology of the Review

In advance of the onsite visit, the review team requested that North Dakota complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of April 4, 2011, the MIG review team visited the MSD office. The team conducted interviews with numerous officials including staff from the Office of the State Auditor (OSA) and MPI, staff responsible for non-emergency medical transportation (NEMT) oversight, and a transportation service provider. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the North Dakota MPI. North Dakota's Children's Health Insurance Program (CHIP) operates both a Medicaid expansion program under Title XIX of the Social Security Act and a stand-alone program under Title XXI of the Social Security Act. The stand-alone portion of CHIP was, therefore, not included in this review.

The State's expansion CHIP operates under the same billing and provider enrollment policies as the State's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid program also apply to the expansion CHIP.

Unless otherwise noted, North Dakota provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information provided.

Results of the Review

Noteworthy Practices

As part of its comprehensive review process, the CMS review team has identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Mandatory enrollment of qualified service providers and qualified service provider agencies

According to MSD Home and Community Based Services (HCBS) staff, all personal care assistants (PCAs) and the agencies that employ them must enroll in the Medicaid program. In North Dakota, PCAs and PCA agencies are referred to as qualified service providers (QSPs). All individual QSP applicants are screened against the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), State Sex Offender Registry, District State Court, Certified Nurse Aide registry, and the Board of Nursing websites for offenses and/or exclusions.

Individuals and agencies applying to become QSPs must complete the same provider agreement and ownership and control disclosure information as FFS providers. The QSP agencies are screened by HCBS staff and QSP agencies must then screen individual QSPs using the same websites listed above along with a check to verify exclusion status annually.

However, the State is not properly checking for exclusions on its own as noted later in the Regulatory Compliance Issues section of this report.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding identifying, investigating and referring fraud cases, monitoring of program integrity functions, payment suspensions, disclosure requirements, exclusion searches, False Claims Act requirements, and reporting of adverse actions.

North Dakota does not have methods for the identification, investigation, and referral of suspected fraud cases.

The regulation at 42 CFR § 455.13 requires a State Medicaid agency to have methods and criteria for identifying suspected fraud cases and investigating those cases, and to have procedures for referring suspected cases of fraud to law enforcement officials.

The Federal regulation at 42 CFR § 455.14 requires State Medicaid agencies that receive complaints of Medicaid fraud or abuse to conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

The Federal regulation at 42 CFR § 455.15 requires State Medicaid agencies to refer suspected cases of provider fraud to the MFCU, or, in States with no certified MFCU,

conduct a full investigation or refer the matter to an appropriate law enforcement agency.

During an interview, the OSA reported that over the past three Single State Audits (SSA) of the DHS, the MSD has stated that there is limited fraud in North Dakota. The OSA report titled "Single Audit Report (SAR) fiscal year ended June 30, 2010 and 2009" indicated that this belief is pervasive throughout DHS management, and that DHS has failed to provide adequate resources to the SURS unit. The OSA report also indicated that DHS has not provided sufficient training to employees so they can adequately identify and investigate fraud and abuse.

During interview, MPI staff reported that MPI does not conduct significant preliminary investigations in relation to provider fraud due to staffing limitations, and that very little is done in the area of fraud detection. Moreover, identified cases of potential fraud are not pursued due to lack of staff to investigate the cases. While North Dakota is pursuing beneficiary fraud, with more than 250 beneficiaries in the lock-in program, the State does not demonstrate as much dedication to provider fraud and abuse investigation. The MPI section does not have any full-time investigators to pursue provider fraud and abuse.

The MPI conducts very few preliminary investigations in relation to provider fraud. The MPI reported referring a total of 14 cases of provider fraud to the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) in the last 4 SFYs. Closer inspection revealed that 11 of those cases were related to QSPs. The 11 cases represent preliminary investigations conducted by HCBS staff, not MPI. The MPI reported three cases of provider fraud and abuse for the last four SFYs, and two of these cases were the result of provider self-audits. In addition, all cases of suspected fraud and abuse must be vetted by the State Medicaid Director (SMD) who makes the final decision regarding whether the case is forwarded to HHS-OIG for a full investigation. The State currently has a waiver that allows it to function without establishing a MFCU. The State refers its cases to the HHS-OIG in lieu of a MFCU.

Because the State is conducting very few preliminary investigations, it is not determining if allegations of fraud are credible and therefore the State cannot implement a payment suspension under 42 CFR § 455.23, when appropriate, and refer the case to law enforcement. As previously mentioned, the State reported it does not have sufficient staff to conduct full investigations.

The OSA SAR also cited MPI for not having sufficient methods for investigating and reporting provider fraud and abuse. The report cited instances where MPI was aware that provider billing practices were not in compliance with MPI billing policy through provider self-audits. The MPI recovered the money in question but did not sample or extrapolate to investigate further billing errors and/or overpayments. The review team concurs with OSA's SAR. The MIG review team's sampling of case files confirmed that the MPI did not conduct an investigation into two provider self-audits with identified overpayments.

As of the date of the MIG review, MPI had referred three cases of suspected provider fraud to HHS-OIG in the last four SFYs. In addition, MPI has conducted very few provider audits in the last four SFYs. The MPI reported recoveries of $0 from SFYs 2007 to 2009 and $64,072 (from provider self-audits) for SFY 2010. The MPI staff reported conducting 703

desk and field audits in the last four FFYs. However, HCBS conducted 525 of the 703 audits, while SURS conducted a total of 13 desk and field provider audits.

Recommendations: Develop and implement comprehensive processes to comply with program integrity regulations 42 CFR §§ 455.13-455.15. Develop and implement a comprehensive tracking system to document all program integrity activities such as preliminary investigations, referrals to law enforcement, recoveries from MPI activities, and sanctions. Review the OSA findings in order to develop and implement the necessary corrective actions.

North Dakota is not performing fundamental program integrity functions.
The Federal regulation at 42 CFR § 456.4 requires that the State agency must: (1) monitor the statewide utilization control program; (2) take all necessary corrective action to ensure the effectiveness of the program; (3) establish methods and procedures to implement this section; (4) keep copies of these methods and procedures on file; and (5) give copies of these methods and procedures to all staff involved in carrying out the utilization control program.

The Federal regulation at 42 CFR § 456.6 requires that the State Medicaid agency must have an agreement with the State health agency or other appropriate State medical agency, under which the health or medical agency is responsible for establishing a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services. The purpose of the review plan is to provide guidance to the Medicaid agency in the administration of the State plan.

The Federal regulation at 42 CFR § 456.22 requires that the State Medicaid agency must have procedures for the on-going evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services.

Although State staff indicated that North Dakota has a program in place to monitor the utilization program (consisting of the SURS administrator, a SURS analyst and two coders who are not MPI staff), the State does not have written policies or procedures to monitor the statewide utilization control program. The State program integrity director indicated that the SURS analysts spend most of their time working on the beneficiary lock-in program.

The OSA SAR for SFYs 2010 and 2009 issued several recommendations for corrective actions related to staffing, hiring or training of existing staff including the SURS administrator, development of a sampling plan for audits, improved risk analysis and identification, and tracking of provider overpayments. Based on interviews and documents reviewed by the MIG review team, the State MPI section has not implemented all of the corrective actions recommended to address the concerns of the audit. During the OSA interview, it was reported that audits have revealed repeat findings that continue to go uncorrected.

For example, the finding 10-13 from the OSA SAR, SURS Administrator Qualifications, was also noted in the Federal fiscal year (FFY) 2007-2008 SSA report. The report indicated that “Section N of the OMB A-133 Compliance Supplement for the Medicaid

Program requires auditors to consider the qualifications of the personnel conducting the reviews and identifying suspected fraud. The auditor is to ascertain that the individuals possess the necessary skill or knowledge. As the current administrator does not possess the necessary qualifications to conduct reviews, the auditor determined there is a high risk that significant instances of fraud are occurring within the program and going undetected". The MIG review team noted that the SURS administrator has neither attended nor is scheduled to attend training relevant to the work of SURS to ensure adequate attention is given to work such as reviewing claims and investigating Medicaid fraud. The Medicaid Integrity Institute continues to offer training to State Medicaid staff at no cost to the State.

The finding 10-17 from the OSA SAR, Provider Licensure Requirements, was also noted in FFY 2005-2006 and FFY 2007-2008 SSAs. The finding addresses concerns with the risk of paying ineligible providers due to lack of current information in provider files and lack of health and safety reviews of all providers. The MIG review team noted that State does not have an adequate mechanism in place to receive real-time licensure information to ensure providers with restrictions or other issues are not enrolled or paid. Both during and after the onsite review, the MIG review team had great difficulty obtaining a consistent set of numbers from the MPI related to provider referrals, audits, and overpayments. The MPI SURS staff does not have an adequate recordkeeping system in place to track these activities. MPI SURS uses a spreadsheet for tracking. However, the MIG review team noted that the State had difficulties retrieving information from its spreadsheet.

The interdepartmental agreement that MPI provided as evidence of compliance with 42 CFR § 456.6 is dated 1975 and does not cover the scope of the regulation. The agreement states that it can be amended by the parties at any time, yet the State did not produce evidence of any amendments in the last 36 years. The agreement speaks to facility licensing requirements and a plan to form an interdepartmental survey team composed of individuals from the State Social Services Board, the State Fire Marshall's office and the State Department of Health to survey facilities for compliance with State licensing requirements. The regulation requires review by professional health personnel. The agreement does not speak to how the interdepartmental team will address the appropriateness and quality of Medicaid services rendered. The State program integrity director reported that the interdepartmental team was never formed.

The State does not have a policy or procedure for a sample basis evaluation of services as required by 42 CFR § 456.22.

Recommendations: Develop and implement policies and procedures to monitor the statewide utilization control program. Develop and implement a plan to ensure that MPI has adequate staff to review and assess complaints and other credible evidence of fraud. Develop an effective process to ensure ongoing review of real-time licensure information and evaluation for the need for quality and timely Medicaid services. Update the interdepartmental agreement to include the provisions of the regulations and ensure the agreement is fully implemented. Review the OSA findings in order to develop and implement the necessary corrective actions.

North Dakota's notice of payment suspension does not include all required information.

The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of suspension requires that payments are suspended in accordance with the Federal regulation.

The suspension letter that MPI utilizes to notify providers of the suspension of payments in cases of fraud does not meet the requirements of 42 CFR § 455.23(b) because there is no reference to the Federal regulation.

Recommendation: Modify the notice of suspension letter by adding the required language in accordance with this regulation.

The State does not capture all required ownership, control, and relationship information for its FFS and NEMT programs. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

In the 2008 MIG program integrity review, North Dakota was cited for not complying with 42 CFR § 455.104 because neither the provider enrollment questionnaire nor the provider agreement captured the names of individuals with ownership or controlling interest in the disclosing entity or providers or related subcontractors, their relationships, or the identity of other disclosing entities in which these individuals have an ownership or controlling interest for all provider types. The names were corrected satisfactorily on the revised Ownership/Controlling Interest and Conviction Information form for FFS and NEMT providers. However, the revised form still does not solicit the name of any other disclosing entity in which a person with ownership or control interest in the disclosing entity also has an ownership or control interest as required under 42 CFR §455.104 (a)(3). The State's Ownership/Controlling Interest and Conviction form only asks about controlling interest in another State Medicaid provider.

As of March 25, 2011, State agencies must capture Social Security Numbers (SSNs) and dates of birth and enhanced address information for all persons with an ownership or

control interest in providers seeking enrollment in a State Medicaid program. The State's Ownership/Controlling Interest and Conviction Information, State form number (SFN) 1168, requests either the provider's SSN or date of birth, not both. It requests address information, but there is no indication that the enhanced address information as required by the regulation as amended is necessary.

The State has commercial and private NEMT entities providing transportation services to beneficiaries. During the enrollment process, the State does not collect necessary ownership and control information in accordance with the regulation for NEMT entities prior to enrollment into the Medicaid program.

Recommendations: Modify enrollment forms to collect information regarding any other disclosing entity, as well as both the SSNs and dates of birth of persons with ownership or control interests in the disclosing entity. Modify the enrollment forms to collect the following address information for corporate entities with ownership or control interests in providers: primary business address, every business location, and P.O. Box address. Develop and implement policies and procedures to ensure the collection of required ownership, control, and relationship information from NEMT entities. Obtain necessary disclosures from NEMT entities.

North Dakota does not require FFS providers to disclose business transaction information, upon request. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

In the 2008 MIG program integrity review, North Dakota was cited for not complying with 42 CFR § 455.105 because it did not require provision of business transaction information, upon request, during the FFS enrollment process. This issue was corrected on forms used for most FFS providers. However, the State uses SFN 1169 as the provider agreement for pharmacy providers and SFN 308 for basic care providers. These forms do not contain the language that the provider agrees to submit to State or the Secretary, within 35 days of the date of the request, information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous 12 month period and any significant business transactions between the provider and any subcontractor during the 5-year period ending on the date of the request.

Recommendation: Modify or amend pharmacy and basic care provider agreements to require disclosure of business transaction information upon request.

North Dakota does not require disclosure of health care-related criminal convictions for its FFS and NEMT programs. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on

request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

In the 2008 MIG program integrity review, North Dakota was cited for not complying with 42 CFR § 455.106 because the provider enrollment packages did not request criminal conviction information for owners, persons with control interest, agents, or managing employees of the provider. The current Medicaid Ownership/Controlling Interest and Conviction Information form (SFN 1168) used for the FFS and NEMT programs does not ask for the identity of any person who has an ownership or control interest in the provider and does not include the identification of criminal conviction offenses related to Medicare and Title XX programs since the inception of the programs.

North Dakota has no policy and procedure for notifying HHS-OIG of any disclosures within 20 working days from the date it receives the information.

Recommendations: Modify the FFS and transportation provider enrollment forms to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement policies and procedures to report criminal conviction information to HHS-OIG within 20 working days.

North Dakota does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

Effective March 25, 2011, the Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the HHS-OIG's LEIE and the General Services Administration's EPLS no less frequently than monthly.

The State collects ownership and controlling interest information on SFN 1168. However, the State only checks the name of the provider at enrollment and not all names listed on the form against the LEIE and the Medicare Exclusion Database (MED), and does not check those databases monthly for all enrolled FFS and NEMT providers.

Recommendation: Develop policies and procedures for appropriate collection and maintenance of disclosure information about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the MED) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded person or entities.

North Dakota has not complied with the State Plan requirement to review providers' policies and employee handbooks pertaining to the False Claims Act.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of

these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

North Dakota State Plan Amendment 4.42 was approved by CMS on June 25, 2007 with an effective date of January 1, 2007. The State indicated that the required notices were sent to providers on April 6, 2007. The State provided attachment 4.42-A of its State Plan Amendment which assures that the State Medicaid agency will maintain an annual listing of the identified entities, copies of all notifications, and each entity's written assurance of compliance. The attachment also states that the Department will review an entity's policies and procedures for detecting and preventing fraud, waste and abuse during routine and random SURS reviews. At the time of the review, the State could not provide an annual listing of identified entities or any evidence that entities have been subject to any SURS reviews. Also, the State reported that the provider responses that were received by MPI have not been reviewed by MPI staff.

Recommendation: Develop and implement policies and procedures to ensure the collection and review of False Claims Act information in accordance with the North Dakota State Plan.

North Dakota does not report all adverse actions taken on provider applications for participation in the Medicaid program. (Uncorrected Partial Repeat Finding)
The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

In the 2008 MIG program integrity review, North Dakota was cited for not complying with 42 CFR § 1002.3(b)(3) because it did not collect managing employee information and did not report all adverse actions to HHS-OIG. The current issue is that the State does not report to HHS-OIG when the State has disenrolled a provider or whenever a provider voluntarily disenrolls from the Medicaid program to avoid a sanction.

Recommendation: Develop and implement policies and procedures to report to the HHS-OIG any adverse actions that the State or its contractors take on a provider's application for participation.

Vulnerabilities

The review team identified two areas of vulnerability in the State's practices. These are related to the absence of written policies and procedures and indirect routing of fraud referrals.

Not having written policies and procedures for all program integrity functions.
Under the regulation at 42 CFR § 455.13, the State Medicaid agency must have methods and criteria for identifying and investigating suspected fraud cases. The regulations prescribe additional requirements for the effective functioning of the States' Medicaid program integrity operations. The State has no written policies and procedures for

program integrity functions, but reported that it was in the process of developing policies and procedures that would cover program integrity and provider enrollment operations for the FFS program. The absence of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or provider enrollment staff.

Recommendation: Develop and implement policies and procedures covering all program integrity processes to ensure compliance in accordance with Federal regulations.

Indirect routing of fraud referrals to HHS-OIG.
As mentioned earlier in this report, all cases of suspected fraud and abuse must be vetted by the North Dakota SMD who makes the final decision regarding whether the case is forwarded to HHS-OIG for a full investigation. The process of routing cases of suspected fraud to the SMD for approval was confirmed by the MIG review team as the continued practice for MPI. The State identified case files suspected of fraud for the review team to sample. One of the case files was unavailable for the team to review. The review team was informed that it was pending review by the SMD.

The OSA SAR determined that the North Dakota SMD's direct involvement with several of the processes that are required by a program integrity department is interfering with how effectively and efficiently the department conducts its operations. The OSA SAR noted that "The Medical Services Division Director is involved in the process of determining areas to be reviewed by DHS. The Director also receives the results of reviews and investigations. The Director is responsible for determining the actions to be taken following a review or investigation. In review of actions taken with providers who had submitted inappropriate billings, we identified DHS would recoup Medicaid funds in most instances. However, instances were identified where a determination was made not to recoup Medicaid funds even though the Medicaid funds were expended inappropriately."

Recommendations: Develop and implement policies and procedures for immediately referring all cases of suspected fraud to HHS-OIG for determination of fraud and assessment to determine if cases require administrative actions only. Review the OSA findings in order to develop and implement the necessary corrective actions.

Conclusion

The State of North Dakota applies one noteworthy practice that demonstrates program strengths and the State's commitment to program integrity, regarding mandatory enrollment of PCA providers and PCA agencies. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of thirteen areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, two areas of vulnerability were identified. The CMS encourages the State to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of North Dakota will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If DHS has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of North Dakota on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from North Dakota
April 2012

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April 4, 2012

Ms. Angela Brice-Smith, Director
Center for Program Integrity
Center for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Brice-Smith:

Enclosed is the North Dakota Medicaid formal response to the Final Report published by the Medicaid Integrity Group for the North Dakota Medicaid Program Integrity Unit based on the results of the on-site review that was conducted the week of April 2, 2011.

The North Dakota Department of Human Services recognized the importance of Medicaid Program Integrity (PI) and in 2012 created a Program Integrity Administrator position and over the past year has assembled a PI unit to build a strong PI effort within the Medical Services Division. Provider Enrollment, Surveillance Utilization Review Section (SURS) and Third Party Liability (TPL) are now part of the Program Integrity Unit. This reorganization allows the Medical Services Division to better address and control elements unique to Medicaid Program Integrity.

Dawn Mock was assigned as the Program Integrity Administrator of the newly organized PI unit on March 1, 2011 and this review was conducted after one month of her working in that capacity. The unit was authorized an additional full time employee (a Program Integrity Audit Coordinator) effective January 1, 2012 and was granted funding for an additional SURS analyst position effective January of 2013. The PI unit continues to make strides in process improvements, policies and auditing practices. During the past two years Medicaid programs have seen additional requirements in terms of MIC, RAC, provider enrollment and screening and other program integrity efforts.

The Department of Human Services strongly believes that program integrity is everyone's responsibility and the Medical Services Division views it as a collaborative effort that is not confined to the PI unit but shared by all of the Division staff. The Department has demonstrated its commitment to PI and will continue to improve practices to protect the integrity of the Medicaid program.

The Program Integrity Review Corrective Action Plan is enclosed. Please feel free to contact Dawn Mock if you have any questions. She can be reached at dmock@nd.gov or 701-328-4895.

Sincerely,

Maggie Anderson
Medicaid Program Director.

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